Does a PBF scheme affect the choices of training activities by health facility managers?

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Main messages

- PBF may have ‘ecosystem’ effects – including on the market of continuing professional education

- First insights from our experiment in Burundi

PBF as a health sector reform

- *"Our experience is that performance-based financing can **catalyse comprehensive reforms and help address structural problems of public health services**, such as low responsiveness, inefficiency and inequity. The emergence of a performance-based financing movement in Africa suggests that **it may contribute to profoundly transforming the public sectors of low-income countries**."*

Meessen, Soucat & Sekabaraga, WHO Bulletin 2010

Perdiemitis – one of those structural problems!

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Editorial

Per diems undermine health interventions, systems and research in Africa: burying our heads in the sand

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Acute 'perdiemitis' is decidedly one of the most prevalent illnesses in African public health projects. When a novice (African or Westerner) first undertakes a research project or implements a public health intervention, he will encounter the diplomatically phrased question: 'What are the administrative modalities?' These days, anyone attending a research results presentation workshop, a training session, or an intervention expects that the organizers will pay him a premium – a per diem – for his participation. While per diems appear to have been originally used to compensate for the loss of time and income caused by such participation, today they have become political instruments that taint research and

with their salaries and no other payments except for travel costs. They were often hosted in remote regions by their colleagues or by villagers, who housed and fed them. Then, the massive arrival of the development industry gave rise to new funding modalities. In these development projects, very well-paid expatriate aid workers carried out activities with their African colleagues who were much less well paid. Thus, the aid workers introduced these per diems, perhaps out of ethical concerns, but mainly motivated by a desire for effectiveness, to ensure these activities would take place. As the years went by, habits were formed, and the practice was institutionalized; even the Financial Times called it 'the culture of the 'per diem''

Five causes?

1. Willingness to compensate for low salaries
2. Capacity buildings are driven from the top, with heavy influence from aid agencies - they compete for a rare resource: time of health staff
3. The MoH is a weak steward
4. Decentralisation to health facilities is limited
5. Path dependency

Consequences

1. Diversion of the time of health staff
2. Possible misalignment of training courses (not on the actual needs, as felt by the trainees)
3. Poor performance of the capacity building effort (one does not always train the right person)
4. Crowding-out of intrinsic motivation for learning
5. Staff demotivation (those who are not invited to workshops)
6. No extrinsic incentive to apply what was taught

A solution

- **to turn the continuing professional education market in the health sector in LICs upside down**: replace the existing ‘supply-induced demand’ model of today by a market which really takes the demand of frontline providers into account.

- This requires action on both the demand and the supply side.

Health facilities will formulate a demand if they…

1. have sufficient **financial resources** to purchase training courses for their staff;
2. have enough **autonomy and information** to decide which training courses they need in order to improve their services and which staff member(s) should be trained;
3. function in an **institutional environment that *incentivizes* them** to encourage their staff to acquire and apply new skills (that will in turn lead to a better performance).

Feasibility of the proposition

- All these conditions are met in a PBF environment!
- Could we check that at country level?

The experiment in Burundi

Background

- Impact evaluation (IE) in Burundi on a PBF Nutrition scheme
  - *Intervention: PBF + PBF for nutrition indicators*
  - *Control: PBF + lumpsum equal to the average of the extra income earned from nutrition by the intervention group.*
- Sample: 90 health centers
- Baseline: 9-10/2014
- Intervention: since January 2015
- Major political crisis since May 2015!

A willingness to pay survey (WTP)

- During the assignment workshop (1/12/2014)
- We offered health centre managers the opportunity to express their WTP on two nutrition courses:
  - *Course 1 – rehabilitation 2 days*
  - *Course 2 – growth promotion – 4 days*

"ITM has the expertise, but not the budget – we can cover our own costs, we have to charge participation costs"

Hypotheses under test

- There is a demand for training on nutrition
- The WTP is higher:
  - if you know that you will be in the I group
  - If your needs are measured as higher
- The WTP is high enough for attracting a private supplier

Three rounds

R1: Description of the two nutrition courses (+ an indication of the estimated prices)

R2: They know their IE status (intervention or control)

R3: We feedback them a score of their current performance with nutrition activities (an index from the baseline facility survey)

Results from R1 to R2

Average / FBU	WTP differences between R1 and R2				WTP R2			
	Control	Inter	Diff	p-value	Control	Inter	Diff	p-value
Nutritional rehabilitation	-9,868	-5,292	4,576	0.688	160,375	184,649	24,274	0.09
Nb obs	38	39			40	41		
Growth monitoring	-32,924	**21,062**	53,985	**0.000**	220,891	270,415	49,524	**0.017**
Nb obs	36	39			39	41		

I: WTP increased for the growth monitoring course only – some of sort of shift in the demand?

Results: from R2 to R3

Moyennes / FBU	WTP difference between R2 and R3				WTP at R3			
	Score < median	Score > median	Diff	p-value	Score < median	Score > median	Diff	p-value
Nutritional rehabilitation	21,428	7,586	-13,841	0.408	189,742	169,667	-20,075	0.272
Nb obs	29	29			31	30		
Growth monitoring	16,379	-179	-16,557	0.377	248,770	252,759	3,989	0.875
Nb obs	28	28			30	29		

The lower the performance score, the higher your WTP, yet, not statistically significant

Early findings

- Our hypotheses do not seem wrong.
- Yet, these are only WTP surveys. Could we look at the revealed preferences?

Next step

- Letter to Health Facilities (4/2015):
  - Courses will be delivered in the second half of 2015, please introduce **an order**
  - Only the first edition will be delivered by the ITM professors; only 10 seats available → we will rank you on the basis of the price you bid; yet we will only charge you the price proposed by the 11th bid (*Vickrey auction*).

- We will be able to compare prices by I/C (and assess the economic viability of the course).

Possible implications

- Possibly another argument in favor of PBF
- Reorganisation of policy instruments (avoid competition between instruments)
- Ecosystem effect: growth of market for training
- May also have implication on the acquisation and application of knowledge