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Taking Stock: World Bank Experience with Results-Based Financing (RBF) for Health

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This paper provides a summary of "Taking Stock: World Bank Experience with Results-Based Financing (RBF) for Health which is posted on this website. This summary describes the rationale for the exercise, methods used, major findings, and lessons learned from the review of World Bank project documents.

Introduction

Results-Based Financing (RBF) for health is a cash payment or non-monetary transfer made to a national or sub-national government, manager, provider, payer, or consumer of health services after predefined results have been attained and verified. Payment is conditional on measureable actions being undertaken.

This paper reviews HNP project lending to identify the extent and nature of World Bank support for RBF for health in order to draw lessons for strengthening design, implementation, monitoring and evaluation of Bank projects with RBF activities in the future. This review addresses the following questions:

- What policy or health system issues were RBF mechanisms trying to address in countries?
- What are the scale, scope and types of RBF mechanisms that have been supported by the World Bank across regions?
- Who are the beneficiaries of RBF mechanisms and to what extent are the needs of the poor being addressed?
- What type of lending instruments has been used and what is the level of World Bank lending for RBF?
- What were some of the design features of the RBF mechanisms?
- What has been the experience with monitoring and evaluating RBF mechanisms?
- What results have been achieved in these projects?
- What have been the challenges in the design and implementation of RBF mechanisms?
- What are the lessons learned from the review of projects, and what are the prospects for sustainability?
- What are some recommendations for the way forward for the World Bank on RBF?

This review is expected to provide useful information for Bank staff interested in supporting countries in the design, implementation, monitoring and evaluation of RBF operations; and, to establish a baseline for monitoring progress in implementing the HNP Strategy, *Healthy Development: The World Bank Strategy for Health, Nutrition and Population Results* (2007).

Methods

The starting point for the review was all closed and active World Bank lending operations in the HNP sector approved by the Board between FY95 and FY08 that were classified as having a primary health system performance theme (code 67).[1] Projects with this code include pro-

1 Bank Health, Nutrition, and Population (HNP) lending and sector work is classified by the task manager into one of the following primary

Table 1: Results-Based Financing Mechanisms Used in the Review of Bank HNP Projects

Recipients	RBF Mechanism	Behavior Change
National Government	Transfer of a portion of the loan or grant on the basis of verified achievement of health targets from a set of pre-specified indicators	National government puts in place the necessary policy framework and programmatic support to achieve results.
Ministry of Health Administrative Levels (entities that manage, support, and supervise delivery of services at central, provincial, district levels, and/or their managers)	Portion of budgets or performance bonuses received at sub-national administrative levels contingent on achievement of pre-agreed performance targets often codified within a contracted arrangement. Sub-national administrative levels often have performance agreements with health facilities.	Central, provincial, and/or district level managers have an incentive to support achieving results and to organize their planning, budgeting, supervision and monitoring systems accordingly
Health Insurance Entities	Payments made to health insurance entities conditional on their meeting pre-agreed targets for numbers of new enrollees per period.	Health insurance entity organizes itself to meet coverage targets
Health Facilities (entities that deliver services, such as hospitals, health centers and clinics, group practices, public and private sector, including NGOs)	Payments made to health facilities (fee-for-service or target-based payments) on the basis of providing an agreed-upon type, level, and quality of services. Payments are retained in the health facility to improve quality of services and performance.	Facility organizes itself to deliver services and/or meet performance targets and achieve results to receive payment or bonuses.
Health Care Workers (individuals, managers, or the team as a whole)	Payments (performance bonuses or in-kind rewards) made to individual health workers, managers, or to teams of health workers on the basis of services provided or achieving/ exceeding pre-agreed targets and results between the health facility and the health worker(s).	Health workers motivated to provide specified types and quality of services, and to be present at the facility
Community-level organizations	Payment provided to community-level organizations conditional on achievement of results spelled out in agreements between the community and the health facility or other administrative level in the government.	Community groups solve problems and organize themselves and community members to achieve results
Households	Financial payments made to households as a welfare transfer conditional on household members utilizing specific health and education services (CCTs)	Households are motivated to seek and use services to receive the welfare transfer that has both a price effect (the cost of seeking care and the opportunity cost of time is wholly or partially subsidized) and an income effect (transfer is large enough to affect household income and alter intra-household resource allocation toward healthier consumption)
Consumers/patients	Payments made to an individual through a voucher, one-time cash payment (CCP) or in-kind payment conditional upon use of specific health service (e.g., institutional deliveries) or to complete a specific treatment protocol (e.g. compliance with DOTS)	Individual is motivated to use a service because of a price effect (the cost of seeking care and the opportunity cost of time is wholly or partly subsidized)

grams and policies that aim to bring about improvements in the management, financing and overall functioning of health systems. This theme was selected because HNP projects with RBF activities were more likely to be captured by this category.

