

Review of Global Fund experience with facility-level financing: some insights for Health Financing Accelerator

SOPHIE WITTER, MARIA BERTONE & KARIN DIACONU

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Overview

1. Framing and core concepts
2. Present a summary of the overall literature on their effectiveness
3. Reflections on selected GF experiences with PBF
4. Lessons arising for the Global Fund and other global actors
5. Q&A

Section 1

FRAMING AND CONCEPTS

Core concepts

Focus on **front-line funding** (so not whole range of RBF/PfR instruments)

PBF vs DFF

- DFF less clearly designed but generally seen as prospective payment which bypasses middle levels of health system; budgets can be set in different ways

Both driven largely by **shared failure to adequately finance primary care** in many LMIC settings

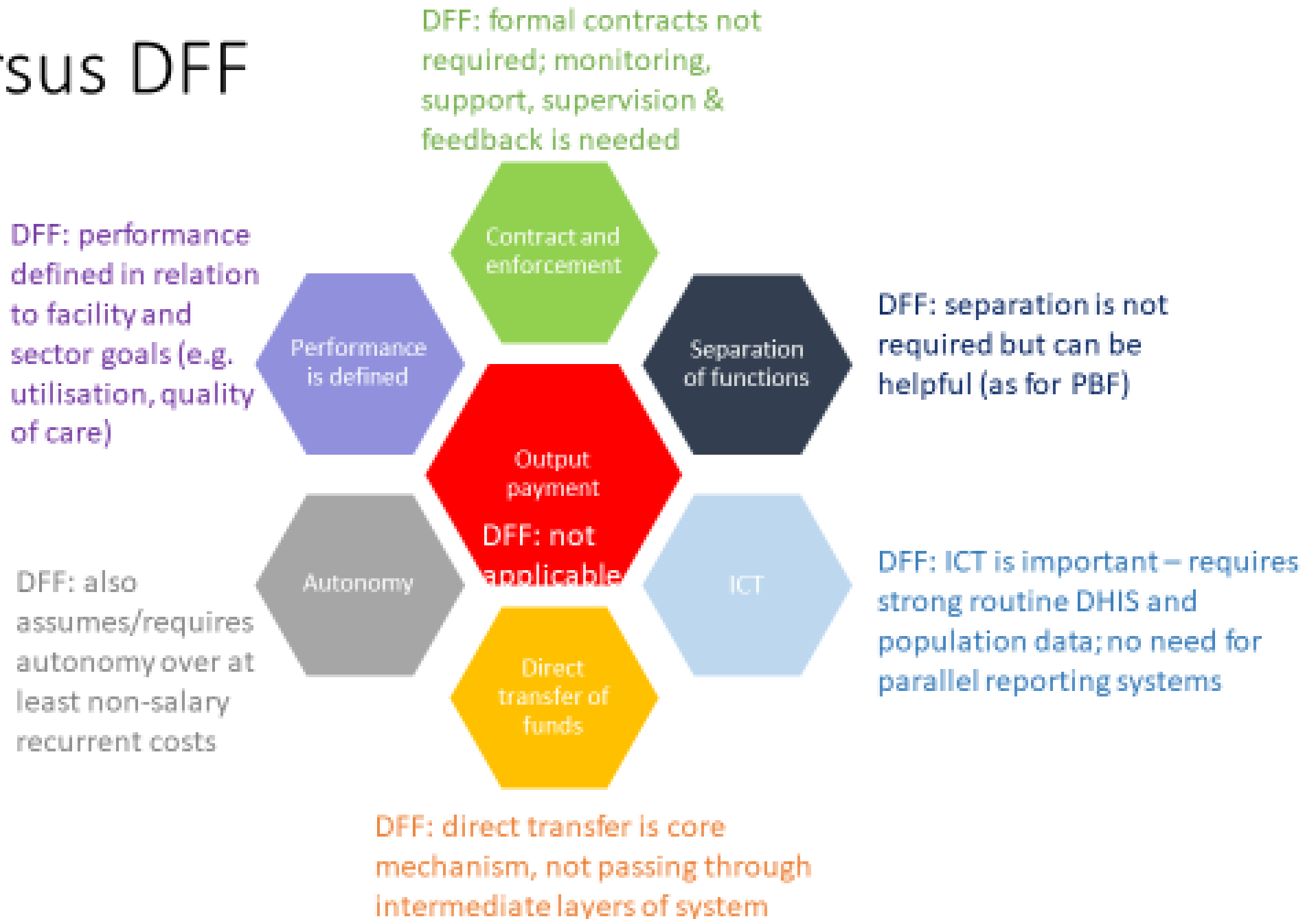
- This failure reflects a combination of resource shortage, political economy (favouring higher level facilities), system failures (weak PFM) but also low levels of trust
- PBF incorporates more of a focus on lack of effort by facilities/staff – hence incentives + measurement
- DFF emphasises resource shortages more – can't be accountable without funds
- Whether it is best to address these through PBF, DFF or reforms to basic PFM systems will depend on the context

Neither PBF nor DFF are new, and they have had many earlier forms with different labels

Seen as alternatives but could also be complementary

Share many prerequisites for effectiveness in terms of health systems

PBF versus DFF



Section 2

COMPARING PERFORMANCE BASED FINANCING WITH DIRECT
FACILITY FINANCING: INSIGHTS FROM GLOBAL HEALTH LITERATURE

Methods

Report and presentation outline available evidence on PBF and DFF and their effectiveness

Literature on PBF draws primarily on:

- Cochrane review – conducted by study authors over 2017-2020, in public domain soon
- Comment on similarities with World Bank meta-analysis

Literature on DFF draws on a rapid review of the evidence

- Non-systematic search using combination terms ‘facility’ or ‘clinic’ with ‘finance’ and/or ‘direct’;
- Drawing on available reviews –e.g. on prospective financing mechanisms;
- Reviewing documentation submitted by GF.

