A Personal Story:

Seeking the Roots of Performance-Based Financing (PBF)

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Getting Started in Mozambique

I took my first steps as a tropical doctor in Mozambique in the early 1980s when African Socialism was seen as the way forward by many in the world of development cooperation. Working during four years in a war-affected health district – the ideological battle was between the Soviet Union and the West and providing health care in Mozambique was the sole responsibility of the state. While admiring the social objectives and the idealism in the newly independent country I also witnessed the failures of the central plan model with their suffocating effects on entrepreneurship and economic development.

For example, while there was a huge sugarcane factory at just 300 km distance from where I was working there was a shortage of sugar. At the same time farmers in my district could not sell the much-needed maize and beans in the district of the sugar factory. This was because national policies did not allow businesses to sell products at more than the centrally established low prices and few people dared to illegally transport products at the risk of severe punishment for "economic crime". Government also nationalized religious and private health facilities and thereby reduced the already very limited access to health serves for the population. I realized that such factors contributed to Mozambique remaining a very poor country with empty shops and inadequate social services.

As a medical doctor I also unsuccessfully tried to manage measles outbreaks killing hundreds of children due to inadequate health services matched with malnutrition. All this contributed, besides other political factors such as the struggle against apartheid, to social unrest and war. These problems made my work frustrating and I started to look for alternative answers for improving health services moving away from established ideas, which in those days were firmly embedded in Alma Ata's primary health care approach. Yet, despite the dogmatic orientation in Mozambique there was a reasonably open atmosphere of debate from which I greatly benefited. While in each society it is very important to redistribute

Robert Soeters at Batur volcano in Indonesia.

wealth for poverty reduction and stability, the Mozambique experience also taught me that this wealth must first be generated. It is impossible to redistribute something that does not exist. The oppressive atmosphere of central planning in Mozambique made the population into passive recipients of government hand-outs and I learned that there should be incentives to motivate people and private entrepreneurs to respond to market opportunities. A society without these economic conditions most likely remains poor. Such ideas were not fully appreciated by development experts of those days and asking for competition or challenging the supremacy of the state in favor of the private sector was not commonly accepted. My thoughts were also rudimentary and I felt frustrated from the inability to be more effective. I considered stopping work for any government institution and even quitting public health in exchange for starting a private hospital somewhere in Africa to start testing alternatives and thereby I hoped to become more useful for society.

On to Zambia

My Masters in Public Health from Amsterdam equipped

me with much-needed knowledge and I came in contact with the Dutch Ministry of Development Cooperation. They gave me in 1987 the great opportunity to test these ideas and offered me the opportunity to coordinate the Primary Health Care (PHC) Programme in the Western Province of Zambia. This provincial project had adequate human and financial resources and was able, due to its relatively large size, to innovate and act as a pilot for deeper reforms of the Zambian health system. While we had a good idea of *what* we wanted to achieve it was unclear *which strategies* to use. A period of trial and error started with around 1200 Zambian health workers and 20 expatriates. Having no Internet and greatly helped by the fact that the Western Province was in a remote corner of Zambia, the 6 districts could more or less do what they wanted as long as they convinced project management. The districts advanced despite conflicts with provincial and to a lesser extent national health authorities because they were not sure why change was necessary or simply because they defended their interests.

Decentralization of decision-making power seemed the best solution and the project started a revolving fund whereby cash was given to district authorities and local health facility managers, which they could freely use for achieving their objectives. After spending the money within a broad range of budget lines, fresh money was reimbursed monthly after accounting for the previous allocation. This new approach also created a problem because the government monopolies which were supposed to assure the logistics of the health services were unable to respond to the increasing demand for inputs and services. Their prices were below the market equilibrium and stocks quickly depleted. The government monopolist institutions could not increase supply due to their centrally planned and rigid procedures and the systematic losses as the result of the low pricing.

Demand in the project quickly outpaced supply for stationery, building materials, spare parts for vehicles and bikes as well as for services such as vehicle maintenance, sinking of water wells. This threatened its success. Reforming government institutions during the late 1980s was still unthinkable and project management then started a PHC business company with shops, a garage, a soap factory as well as a metal workshop to solve the logistic problems. Also benefiting from the power vacuum in the remote province, the PBF company was allowed to operate despite the fact that there was no clear legal status. Local and national politicians looking for votes and alternative policies generally supported the experiment but representatives from the Ministry of Health and the donor community were mostly opponents. The company managers started to buy and sell at market prices and made profits of between 15-40%. With these profits new buildings were constructed, investments were made and stocks gradually increased. After 2 years the company provided work for 200 employees and was one of the main private enterprises in the province.

This experiment unfortunately stopped after a few years because it continued to lack legal protection and never found an acceptable institutional set-up. Only some hospital shops still remain open today. We learned from this case that for similar initiatives to be successful there should from the start be a better conceptual understanding and institutional set-up among the main stakeholders. For example, how far do we agree to introduce market principles and should the private sector be included as a full contractual partner with similar treatment to public providers? How far do decision makers agree that there should be competition for patients and that money should follow the patient?