This approach generated a total of 260 HNP projects: 148 active projects and 112 closed projects. Project documents obtained from the Project Portal were reviewed, including Project Appraisal Documents (PADs), Staff Appraisal Reports (SARs), Project Information Documents (PIDs), Implementation Completion Reports (ICRs) and other relevant documentation.

themes: child health, health system performance, HIV/AIDS, injuries and non-communicable diseases, malaria, nutrition and food security, other communicable diseases, population and reproductive health, and tuberculosis. A project can also have secondary and tertiary themes, but these were not explored in the analysis.

Projects were reviewed to see whether they contained at least one type of RBF mechanism contained in the framework presented in Table 1. A total of 40 HNP Projects with RBF activities were identified and assessed more extensively. A range of project information was entered into Excel-based spreadsheets in order to facilitate cross-country comparisons.

The approach has several limitations. Focusing on projects with health systems performance as the primary theme will likely miss out some projects with RBF activities classified in other thematic areas. In addition, the documentation reviewed describes the intentions of a project, but does not indicate whether the project was able to successfully implement RBF mechanisms as planned. Analysis of implementation details could not be included because of the breadth of this review.

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Finally, levels of financial support for RBF activities were extremely difficult to determine from the documents reviewed. Often, RBF activities were part of a component, and the costing of the component did not have a sufficient level of disaggregation to assign specific amounts to RBF. In other cases, performance-based funding might be one type of innovative financing mechanism to pilot among a range of other activities. Therefore, the amount of funding specific for RBF for health is still not known.

Findings of the World Bank Project Review

Of the 260 projects reviewed, 40 contained RBF activities: 28 active projects and 12 closed projects in 29 countries (Table 2). The Latin America and Caribbean (LAC) region had the most projects with RBF activities (15), followed by the East Asia and the Pacific Region (EAP) (9), African Region (AFR) (8) and South East Asia Region (SAR) (8).

Figure 1 shows that the number of HNP projects identified with an RBF element hovered between one and two approved by the World Bank Board per year between FY95 to FY01. Beginning in FY03, the number of new projects with RBF activities jumped to four to five per year until FY08, when nine projects were approved.

The analysis identified 24 HNP projects in 19 countries between fiscal year (FY) 1995-2008 that provided 'substantial support' to RBF activities (17 active and 7 closed operations), either because RBF was the focus of the entire project or the project had several components related to RBF. Operations in the LAC region predominated in this sub-group (Table 3). Substantial support for RBF activities was found more often in AFR and LAC regions than in the full sample. Performance-based agreements with sub-national government entities, public facilities, and NGOs were the most common type of RBF mechanism among more substantial projects. A greater proportion of 'substantial' projects were Adaptable Program Loans (APLs) (29% compared to 20% in the full sample).

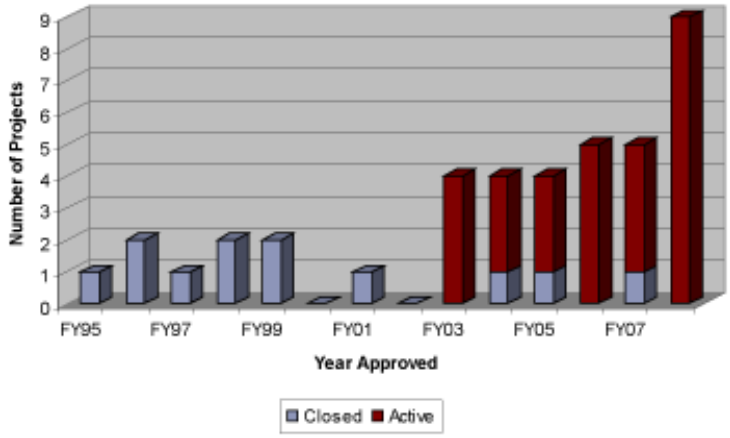
In the 40 HNP projects supporting RBF activities, there were a total of 90 different mechanisms identified in active and closed HNP projects between FY95 and FY08, or 2.3 mechanisms per project on average (Table 4). The most

Table 2: Description of HNP Projects with RBF Activities

Indicator	Active	Closed	Total
Total HNP projects reviewed	148	112	260
HNP projects with an RBF element	28	12	40
Percent of HNP projects reviewed with an RBF element	19%	11%	15%
Countries with an HNP project with an RBF element	19	10	29

Source: Author's calculations

Figure 1: Evolution of World Bank Support to RBF in Health



Source: Author's calculations.

common type of RBF mechanism was performance-based agreements between central and sub-national government entities (21% of mechanisms), followed by performance-based contracting of public facilities (18%) and performance based contracting of non-governmental organizations (NGOs) (16%). The LAC region had the largest number of RBF mechanisms (30 out of 64, or 33%), followed by SAR (22 mechanisms or 24% of total). Nine different demand-side RBF mechanisms were identified: five voucher schemes and four projects that supported Conditional Cash Transfers (CCTs).