Section 2: Evidence on PBF

Main source of evidence: Cochrane review (1)

Cochrane review included 59 studies which assessed effects of PBF

- Majority from Rwanda, China and Tanzania
- Schemes predominantly focusing on reproductive maternal and child care, but some on TB/HIV specifically
- Usually P4P implemented in public/faith based facilities
- Majority of schemes funded by national governments, but similar numbers supported by external agencies (WB among others)

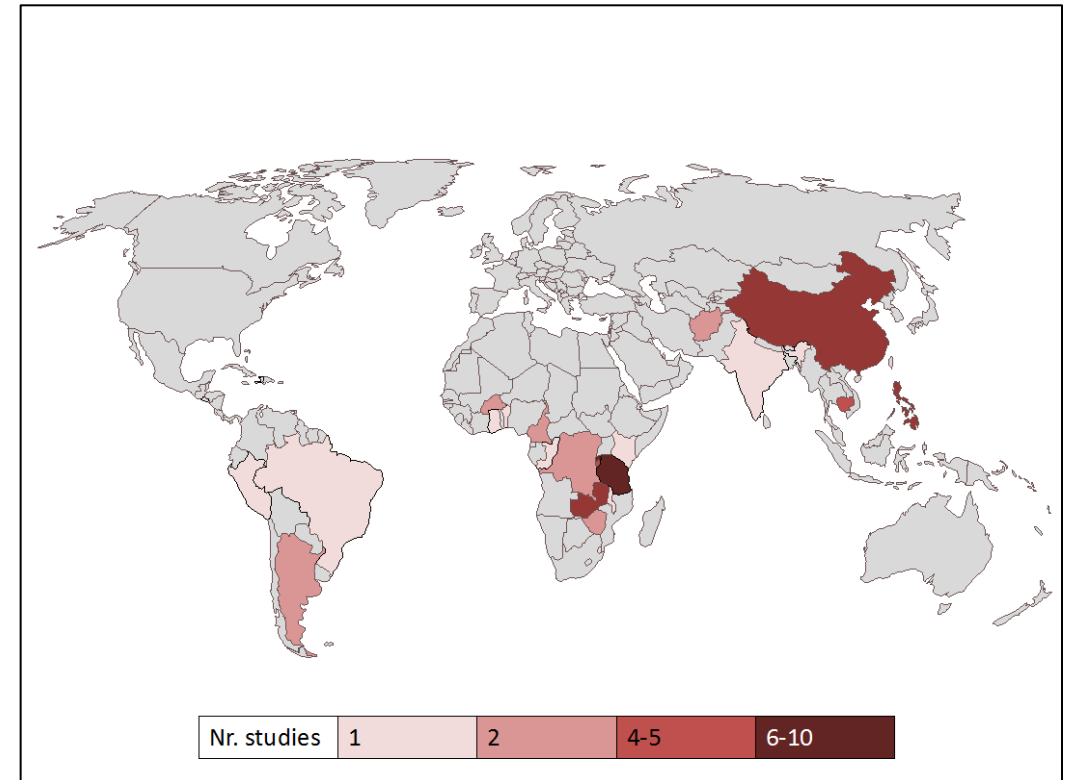
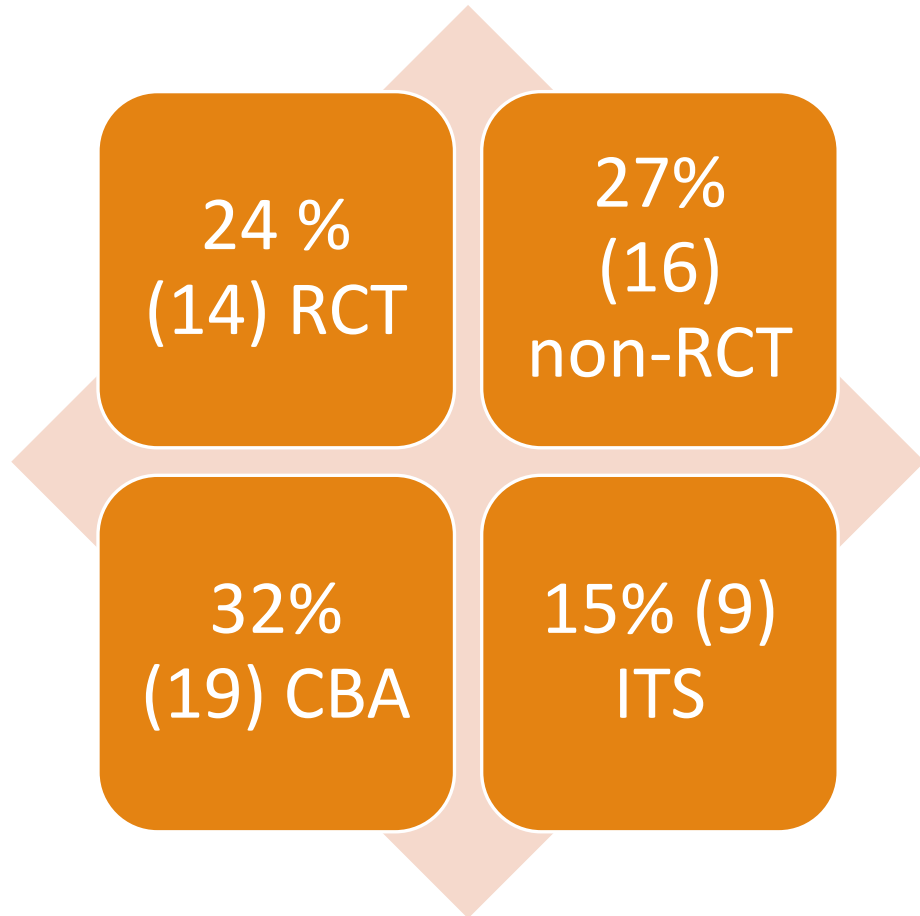


Figure 1: Number of PBF impact evaluations by country (as included in review)

