Making Health Care Accountable: Why Performance-based Funding of Health Services in Developing Countries is getting more Attention** - A Review

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I. Introduction

Developing countries and their international partners are increasingly adopting methods of financing health care activities that link the availability of funding to concrete, measurable results on the ground. This was advocated in the World Bank Development Report (1993) Investing in Health - even when little resources were available for this type of financing as at that time. Over time, much experimentation has taken place, and we are seeing with clarity the importance, as well as the challenges of performance-based financing for achieving national and global health goals. The authors looked at the advantages which performance-based health funding confers on developing countries, with regards to being able to meet the Millennium Development Goals (MDGs). The objective of this article is to look at why performance-based funding of health services in developing countries is receiving more attention, so as to enable them achieve their national health goals.

II. Synopsis of the Article

Government and partner agencies are interested in performance-based financing of health for a number of reasons. First, there is a growing focus globally on achieving measurable results with development assistance, and performance-based financing spotlighting such results. In terms of health care, these results are being closely tracked as governments and their partners strive to achieve the Millennium Development Goals. Second, there is great need for

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development assistance to be tailored towards the attainment of the health MDGs. Also, linking the availability of financing to measurable results, whether in terms of changes in health services, is consistent with the objective of making service providers more accountable. Linking financial payments to the job done can be a tremendous encouragement for those providing the services, because it exposes their performance to their clients and others footing the bill. The 1993 World Development Report advocated the expanded use of public monies to pay private non-governmental organizations and doctors and clinics to deliver basic health services to the poor. Performance-based contracts between the government and these private providers are the principal instrument for putting this recommendation into practice.

Performance-based financing in health is now being widely and actively practiced at several levels of the health care system. First, Governments of developing countries pay health care providers, non-governmental organizations (NGOs) and the private sector for delivering essential health services to poor households on a performance basis. The authors made a case study of Guatemala, which successfully implemented, on a large scale, the contracting of non-governmental organizations to deliver health services. By 2000, 89 NGOs under 137 separate contracts provided health care to about 3.7 million of Guatemala's population of 14 million. The contracts specify a range of maternal and child health services and prevention and treatment of a number of diseases, including malaria. The NGOs are paid about $8 for each person served, mostly in cash but also in kind, in the form of such items as vaccines and medicines. Payments are released quarterly, once performance has been checked and verified.

Performance was measured by a series of indicators, including coverage of immunization and prenatal care, distribution of iron sulfate tablets to pregnant women and children, and frequency of home visits by the NGO outreach staff. Private firms have been hired to develop the monitoring system, which also looks at the accounting practices of the NGOs. The contracting system adopted in Guatemala yielded some positive results, and has produced important gains in health service delivery. Immunization rates in Guatemala rose from 69 per cent to 87 per cent between 1997 and 2001. Household surveys now under way

will be able to assess the impact of the programnme on mother and child health outcomes.

Again, the central government determines the transfer of funds to local governments on the basis of their performance in strengthening health services. In the World Bank supported Family Health Project in Brazil, the central government makes per capita transfers to the local municipalities on the basis of planned increases in certain services, such as safe delivery of babies for low-income women, monitoring of infants' nutritional status and growth, and treatment of poor children for various illnesses. If the municipalities reach the agreed targets and others set for them, they will continue to be eligible for future financial transfers; otherwise, the level of central government support will be reduced and other remedial measures put in place in an effort to improve the targeting and effectiveness of the activities of those under performing municipalities.

Also, donors release funds (disbursements) to recipients in developing countries as and when certain key health targets are achieved. A number of innovative programmes are in place to make donor financing of health programmes conditional on successful performance on ground. A good example is the World Bank's credit “buy down” programme for polio eradication. Under the programme, countries receive low-interest loans to purchase polio vaccines in an effort to eliminate the last remaining pockets of the disease that persist in Africa and South Asia. If the vaccine is judged to be purchased, delivered, and administered in a timely and effective manner, additional resources in a trust fund financed by Bill and Melinda Gates Foundation, the United Nations Foundations, and Rotary International are used to buy down the interest and principal repayment on the loan, thus converting it to a grant. The authors mentioned that Nigeria and Pakistan also benefited from polio eradication projects for about $50 million.