Most projects supporting RBF activities utilized monetary incentives (95%). Approximately 15% of projects also included non-monetary incentives, such as better housing or additional schooling as motivation for improving coverage and utilization of health services. Non-monetary benefits were part of RBF mechanisms in six projects (two in EAP and SAR, and one each in AFR and LCR).

In one-third of cases, RBF encompassed the entire project, and in almost half of the sample, RBF activities represented at least one component of the project. Piloting of approaches was also an important feature in 38% of projects. A few projects included study tours, workshops, or other exploratory activities.

Most Bank operations supporting RBF relied on investment lending. Nearly one-half (48%) of projects used Specific Investment Loans (SILs); 20% used Adjustable Program Loans (APLs) or Sector Investment Management Loans (SIMs). Emergency Relief Loans (ERLs) served as the basis for RBF projects in Afghanistan. Two projects (Rwanda and Argentina) relied on Development Policy Lending instruments, such as Poverty Reduction Strategy Credits (PRSC).

The total value of active and closed projects supporting RBF activities during this period was $3.79 billion: $2.29 billion for active projects with RBF activities and $1.5 billion for closed projects. IDA funding accounted for 68% of total project funding, but only 9% of project funding for the closed projects in the sample. This suggests that

Table 3: World Bank Projects with RBF Health Activities (FY95-FY08)

Region	Active	Closed	Total	Percent	Substantial RBF	Percent substantial
AFR	7	1	8	20.0	4	50.0
EAP	7	2	9	22.5	6	67.0
ECA		2	2	5.0	1	50.0
LCR	6	7	13	32.5	10	77.0
MNA						
SAR	8	0	8	20.0	3	37.5
TOTAL	28	12	40	100.0	24	
PERCENT	70.0	30.0	100.0		60.0	

Source: Author's calculations

Table 4: RBF Mechanisms in Active and Closed Bank-financed HNP Projects (FY95–FY08)

Region/type	AFR	EAP	ECA	LAC	SAR	Total	Percent
Loan Disbursement Based on National Government Performance	2	0	0	4	2	8	8.9
Performance Agreements with Sub-national Government Administrative Entities	3	5	0	8	3	19	21.1
Performance Agreements with Insurance Entities	1	0	1	5	0	7	7.8
Performance-based Agreements with Public Facilities	4	1	2	7	2	16	17.8
Performance-based Agreements with Private Providers	3	0	0	4	3	10	11.1
Performance-based Agreements with NGOs	6	1	1	1	5	14	15.6
Performance-Based Health Worker Incentives	1	3	0	0	2	6	6.7
Performance-based Agreements with Communities	0	0	0	0	1	1	2.5
Vouchers and conditional cash payments	1	3	0	0	1	5	12.5
Conditional cash transfer	0	0	0	1	3	4	10.0
Total	21	13	4	30	22	90	100.0
Percent of mechanism	23.3	14.4	4.4	33.3	24.4	100.10	

Source: Author's calculations

RBF activities for health are being utilized increasingly in poorer IDA countries. Projects with substantial support for RBF activities accounted for 60% of total project funding in the sample reviewed. Projects characterized as having substantial RBF activities accounted for 63% of the total value of the 40 RBF projects ($2.4 billion).

Qualitative Assessment of World Bank Projects

Rationale for the RBF approach: In active projects, RBF mechanisms were pursued to address the unacceptably high levels of infant, child and maternal morbidity and mortality, or under-nutrition (Argentina); to achieve greater efficiency and equity of the health system, and as a way to increase access and lower costs of services (Armenia); and to bring basic health services to the population, particularly in post-conflict settings. In Afghanistan and Democratic Republic of the Congo, where government health services were weak or non-existent, performance-based contracting of NGOs was initiated.