Cochrane review: Types of studies included



42 studies reporting effects against standard care or status quo, no change

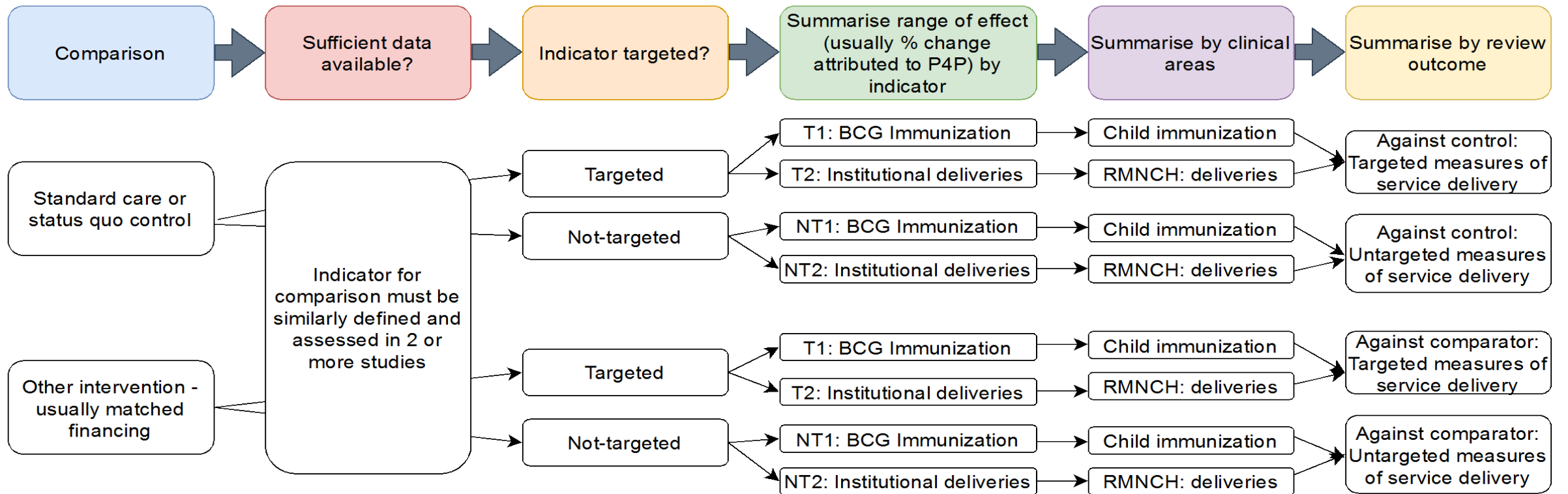
13 report effects against an enhanced financing control / other financing modality or alternative

4 report against both standard care and enhanced financing

On average, studies report effects of the P4P scheme at 3 years, but this varies widely (from 1-17 years in cases)

RCT = randomized controlled trial;
CBA = controlled before and after study;
ITS = interrupted time series;
1 study additionally both ITS + CBA

Cochrane review: grouping evidence to determine effects



We do not produce meta-estimates, instead indicating range of effect and judgment on overarching direction of effects
Is P4P yielding desirable, neutral, undesirable or uncertain effects?

Cochrane review: Classification of effects

Indicate range of effect and judgment for each outcome on whether effects of the intervention are:

- Desirable: consistently positive and over 5%
- Neutral: under 5%
- Undesirable: consistently negative and over 5%
- Uncertain: where either the quality of the evidence or the effects themselves are too varied to judge

5% threshold is contextualized – i.e. for health outcomes we do not adopt this, but for other measures (e.g. utilization) we do

PBF can take many forms (1): Scheme classification

Scheme classification	Details on scheme	Countries (n)	Study types (n)	Comparators (n)
Capitation and PBF	Payment reforms including capitation and PBF elements	China (2)	RCT (1) and quasi-non randomized trial (1)	Fee for service (1) and global capitated budget only (1)
Conditional provision of material goods	Conditional provision of material goods alongside supervision and quality improvement strategies	Tanzania (1)	Quasi-non randomized trial (1)	Unconditional gifts (either immediate or delayed) as alternative interventions and control (all receive a standard encouragement intervention) (1)
Financial and non-financial incentives + clinical decision guide	Mix of financial and non-financial incentives, alongside clinical decision guide and supervision/technical support	Burkina Faso, Ghana and Tanzania (all in 1)	CBA (1)	Control as standard care (1)
Performance related pay	Performance-related pay (results-based management) involving different types of agreement according to province implemented (ranging from multi-level agreements with strategic targets to not specified)	Brazil (1)	ITS (1)	Comparison of impact over time in implementing provinces. (1)
Performance based contracting or service agreements	Service agreements introduced as part of reform and in case of contracting, with indicators for performance chosen at year end to avoid distortion	Cambodia (2), Haiti (1)	CBA (2), ITS (1)	Routine practice as control (2) and comparison of indicators over time. (1)
Hybrid scheme	Payment per output and for target	China (1), Peru (1)	Quasi/non randomized trials (2)	Control as standard care (2)
Results based aid	Fixed element alongside a targeted element as part of results based aid	El-Salvador (1)	CBA (1)	Control as status quo (1)

PBF can take many forms (2): majority of schemes are payment per output

Scheme classification	Details on scheme	N.	Countries included (n)	Study types (n)	Comparators (n)
Payment per output	Payment for each output	9	Afghanistan (1), Argentina (1), China (1), Cambodia (2), DRC (1), Swaziland (1), Rwanda (2)	RCT (4), Quasi/non-randomized (2), ITS (2), CBA (1)	Control as status quo/standard care (4), comparison over time in implementing locations (2), comparator of matched funding or background PBF programmes into which experiments nested (3)
	Payment per output with income potentially withheld	1	China (1)	ITS (1)	Comparison of impact over time in implementing hospital. (1)
	Payment per output including revenue	1	China (1)	ITS (1)	Comparison over time in implementing provinces (1)
Payment per output modified by quality score	Payment per output with quality as multiplicative adjuster (between 0-1)	11	Congo (1), Zambia (1), Benin (1), Rwanda (8)	Quasi/non-randomized trial (8), CBA (1), ITS (2)	Control with standard care (2), Over time comparison in implementation areas (2), Comparator of matched funding (7)
	Payment per output with quality bonuses (quality adjuster an additional but not detracting component)	7	Burundi (4), Zambia (2)	RCT (2) and CBA (4)	Control as standard care (5), Comparator of enhanced matched financing (2)
	No description of payment equation - quality adjustment noted	1	Afghanistan (1)	RCT (1)	Control with standard care (1)
Payment per output modified by quality and equity score	Modification to payment equation based on population equity or remoteness of facilities	5	Burkina Faso (1), Cameroon (2), DRC (1), Zimbabwe (1)	Quasi/non randomized trials (2), CBA (3)	Control as standard care (4) and comparator including equipment and other in kind support (1)
Payment per output modified by quality and satisfaction score	Modification to payment including bonuses for enhanced patient satisfaction	2	Malawi (1), Zimbabwe (1)	CBA (2) and ITS (1) (one study does both)	Control as standard care (2)