The recent experience with performance-based financing in health has been encouraging. When properly designed, performance-oriented contracts can help to stimulate individual providers, such as doctors, nurses, midwives, and village health workers, to expand their coverage, reach poor people and

enhance the quality of what they do. Even when the contract is between a central government and local authorities or between an international development assistance agency and a government, improvement in programme performance can also be stimulated. Performance-based financing is helpful in focusing all resources to the services produced and their impact on health and nutritional status of the intended population, rather than simply counting inputs such as drugs, doctors, ambulances, hospitals buildings and equipment.

But performance-based financing for health must also overcome a number of serious hurdles to work well. One is the difficulty of measuring performance quickly and accurately, as data on such key outcomes can be hard to monitor in the poorest regions and countries. Again, is the problem of widespread lack of capacity in ministries of health to design, negotiate and enforce contracts with NGOs and private health care providers. Lastly, is the risk that performance-based financing might be perceived as a harsh or unfair imposition of conditions by the financing source on the health service providers.

The authors concluded that performance-based financing for health is not only likely to continue, but expand due to many factors. They include government and donor concern for health outcomes; interest in improved measurement of results; the push for greater accountability of health care providers to their clients and to governments and for stronger accountability of governments to donor agencies; and a recognition that NGOs and the private sector can, in some cases, deliver essential health services to poor people more efficiently than the public sector. It is important for the developing community to contribute to monitor closely these promising experiments in performance-based financing and to disseminate and apply the lessons of success and failure as rapidly as possible to maximize the benefits of development assistance in pursuit of the attainment of the health Millennium Development Goals.

III. Comments

This article supports the output-based funding of health care projects, being advocated by developed countries, governments and donor agencies. From its

experience over time, the performance-based funding has the potential of helping to achieve the Millennium Development Goals (MDGs); subsequently helping in reducing poverty pervading people in low-income countries, who hitherto, had no access to some basic health care and social amenities. It is also in tandem with the theme of the 2004 World Development Report - Making Services Work for Poor People - which provides a practical framework for making services that contribute to human development work for poor people.

Despite the challenges being posed, performance-based funding of health services in developing countries is getting more attention for so many reasons:

- It increased access to health services, which was not at the expense of equity;
- It helps to focus all resources on the services produced and their impact on health and nutritional status of the intended population, rather than simply counting inputs such as drugs, doctors, ambulances, hospitals, buildings and equipments;
- There is value for monies being spent, in the sense that it gives room for greater accountability of service providers; and
- It helps partner agencies to allocate resources to countries and programmes that demonstrate progress as measured by performance indicators.

A basic service such as health care is a public responsibility. Therefore, by financing, providing, or regulating the services that contribute to health outcomes, governments around the world demonstrate their responsibility for the health of their people. If these services are left to private/market forces, it will not trickle down to the targeted poor; and that basic health services is considered as fundamental human right if the MDGs are to be achieved. Irrespective of the challenges posed to the public of these basic health care deliveries, governments have to see how collaboration could be made with the private sector, communities and outside partners/donors, to meet this

fundamental responsibility and achieve the MDGs.

This article has varied implications for the Government of Nigeria with regard to improving the well-being of Nigerians and achieving the health related MDGs. They are:

- Government has to intervene in health care delivery so as to control communicable diseases, protect poor people from impoverishing health expenditures, and disseminate information about home-based health and nutrition practices, especially in outreach services, such as immunization, which can be contracted out, but should be publicly financed;

- Basic health services provided by government should be made accountable, to enable a wide coverage of the populace and achieve success;

- Database for these health indicators should be built with great importance attached to accuracy and should be verifiable;

- A concerted effort should be in place to raise the quality and comprehensiveness of national monitoring systems to track health performance; and

- There should be a shift in Ministry of Health's fundamental mission and operating mode, so as to implement a large-scale performance-based system. This will aid the Ministry of Health to design, negotiate and enforce performance contract with NGOs and private health care providers.