Back to School

The Zambian experience motivated me to carry out a Ph.D. study in health economics. While writing the thesis "Health Reforms in Africa. The Case of Zambia" I discovered the conceptual ideas that should have guided me in my previous work. The study equipped me with fresh ideas on how to enhance new health reform initiatives worldwide. I started working for different development organizations advocating rather radical reforms. I failed in Armenia, India, Angola, East Timor and Chad. Sometimes the problems were ideological and often decision-makers were fearful to start reforms that they considered risky or threatening to their power. At times the problem was also a lack of strategic and diplomatic approaches so that proposals were considered as personal attacks on individuals and were therefore rejected. Yet, I believed that only making small adjustments in the health system was not the way forward and that it was better to aim for more radical change. Sometimes this resulted in unbridgeable differences of opinion, and I had to quit the job and look for new opportunities. Yet these sometimes painful failures were also great learning experiences.

Breakthrough in Cambodia

The first breakthrough came in Cambodia in 1998 where the Asian Development Bank (ADB) initiated a contracting-out program. This was based on the conceptual ideas from the World Development Report 1993 of the World Bank in which the options of

subcontracting, working with the private sector and a more important role for user fees had been proposed. International NGOs, working at district level, were invited to start purchasing services from health facilities. These peripheral stakeholders were shielded from government bureaucracy because the ADB had negotiated an exemption for the contracting pilot program. It created the ideal environment for testing new conceptual ideas in practice. It allowed health facilities to define their own user fees whereby they entered into competition with the very active private sector in Cambodia. Managers could make their own decisions on where to buy inputs, on how much incentive to pay to health staff or which strategies to apply. I was also lucky to work with a group of excellent colleagues such as Benjamin Loevinsohn (World Bank), Indu Bushan (ADB), Fred Griffith (HealthNet-TPO), Henk Bekedam (WHO) and Bruno Meessen (Antwerp School of Public Health). A large independent World Bank household intervention–control study then showed in 2002 that this pilot programme had been surprisingly effective in improving access to health services and that it also better protected poor patients than the traditional policies in the control districts.

Reaching Women

The most remarkable story I can remember in Cambodia concerning the force of contracting, or what is now known as PBF or Results-Based Financing (RBF), was that according to established anthropological knowledge Khmer women could not accept to deliver in a health facility. The ancestral spirits would not allow deliveries to take place far from the house where the deceased parents had lived. And, indeed, 2 years (1999–2000) into the contracting program, the institutional delivery rate remained at a dismal 2-3% irrespective of the subsidies. However, we kept increasing the subsidy per delivery more or less every six months to ever higher levels. Then in 2001, I visited a Khmer health centre where a doctor suddenly achieved 50% institutional delivery coverage in his community. This was a spectacular result. I asked him “how did you do this” and he told me the story that during the Pol Pot regime the health centre had been a killing field and that bad spirits lived in the trees around the health centre. This stopped women from agreeing to stay through the night. The doctor was unhappy to lose the PBF subsidies and after consultation with local authorities then cut the trees. From that moment onwards women started to attend. The problem was solved – a very unlikely outcome in traditional health systems. Based on his success, other chiefs in the surrounding health centers also took similar drastic measures such as chasing spirits, paying demand side incentives to beneficiaries or other strategies. It proved the force of PBF, whereby the strategy to achieve results should be left to local providers able to respond to specific local problems and not to central bureaucrats in a Ministry of Health office, for example.

Back to Africa

I witnessed that PBF programs can be successful in a wide variety of countries such as in Cambodia, Rwanda, Burundi, the Democratic Republic of Congo (DRC), and Central Africa. I don’t believe this is a coincidence anymore. When we first succeeded in Cambodia, common wisdom was that it would probably not work in Africa. When it became successful in Rwanda others argued that this was a special country but PBF could not work in other African countries. Now that we have recently published a report of a successful PBF program in the Democratic Republic of Congo – by any measure a failed state - these arguments do not seem valid anymore. The conceptual ideas behind PBF of creating performance incentives and making use of market forces work better than government-oriented and centrally planned approaches of the primary health care era of Alma Ata.

PBF may even have become an alternative to the primary health care approach of the last 30 years. Twenty years ago we attacked the established ideas and concepts out of frustration and later increasingly with arguments and evidence. It is satisfying that our ideas have now become more mainstream among the peer group. The strength of PBF may also be that it continuously seeks new ideas and instruments for improvement. These are then field tested and adapted to the specific circumstances of each country or situation. PBF is not a model but a flexible approach based on best practices and a toolkit of instruments such as business plans, a costing and equity approach, a national web data base and software to calculate individual performance bonuses. Decisions-makers when starting reforms should not move too far away from these best practices and instruments. The biggest risk for PBF is not its concepts or instruments but that decision-makers only hand-pick a limited range of them. This may lead to confusion and even failure whereby the reputation of PBF may suffer in the process.