PBF can take many forms (3): Target payment

Details on scheme	N.	Countries included (n)	Study types (n)	Comparators (n)
Potential for income gain only	12	Argentina (1), Kenya (1), Philippines (4), Tanzania (4)	RCT (5), CBA (5)	Control as standard care/status quo (12)
Potential for income withheld	1	China (1)	ITS (1)	Over time (1)
Target payment or payment per input	1	India (1)	RCT (1)	Control as status quo (1)

How do scheme effects compare?

- Performance based contracting and results based aid seem to achieve best outcome effects, but minimally assessed.
- Overall, schemes adjusting for quality + equity perform best against utilization outcomes (payment per output schemes performed best, but target payment + adjustments also).

Overview of results against standard care (1)

Outcome	Summary of impacts	GRADE
Utilization and delivery of health services	<p>Overall inconsistent picture: the intervention may improve some utilization and delivery indicators but may lead to poorer results for other indicators.</p> <p>When targeted:</p> <ul style="list-style-type: none"> • Proportion of persons receiving HIV testing (range 6-600%) and delivery of PMTCT (range 3.8 to 21%) may be affected positively; proportion of persons receiving ART and children (up to 120% decline) and households protected with bednets may decline (up to 7.3%); • effects on tuberculosis adherence are uncertain given very low certainty evidence; • effects on family planning outreach may be positive (moderate certainty evidence, increase up to 300%) • Evidence on mother and child immunizations and antenatal care utilization is mixed. <p>Effects on indicators when they are not targeted are largely uncertain or neutral.</p>	<p>⊕⊕⊖⊖ Low</p>

Overview of results against standard care (2)

Outcome	Summary of impacts	GRADE
<p>Quality of care (mainly assessed by score)</p>	<p>Largely uncertain overall.</p> <p>Effects on quality of care indicators appear to be sustained only when indicators are targeted. Indicators for which moderate certainty evidence was found include:</p> <ul style="list-style-type: none"> • P4P probably improves quality of care scores (range 5 to 300% relative increases); • P4P probably improves the quality scores of available medicine and equipment, effects ranged from 2.7% to 220%; • Overall quality of service by specific departmental area/service: P4P probably improves the average quality of service scores in specific targeted areas (effects ranged from 39% to 15-fold increase in scores). <p>P4P may make little or no difference to staff knowledge and skills (low certainty evidence).</p>	<p>⊕⊕⊖⊖ Low</p>

Overview of results against standard care (3)

Outcome	Summary of impacts	GRADE
Health outcomes	<p>When targeted:</p> <ul style="list-style-type: none"> • P4P may reduce child mortality / 1000 children born alive (range: relative change 0.2-6.5%); • P4P may lead to a modest reduction of 2-3% in the proportion of children with reported anaemia; • P4P may increase the likelihood of tuberculosis treatment success (range: 12-20% improvement in treatment success). • Evidence on neonatal mortality is inconsistent: P4P may have desirable effects and ensure reduction in neonatal mortality in implementing clinics by up to 22% in one study, however, another study identified increases in region of 6.5% across catchment areas of P4P incentivized providers. 	⊕⊕⊖⊖ Low
Unintended effects	No distorting unintended effects.	⊕⊕⊖⊖ Low

Overview of results against standard care (4)

Outcome	Summary of impacts	GRADE
Changes in resource use	<p>Overall certainty in evidence across indicators is low, for those where moderate certainty observed:</p> <ul style="list-style-type: none">• P4P probably has a positive effect on human resource availability (range for relative change compared to control: 19-44%, moderate certainty evidence).• P4P probably affects infrastructure functionality and medicine availability positively.	⊕⊕⊖⊖ Low

Overview of results against standard care (5)

Outcome	Summary of impacts	GRADE
Provider motivation, satisfaction, absenteeism and acceptability	<p>P4P probably makes little or no difference to provider absenteeism (range: 0.7-2%, low certainty evidence). Effects on overall motivation scores and satisfaction are largely neutral (low certainty evidence).</p> <p>Where these outcomes were not directly targeted, the intervention may have desirable effects.</p>	⊕⊕⊖⊖ Low
Patient satisfaction and acceptability	<ul style="list-style-type: none"> • Overall positive, with only two outcomes noting limited to no effect in relation to the intervention (satisfaction with care quality and provider communication). • When not targeted, effects may be largely positive, except for satisfaction with provider-patient contact time and facility opening hours. 	⊕⊕⊖⊖ Low

Overview of results against standard care (6)

Outcome	Summary of impacts	GRADE
Impacts on management or information systems (if not a targeted measure of performance)	P4P may positively affect facility managerial autonomy (low certainty evidence), probably makes little to no difference to management quality or facility governance.	⊕⊕⊖⊖ Low
Equity considerations: evidence of differential impacts on different parts of the population	<ul style="list-style-type: none"> • P4P may increase the proportion of poor persons utilizing child immunization services, however the intervention may potentially decrease the proportion of poor persons utilizing antenatal care. • P4P may make little to no difference to the utilization of institutional deliveries by poorest groups. • If not explicitly targeted, effects are mixed. 	⊕⊕⊖⊖ Low

Comparison to WB meta-analysis

Not yet in public domain, so based on presentation summarising results

Overall results of reviews are consistent, but the aggregation of indicators in WB meta-analysis different than Cochrane (bear in mind when reading both!)

