



# Lessons from results-based financing to improve health services in Afghanistan

The Afghanistan experience of nearly 15 years of contracting for health services has demonstrated both how results-based financing (RBF) can serve to increase utilisation of health services and the equity in use, as well as the limitations and failings of RBF approaches to work consistently.

Future Health Systems (FHS) findings, generated through robust experimental and quasi-experimental studies in a rapidly changing context, suggests that attention to scheme design (especially to address demand side concerns, supply side capabilities, and the size and mechanisms of payments) and implementation (timeliness and communication about payments) are critical.

## Key messages

- 1 In the early contracting phase (2004–2005), the Ministry of Public Health in Afghanistan successfully managed contracts in a post-conflict context. Contracting-out was associated not only with an overall increase in curative care use but also with an increase in use by the poor and female patients. Whether or not contracts had performance bonuses resulted in minor differences.
- 2 A comparison study (2005–2008) on the pro-poor effect of different contracting schemes revealed that contracting-out with non-negotiable deliverables, but some flexibility in the arrangement, and performance bonuses linked to equity goals, can be effective for reducing the inequity of facility-based health services. Community Health Workers should also be included in performance-based financing arrangements.
- 3 The 2010–2012 pay-for-performance (P4P) intervention to improve maternal child health services did not produce the intended results. The impact evaluation of this intervention highlighted the need for more attention to demand-side factors, a better understanding not only of the relationship between P4P and health worker motivation and behaviour, but also of the bottlenecks to service use in order for these to be addressed holistically.
- 4 System dynamics modelling was used to explore implementation pathways for improving health systems performance through P4P schemes. Specific implementation strategies, such as prompt disbursement of adequate levels of performance bonus distributed per health workers' contribution to service, increase the likelihood of P4P success. Poorly designed P4P schemes can have a negative overall impact on health service delivery systems.



## Introduction

The Afghanistan Government, with the support of the World Bank, USAID, and the European Union, has experimented with several models of RBF schemes since 2004. These include contracting models involving performance bonuses; three other contracting-out and contracting-in models with local and international NGOs, which were tested from 2004 to 2008, renewed in 2009/2010 and are still ongoing; and a large-scale P4P contracting scheme supported through World Bank funding that started in 2010 and continues as one of the contracting models.

Future Health Systems partner, [Johns Hopkins Bloomberg School of Public Health](#) had a field office in Afghanistan from 2003 to 2013, working with the Ministry of Public Health (MoPH) to develop a national Balanced Scorecard (BSC) for health services. This BSC was intended to help the MoPH operationalise its national health policies and assess its health system performance, the first of its kind anywhere in the world. The initial BSC covered the assessment of a basic package of primary care services, with a subsequent BSC created for the assessment of essential hospital services. Community level scorecards were later piloted as a planning and social accountability intervention with DFID support. The BSCs – which collected data nationally from health facilities, patients and health providers, and from household surveys – provided a platform to improve performance and test a number of policy experiments, including assessments of the initial contracting schemes and the subsequent P4P scheme.

## Evidence

### Early contracting experience (2004–2005)

In the early contracting phase, which included contracting models involving performance bonuses, the MoPH, which was inexperienced at the time, was able to successfully manage contracts in the context of restoring health services and rebuilding institutional capacity after long-standing civil conflict. Evidence suggests that large-scale contracting for health services

in Afghanistan can result in substantial increases in curative care use. Not only is contracting-out associated with an overall increase in service use, but also with an increase in use by the poor and female patients, thus making it an effective approach to achieving the MoPH's public health policy goals for service utilisation. There were only minor differences between providers with contracts that had performance bonuses and those that did not. Having performance benchmarks, disclosing results, and linking performance to the continuation of a contract seem important to the success of each form of the contracting.

### Reaching the poor (2005–2008)

A comparison of four contracting models and a non-contracting model from 2005 to 2008 shows that how contracts are designed matter significantly, in how health services can reach the poor. Contracting out health services provision to non-state providers and allowing contractors to allocate funds within a fixed budget sum with non-negotiable deliverables is effective for reducing the inequity of facility-based health services. Flexibility in the contracting arrangement provides the opportunity for contractors to seek innovative pathways that may not be perceptible to the contractee in meeting the contract deliverables.

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Linking equity goals to a performance bonus for service providers may be an effective strategy for reducing the inequity of facility-based services utilisation between the poor and non-poor. Community Health Workers are critical for increasing demands for health facility-based services among the poor and should be included in performance-based financing arrangements for achieving health equity.

### The 2010–2012 pay-for-performance intervention

From 2010 to 2012 a P4P programme in Afghanistan provided quarterly bonus payments to health-care providers for increases in the use of maternal and child health (MCH) services,





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adjusted by a quality of care score. A large-scale cluster randomised trial of this P4P scheme revealed that despite high expectations, P4P incentives to improve maternal child health services do not always work as intended at the population level. P4P is intended to improve health worker motivation and satisfaction, but this did not occur in the Afghanistan study. The insufficient focus on demand-side factors and difficulty in communicating to health workers about the intervention may have undermined the potential effects of the P4P intervention. Therefore, more attention needs to be given to these factors in the design, management and implementation of P4P programmes. Further research into the relationship between P4P incentives and their effects on health worker motivation and behaviour, as well as on organisational culture, leadership, management and psychology, would help address important bottlenecks to service use in the intervention design.

### How to improve health systems performance through pay-for-performance schemes

System dynamics modelling was used to explore implementation pathways for improving health systems performance through P4P schemes, based on the Afghanistan data. Theories of change are critical to understanding how P4P interventions can work: Modelling provides quantitative results to inform the theory of change of supply-side P4P intervention and show the impact of various implementation scenarios and design choices on P4P effectiveness. The optimal P4P design and implementation features for improving performance of health systems in low-and-middle income countries include prompt disbursement of adequate levels of performance bonus distributed per health workers' contribution to service. Other ways of paying providers (such as equal allocation or allocations proportionate to salaries) and failure to mitigate gaming can result in health services quality and volume levels that are substantially lower, sometimes even below baseline levels.

## Conclusion

Afghanistan's use of RBF to increase access and equity in health services utilisation provides useful learnings for other countries exploring options for contracting providers, as well as those reflecting on their own experiences. Future Health Systems partners' collaboration with the Afghanistan Government helped to facilitate embedded research and evaluation to test and guide the implementation of a number of policy initiatives, generating important knowledge to strengthen and adapt strategies.

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