Objectives of the projects to which the RBF activities belong: Project Development Objectives fell into two categories: 1) those projects supporting changes in health system outputs (improved access, utilization, or quality of

Table 5: Types of Evaluations Planned or Conducted in the Sample of Projects with RBF Activities

Type of evaluation	Active projects (*n*=28)	Closed projects (*n*=12)	Total (*n*=40)
Annual assessment of project performance	10 (36%)	3 (25%)	13 (33%)
Pre/post evaluation	5 (18%)	1 (8%)	6 (15%)
Baseline survey	14 (50%)	0	14 (35%)
Impact evaluation (randomized controlled trial)	8 (29%)	4 (33%)	12 (30%)
Other evaluations	6 (21%)	2 (17%)	8 (20%)

Source: Author's calculations

care); and, 2) those focusing on achieving specific health outcomes, such as reducing infant mortality rates. For closed projects, objectives focusing on health systems outcomes were more prevalent (75%) than for active projects which focused more on health outcomes (54% of total).[2]

Beneficiaries: Project beneficiaries, and by extension, beneficiaries of the RBF mechanisms, also varied in the sample. Many projects had a cascading design of multiple beneficiaries, such as MOH administrative levels, public and/or private health facilities, and health care workers. Households in a particular geographical area and poor households were identified as beneficiaries in 48% of sample projects. Women and children were the focus of 38% of projects, and health care workers or clients the beneficiaries in 5% of projects. One project focused on HIV-positive individuals (Guinea). Active projects have a slightly greater focus on poorer households.

Monitoring and evaluation: One-third of projects with RBF activities planned to conduct annual assessments of project performance based on reporting of project indicators. Pre-post evaluations were intended in 15% of the sample and impact evaluations were planned in less than one-third of the sample projects. While 35% of projects had conducted or were planning to conduct a baseline study, not all of those would be used for pre-post evaluations or impact evaluations (Table 5). In the sample of projects, other types of evaluations included assessment of pilots in Russian Federation and Indonesia; lot quality sampling in Cambodia; poverty mapping in Philippines; expenditure tracking (Guinea); and third party evaluations (Afghanistan).

2 These differences may also reflect changes in project policy guidance from OPCS over this period.

Project Outcomes and Emerging Lessons

The review finds that projects with RBF activities are associated with increased utilization and coverage of priority health programs; strengthened service provision and quality of care; increased enrollment of insurance beneficiaries; and, enhanced overall institutional and policy framework for the health sector. However, these outcomes do not necessarily control for other factors contributing to changes in the health sector. Some examples of the range of reported outcomes for projects with RBF activities are the following:

Afghanistan (P078324): The number of primary care facilities in Afghanistan more than doubled from 496 to 1,169, and a female doctor, nurse or midwife was present in over 80% of these facilities between 2002 and 2007. The number of outpatient visits increased to almost one visit per resident per year. Quality of care, measured through a Basic Scorecard improved by 32% between 2004 and 2007. Household surveys revealed a doubling of the rate of use of a skilled birth attendant at delivery, and a tripling of the contraceptive prevalence rate and the proportion of women receiving prenatal care. Under-5 mortality rate fell from 250 to 191 per 100,000 live births between 2002 and 2005.

Rwanda (P085192): Successful performance-based schemes were rolled out nation-wide. *Mutelles* (community-based health insurance) were scaled up and

coverage reached 75% of the population. Contraceptive prevalence increased from 7 to 28%, and assisted deliveries increased from 29 to 52%. Fertility declined, as did HIV prevalence, malaria incidence, and child mortality. Between 2005 and 2007, under-5 mortality declined from 198 to 103 per 1000 live births, and immunization (DTP3) coverage increased from 83% to nearly 100%. Use of insecticide treated bed nets increased from 4% to 65%, and utilization rates from 0.4 to 0.7 per capita. An impact evaluation has been completed and results are forthcoming.

Argentina (P072637): The project reached 1.3 million children <2 with milk supplementation, 4.7 million children with immunization, more than 457,000 uninsured mothers and children (12,000 indigenous pop), 12,000 TB patients and 23,000 HIV patients with their respective treatments. Declines in IMR were achieved over a 3-year period. The Maternal Child Health Insurance Project was fully implemented with 78,400 beneficiaries enrolled, transforming the incentives structure of the health structure at the provincial level. 2000 health care providers signed performance agreements with provinces, and 1,100 were billing for services rendered. The incentive system was functioning in 22 out of 24 provinces.

Bolivia APL1 (P060392): The project succeeded in increasing municipal health participation and introducing reforms throughout the country. IMR dropped from 67 to 54/1000 live births. The project exceeded targets each year in 6 out of 8 indicators. Overall, substantial progress was made in increasing coverage of health services. Performance agreements were signed by the MOH and the regional directors of nine departments, and the Seguro Básico de Salud (Basic Health Insurance—SBS) was established with a results-based focus.