PBF has a positive mean impact on utilization of modern contraceptives, however CCTs may outperform PBF designs for this.

ANC: PBF impacts on women accessing 4 or more visits are variable and likely indicative of little to no important effect (ranging from -3% to 2%), however PBF programs appear associated with higher likelihood of women receiving tetanus vaccinations as part of ANC.

Institutional deliveries: PBF may perform better than voucher and CCT programs

Section 2: Evidence on DFF

Review on prospective payment mechanisms

Reviews capitation, global budgets and DRG, and their effects on health expenditure, service utilization and care quality

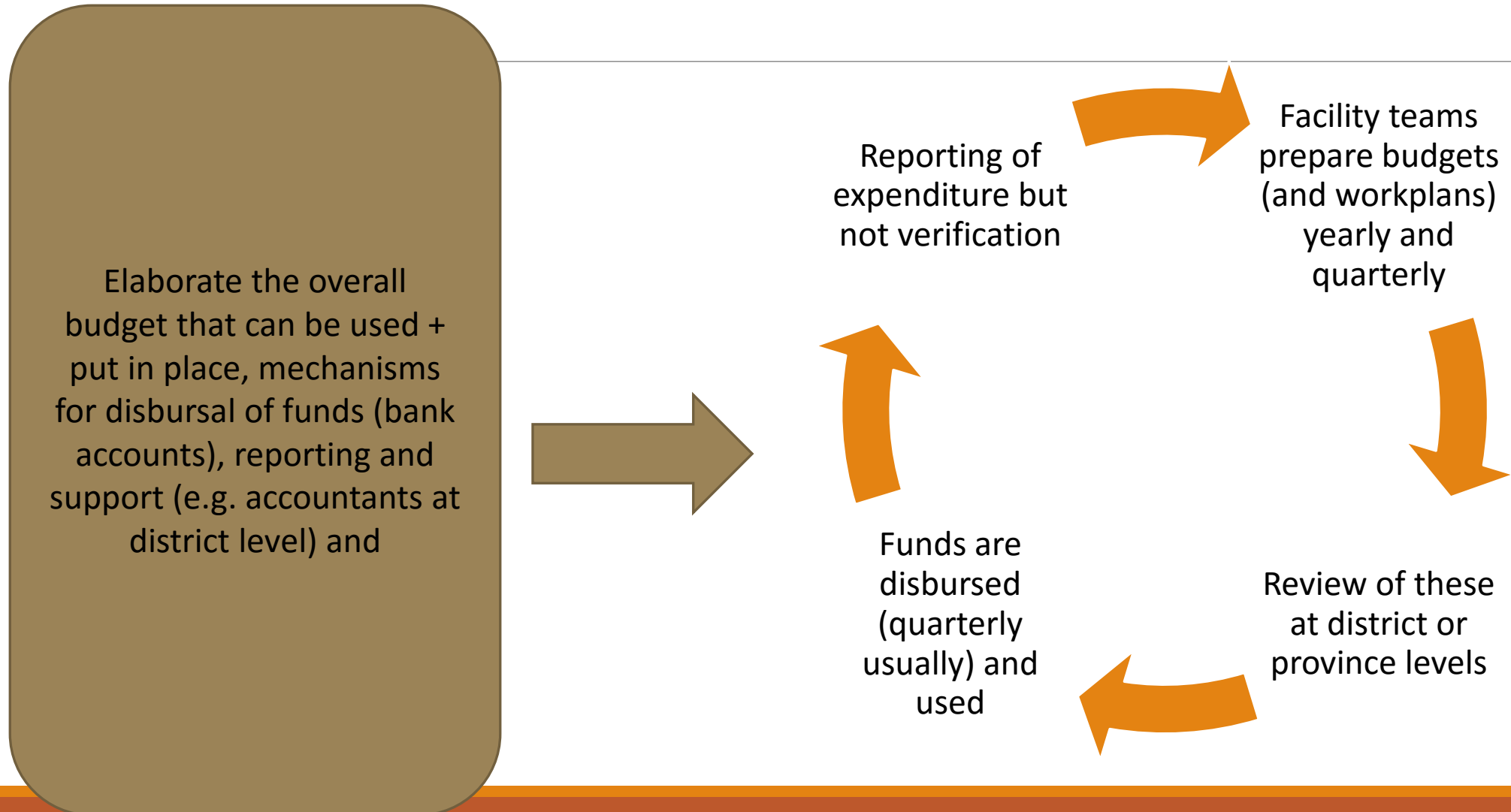
Concludes that such mechanisms can effectively reduce administrative and health system expenditure on health, as well as lower demand-side expenditure.

Mixed designs – where facilities implement a mixed capitated budget and PBF intervention – are noted to be particularly effective

DFE schemes reviewed: context

Context element	Tanzania	Kenya	Papua New Guinea
Policy and service landscape	User fees routinely charged Decentralization desired - fiscal, administrative and for decision-making to ensure responsiveness to population needs	User fees routinely charged Challenges with ensuring service equity, particularly for rural facilities	User fees routinely charged Low level of per capita spend More responsiveness to population
Problem areas to be tackled by DFE	Poor quality of care at facility level, high user fees, delayed transfers of funds from districts to facility	Poor quality of care, infrastructure, supply of medications and low staff morale at facility level; delayed transfers of funds from districts to facility and retention of high % at district	High service coordination costs at district; Limited funding trickling down to facility; Facility ownership of service delivery currently undermined by excessive district and central management
Scale of implementation	Pilot in Bukoba and then expanded to 7 regions	Pilot in Coast Province, 7 district	One province: Bougainville, then expanded to national as part of reform
Time period	Started 2017/18	2005-2007 and further scaled	Pilot start unclear, but 2014 onward for national implementation
Funder	Health Basket Fund (Joint donor)	DANIDA and Ministry of Health	AUSAID NZAID

DFE schemes reviewed: design



DFF schemes reviewed: design and mechanism

Design and mechanism	Tanzania	Kenya	Papua New Guinea
Actors	DHMT and County Health Management Team conduct supportive supervision and mentorship, review fidelity of implementation (respectively); Facility teams and governance committee; financial assistants at district level	Provincial health management team oversees province and has support of provincial accountant; same structure replicated at district; Facility Management Nurse works specifically on community outreach and strengthening planning capacity of health facility committees; health facility committees	Health facility committees main ones to approve plans, budgets and reports (no allowances given); Province CEO and accountants to monitor scheme and ensure accountability – have the option to withhold funds if needed
Capacity building	For reporting and budgeting and community mobilization	For reporting, budgeting, and community engagement	For budget preparation and auditing
Supervision	Enhanced mentorship and supervision as previous	As per routine + for accounting	As per routine + for accounting
Accountability	Enhanced community involvement in planning, enhanced reporting	Health facility committees and financial reporting enhanced; blackboards showcase expenditure to community	Enhanced mechanisms for auditing, including increased meeting frequency for facility committees

DFF schemes reviewed: impacts

Tanzania	Kenya	Papua New Guinea
Evaluations are ongoing – available evidence is positive and suggests similar impacts as in Kenya	<ul style="list-style-type: none">• No reduction in relation to user fees• Improvements in the working environment• Predictability of staff being funded increased and more staff attendance• Increased utilization of services and patient satisfaction + perceptions of care quality increase too	<ul style="list-style-type: none">• Limited impact on user fees• Increases in utilization, but unclear if attributable to the DFF scheme

Section 2: How do PBF and DFF effects compare?

EVALUATIONS TO DATE OF A 'DFF LIGHT' MODEL

Evaluations comparing the two designs

Country	Evaluation reference	PBF design	DFF design
Benin	Lagarde 2015; de Walque et al. Endline report	Payment per output modified by quality score (quality score index with 124 quality criteria bounded between 0-1)	Matched financing equivalent to PBF (adjusting for core indicators as per PBF) and similar managerial autonomy as for PBF.
Cameroon	de Walque 2017	Payment per output modified by quality and equity considerations (bonus, but if verification identified discrepancies, potential for income withheld). Limited managerial autonomy.	Matched financing equivalent to PBF (on monthly basis) and managerial autonomy to use funds facility as desired (including staff hire)
DRC	Huillery 2017	Payment per output.	Matched financing equivalent to PBF, calculated based on number of health care workers available.
Nigeria	Kandpal 2018	Payment per output modified by quality and equity considerations (bonus)	Facilities receive half of funds that PBF facilities receive, and there is autonomy to spend as desired (no allowance to pay staff).
Zambia	Friedman 2016	Payment per output modified by quality and equity score	Matched financing equivalent to PBF and additional equipment (same as the PBF).

Which one is preferable? (1)

Country	Health service utilization and delivery	Quality of care
Benin	At midline, DFF desirable: Consultations logged per staff in PBF group lower than in DFF. At endline (2017), DFF and PBF perform relatively similarly, there are no statistical differences, but DFF still assures higher utilization for postnatal utilization, family planning utilization and malaria cases treated in under 5s.	At midline: Process quality of care across diverse RMNCH areas increases, but equipment quality decreases in comparison to DFF; PBF facilities had overall 10.1% more financial resources than comparator.
Cameroon	DFF group sees 2 additional deliveries/month, similar effects observed on ANC quality. For immunizations, family planning, HIV testing, PBF group outperforms DFF, but no important effects on PTMCT or ART delivery.	Equipment availability higher in the DFF groups, but no important effects and differences on vaccine availability or medication availability. Family planning supplies predominantly available in PBF facilities, no important effects on malaria treatment.
DRC	DFF desirable: limited effects on likelihood of having BCG vaccination, reduction in postnatal care utilization and other items.	PBF effects on process quality compared to DFF are mixed, but overall 8% reduction in correct medical prescriptions, increases in length of stay following delivery and overarching quality score is lower. Equipment availability is also relatively lower, though infrastructure functionality higher compared to DFF.
Nigeria	"Of the 8 quantity indicators included in the IE, DFF achieved larger adjusted DiDs on 4, however, PBF achieved statistically greater improvements in skilled birth attendance and the related institutional delivery rate. PBF may have also done better on modern contraceptive prevalence rate but DFF likely achieved better results on immunization and ITN use."	Evaluation notes similar impacts.
Zambia	Immunization service delivery and utilization 40% higher in PBF groups, increases of 8% in curative visits in over 5 year olds, but decrease in under 5. Generally neutral impacts on ANC in comparison to DFF but negative effects relative to DFF for family planning utilization.	PBF likely desirable: Slight positive effects on procedural care quality in general, except for family planning where effects are 40% higher compared to DFF; 75% more equipment available, however significantly less medicines available (relative effect -160%).

Inconclusive

DFF preferable

PBF preferable

Which one is preferable? (2)

Country	Health outcomes	Facility autonomy
Benin	Not assessed.	Similar across groups and difficult to distinguish, initial design emphasised this element across both arms.
Cameroon	Not assessed.	By design similar.
DRC	DFF desirable: PBF facilities have slight increased likelihood of child mortality and reductions in height and weight scores for under 5s observed.	Not assessed quantitatively.
Nigeria	Not assessed.	Not assessed quantitatively.
Zambia	PBF desirable: 10.5% reduction in sickness in under 5s.	PBF desirable: autonomy scores are 46% higher in PBF facilities compared to DFF.