Armenia (P050140): There was evidence of increased efficiency and reduced costs for patients under the new PHC model. Immunization rates and other impact indicators were maintained or increased during the project. A purchase-provider split was accomplished and facilities were successfully contracted, but selective contracting was thwarted by special interest groups. Communities became involved in decision-making and contributed to financing of PHC development. The project appears to have unintended consequences, as there was some evidence of informal and out-of-pocket payments because of underfunding of the health services and low reimbursement rates.

Conclusions and Lessons Learned

The main conclusions and lessons learned are the following:

1. The World Bank has supported results-oriented operations in health for nearly 20 years. The level of support has risen in recent years, and is expected to increase with the support of the Health Results Innovation Grant funded by the Government of Norway.

2. Political commitment and country ownership at national and sub-national levels are essential to good design, effective implementation, and sustainability of RBF elements.

3. The design process for RBF mechanisms and pilots need to involve all relevant stakeholders and to build their capacity in RBF principles in order to improve understanding and success of the mechanism. RBF projects need to focus on improving quality of services provided in addition to increasing overall service provision and utilization.

3. There have been missed opportunities to have more of a results-focus in project design. Projects that include contracting with NGOs could include a performance-based element, for instance.

4. Selection of performance indicators is critical. Independent validation of achievement of indicators linked to performance-based contracts is necessary to mitigate gaming and perverse incentives to over-report results.

5. Evaluation of projects with RBF elements has been weak. The lack of robust impact evaluation has prevented the Bank from contributing to the evidence base on RBF in any significant way to date.

6. Most RBF mechanisms require resources not only to finance the additional incentives, but also to set up the accompanying systems required for successful implementation, such as management and health information systems.

7. Adequate organizational structures and institutional capacity are key for RBF mechanisms to work well. The

need for a focused and gradual approach is a common lesson from the sample of closed project documents, as it appears useful for layering reforms and needed institutional requirements for creating the right environment. However, RBF mechanisms have been established quickly in fragile states and post conflict environments.

8. None of the projects with RBF mechanisms examined the cost-effectiveness of the intervention relative to other types of strategies that could strengthen health sector performance and achieve health outcomes, particularly for MDGs 4 and 5.

9. Few of the projects documented possible gaming or perverse incentives created by the RBF mechanisms.

10. The 2007 HNP Strategy encouraged Bank financing for well-evaluated pilot efforts of output- and performance-based financing in HNP projects and programs. The 2007 Strategy estimated a baseline of four active RBF projects in FY06 and proposed a target of at least 14 active projects by FY2010. Current trends in World Bank support for RBF mechanisms in health should achieve or exceed the 2010 target proposed in the Strategy.

Recommendations

The report made a series of recommendations for strengthening the design, implementation, monitoring and evaluation of RBF activities and projects for health. Chief among these was to encourage that Quality Enhancement Reviews (QERs) consider whether RBF projects and components have an adequate national and sub-national commitment and ownership, relevant poverty focus, appropriate indicators, feasible mechanisms for disbursing against results, required institutional frameworks and capacities, and adequate evaluation strategies. A checklist could be developed to guide review of RBF operations during QERs.

In addition, the review suggested there be ongoing tracking and monitoring of RBF activities World Bank HNP projects. A review of reproductive health and nutrition projects would help identify additional RBF projects.

The design of RBF mechanisms needs to reflect how these schemes will be sustained financially as Bank support declines over time. At a minimum, the cost of the RBF mechanism, both during and after the project period, needs to be assessed as part of project design to estimate the incremental recurrent costs and fiscal impact of the incentive scheme. Tools and approaches for evaluating the cost-effectiveness of RBF mechanisms, and for identifying and assessing unintended consequences of performance-based incentives need to be developed.

Additional support needs to be provided to Bank operations staff in developing adequate monitoring and evaluation frameworks for RBF components or projects. This support could include, but is not limited to staff training, development of guidelines, and technical exchanges. Alternative and innovative approaches to obtaining robust results on health impact and health system performance need to be explored. All RBF projects or pilots should have baseline estimates of indicators.

Finally, capacity building on design, implementation, monitoring aspects of RBF mechanisms needs to continue, perhaps through cross-country exchanges. The Global Development Learning Network may be a useful platform for this. Bank staff may benefits from establishment of a community of practice for RBF in health to foster greater cross-regional sharing of experiences. Bank staff needs to be engaged in a discussion about how to more effectively disburse against results. Priorities for strengthening design and implementation of projects also should be identified.