Inconclusive

DFF preferable

PBF preferable

Section 3

REFLECTIONS ON SELECTED GF EXPERIENCES WITH PBF

Methods

We carried out four case studies to accompany the main report on PBF/DFF:

- PBF programmes which were co-funded by the GF
- Present the overall context, design and implementation (including challenges and outcomes) of PBF
- Focus also on the GF's perspective – what was the set up and the specific challenges related to the GF's contribution
- DFF is not considered (in some of these setting DFF-like interventions were included as 'control' for a PBF IE, but not all were funded by the GF)

Cases selected: Benin, DRC, Cote d'Ivoire and Haiti

- Note that all are *rapid* case studies, and in particular the last two



Focus

In this presentation, after an overview of the PBF programmes, we focus on the following specific themes/issues:

1. The GF's perspective – GF's involvement in PBF, partnership structures, challenges and lessons learnt
2. PBF integration and sustainability
3. PBF as a donor coordinating mechanism

	Benin	DRC	Cote d'Ivoire	Haiti
History of the project				
Period of implementation	2012 – 2017	2014 - ongoing	2015 - ongoing	2013 - ongoing
Coverage	2012-2015: 8 out of 34 districts in the country (WB) 2015-2017: additional 19 districts (GF), 3 districts (GAVI). Remaining districts supported by a separate PBF/HSS project of the BTC.	140 zones in the (old) provinces of Katanga, Équateur, Bandundu and Maniema	2015-2017 pilot in 4 districts 2017-2019: extended to 19 districts (out of 86) 2019-2021: plans to scale up to entire country - additional 31 districts in 2019 (to 50 districts), additional 23 districts in 2020 (73 districts in total), additional 13 districts in 2021 (86 districts in total)	3 departments, later extended
Main implementing partner	World Bank	World Bank	World Bank	World Bank
Funding (WB)	\$11 million	\$226.5 million	\$35.8 million (2015-2019)	\$90 million (2013-2018)
PBF design features				
Facilities covered	Public and private not-for-profit (PNFP) facilities	Public and private not-for-profit (PNFP) facilities (agrées)	Public and some private not-for-profit (PNFP) facilities	Public and private not-for-profit (PNFP) facilities
Indicators covered	28 indicators at health centre level and 14 indicators at hospital level	22 indicators at health centre level and 24 indicators at hospital level.	26 indicators at health centre level and 28 indicators at hospital level,	16 indicators at health facility level, and 5 at hospital level.
PBF payment calculation	Fixed payment per output, modified by a facility quality score	Fixed payment per output, modified by a facility quality score <i>with an equity bonus element to compensate for remoteness</i>	Fixed payment per output, modified by a facility quality score	
Use of PBF funds	Max 50% health workers Min 50% facility operational costs	Max 50% health workers Min 50% facility operational costs	Max 50% health workers Min 50% facility operational costs – <i>excluding drugs</i>	Max 70% HWs - Min 30% facility operational costs
Verification	Quantity: an international agency Quality: district health management teams (peers for hospitals) Community monitoring through contracted local NGOs.	Quantity: provincial EUPs (purchasing structures established by the programme) Quality: health zones Community monitoring through contracted local NGOs External counter-verification by an international agency	Quantity: an international agency Quality: district health management teams Community monitoring through contracted local NGOs.	Quantity: an international and two national NGOs Quality: district health management teams Community monitoring through contracted local NGOs.



1. The GF's perspective

Expectations and rationale for GF's involvement in PBF not always fully explicit but included different elements such as:

- An **experimental interest** to learn about the model as one approach to PfR, by investing in it
- Taking advantage of the existence of well-developed models as a **possible vehicle for HSS**
- Seeing the PBF programmes as an approach to **donor harmonisation**: the Global Fund was not the only partner 'buying in' – a number of other international agencies have also invested in different settings, such as GAVI, USAID and UN agencies.

	Benin	DRC	Cote d'Ivoire	Haiti
Global Fund's involvement				
Period	2015-2017	2018	2017-2019	2015-2017
Funding	\$34m stand-alone HSS grant (Round 9)	\$5.4 million USD (of the initially pledged 10 million)	\$3 million (NFM1 & NFM2 malaria grant) to cover 3 districts	\$1.7 million originally budgeted, less than \$600,000 spent (HIV/TB grant) to cover 50 facilities
Cash flow and partnership set up	Through WB's project implementation unit. Separate bank accounts for WB and GF-supported districts/activities	Trust fund to the WB	To National Malaria Control Programme, GF's PIU and then to the PBF unit of the MoH Separate PIU for GF and WB	To PSI and then to the WB's Project Management Unit in charge of PBF (separate bank account)
Partnership with WB	<ul style="list-style-type: none"> GF's involvement in design: varied across the settings, but the PBF model was essentially determined by the World Bank in negotiation with national partners, with the Global Fund contributing to expansion of the model to new areas of the country for the agreed indicator package as a whole Generally constructive, with a recognition of the expertise developed by the World Bank in PBF, but with some frustration on the Global Fund side about the lack of detailed information sharing and substantive involvement in management of the programme and oversight of results 			
Other GF partners	PR: WB's PBF project implementation unit	No PR	PR: national malaria programme	PR: international NGO (PSI)
	<ul style="list-style-type: none"> Limited role for PRs, CCMs and LFAs to play in relation to PBF programmes, given that the latter already have clearly defined approaches and internal structures The role of a distinct PR when funds are being directly transferred to a PBF management unit needs consideration to ensure value added beyond fund transfers 			
Other partners in PBF programme	WB, GF, GAVI (BTC)	WB, GF, GAVI, USAID, (UNICEF, UNFPA)	WB, GF, (UNICEF, USAID)	WB, GF (Canada, USAID)



Operational challenges to GF's involvement

Lack of fit between the PBF and GF's **budget categories**

- PBF budgets: transfers to facilities, management and verification costs.
- Expenditures depend on outputs → prediction complex (e.g. in **Cote d'Ivoire** GF's budget was expended before end support)
- GF is more used to commodities-based support (easier to predict)

Difference in reporting indicators and **performance frameworks**

- In **Haiti**, indicators in the GF's PF related to the accuracy and consistency of reporting
- In **Benin**, the GF's PF included outcome indicators which were impossible to monitor every 6 months

Lack of specific PBF **expertise**

- In these cases, the GF had no direct design and implementation role, but was relying on WB – there are advantages in the division of tasks but also some frustrations



2. PBF integration and sustainability

Integration with overall **PHC financing**

- Despite PBF, there are system constraints on fund management and autonomy at facility level
- **Benin**: multiple funding streams with different requirements and complex PBF procedures → underspent on PBF
- **Cote d'Ivoire**: despite efforts, limited financial autonomy at facility level, with facilities not seen as autonomous units (e.g., user fees not retained and banking done at district level) → in the context of a wider political economy of decentralisation.

Human resources for health

- Role in retaining and motivating staff especially in underfunded systems. However, risk of adding to the proliferation of health worker incentive payment (**DRC**)

Health Information Systems

- In all case studies, PBF reporting systems remain separate from HMIS. HMIS would have a more important role if 'risk-based verification' is introduced.

PBF integration and sustainability (2)

As found in other studies, integration with HS and tailoring/adaptation to context (including local political economies and health system challenges and features) is important to the question of sustainability of PBF

In the case study settings, PBF sustainability varied – two examples:

- **Benin:** PBF was discontinued nation-wide in due to the impossibility of harmonising different approaches (WB/GF/GAVI – BTC) and lack of ownership from the MoH
- **Cote d'Ivoire:** WB PBF project (SPARK-health) to align with ongoing health insurance reform and complement purchasing mechanisms → potential for integration and sustainability

3. PBF as a donor coordination mechanism

PBF as an approach to donor harmonisation is one of the reasons for GF's engagement in PBF, along with other partners

	Benin	DRC	Cote d'Ivoire	Haiti
Partners in PBF programme	WB, GF, GAVI (BTC implementing a different PBF model)	WB, GF, GAVI, USAID, UNICEF, UNFPA	WB, GF, UNICEF, USAID	WB, GF, Canada, USAID (with different model/implement arrangements)
Division of tasks	Geographical division	Geographical division + support to specific areas	Geographical division + support to specific areas	Geographical division (target specific facilities)
Financing flows	All partners funding the PBF PIU (set up by the WB and within/on the side of the MoH). However, separate bank accounts for each partner	<ul style="list-style-type: none">Trust funds with the WB for GF, GAVI, USAIDComplementary (in-kind) contributions from UNICEF and UNFPA	<ul style="list-style-type: none">GF funding via National Malaria Control Programme -> GF's PIU -> WB/PBF PIUComplementary (in-kind) contributions for UNICEF and USAID	<ul style="list-style-type: none">GF funding via PSI and WB PBF PIU (separate bank account)Separate funding for others



PBF as a donor coordination mechanism (2)

How did that work in practice?

- Overall, there was no real **pooling of funds** in a joint basket in any of the case studies.

Benin: coordination worked well for WB, GAVI, GF adopting the same PBF model/design and implementation mechanisms – but it proved difficult to harmonise with that of the BTC

DRC: frustrations around the time-consuming creation and management of the Trust Fund, so the experience was short lived. WB's coordination with other partners (partially) continues.

Cote d'Ivoire & Haiti: partnership was less close (involving separate PIUs and cash flows) and reverted to a 'division of tasks' with WB and GF coordinating their activities and providing separate, but complementary support

- Haiti: *'joint investment'* modality as per WB-GF Framework Agreement

Section 4

CONCLUSIONS

PBF vs DFF?

The review highlights the **shared health system requirements** of PBF and DFF, their potential complementarities, and their shared potential to strengthen health systems and outcomes when appropriately deployed.

The evidence base in relation to effects is more developed for PBF.

In studies comparing PBF with interventions using less conditional direct cash financing, **neither model comes out as consistently superior** in general.

- When adjusted for additional resources, PBF performs somewhat better than input-based controls for some quality and autonomy measures
- But less well for utilisation
- And with no difference in general on health outcomes, despite slightly higher expenditure

Shared requirements

PBF is sometimes portrayed as complex and DFF simple but **both require considerable groundwork** in terms of:

- design and implementation of system strengthening components (such as reinforcing management skills at facility level, access to banking, improved supervision and health information systems);
- a broader supportive environment in which there is a willingness to decentralize and adequate funding;
- programme design and implementation components, such as:
 - estimating funding amounts needed by facilities, taking into account the degree of subsidies from other sources and the funds which are required at facility level;
 - determining reporting, verification and performance review approaches;
 - agreeing, monitoring and enforcing policies on charges to users;
 - determining and enforcing any rules on staff benefits from the funds, and on how funds can be used more generally.

Both are/can be HSS

PBF/DFF should be seen as **health system strengthening interventions** (not just health financing interventions), as they impact on all system areas and should in principle be coherent with arrangements in them

- e.g. health worker remuneration, drug supply systems, governance, public financial management (PFM) systems, health information systems, service packages, infrastructure quality and distribution, and measures to address community access barriers

PBF/DFF **mechanisms of change are also more complex** than the labels imply: the labels focus on finance, and resources are indeed important to effects observed. However, there are many other components which are important

- including feedback on effort, signaling of priorities, support for planning, more focus on data and results and greater autonomy for facility managers among others

There **are differences** between PBF and DFF: verification/risk approach different, so depends on the context needs (and degrees of trust)

Rationale for GF investment

- Neither approach is likely to improve **'operational efficiency'** of the Global Fund, in that they are relatively complex to establish, monitor and assess;
- In terms of **increasing disbursement**, DFF is more promising, in that it has fewer controls that limit expenditure; overall costs are also easier to predict and control;
- In relation to **reducing financial barriers for users**, both programmes could potentially reduce these, but this component needs more explicit attention and enforcement as results have been disappointing to date
- More generally, as a **system strengthening intervention**, both have promise if designed with good fit to the context and its blockages.
 - Both (independently or complementarily) can provide the small but essential flexible resources which are needed at facility level to support integrated care packages
 - Both can provide a mechanism for donor harmonization.
 - PBF benefits from a longer period of intense experimentation and documentation of its model
 - DFF benefits from a more integrated approach, with lower costs and potentially more sustainability
 - Both require **complementary interventions at community level** given that they only focus on facility-based services