Improving Access to Healthcare for the Poor in Northern Uganda

NUHEALTH
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Technical Brief 2 July 2013: Early Implementation Experiences in NU Health

The Northern Uganda Health project (NU Health) is a 4 year project funded and supported by UKaid from the UK Government under the Post-Conflict Development Programme (PCDP).The NU Health project aims to strengthen local and national mechanisms for governance and accountability to improve access to health care, particularly for the most vulnerable populations in the region, through utilisation of results based financing (RBF) mechanisms. The first Technical Brief produced December 2012 described how the programme was established: this Brief presents some of the early implementation experiences from the perspective of one group of key stakeholders – health facility staff.

The Background

Increasing interest in a range of health financing options aiming to improve health system performance by linking payment with output or results, is rapidly extending amongst African policy makers (The World Bank, 2013). However, whilst growing, strong evidence of impact remains scarce (Norad, 2012). It is thus recognised that the strengths and weaknesses of different RBF approaches need more extensive research and documentation (Eurodad 2012).

NU Health aims to contribute to the debate on the potential value of RBF initiatives by using a range of assessment measures to monitor changes in the volume and quality of health services delivery across all participating health facilities, as well as tracking changes in the health system through comprehensive process monitoring.

Information in this brief is based upon process documentation exercises conducted with participating facilities throughout the past three months. The following methods were used for the process documentation:

- Recorded health facility observations by District Health Team (DHT) members and NU Health field staff during the Quarterly Quality Assessments (QQA);
- Key Informant Interviews (KII) with Health Facility Management and Focus Group Discussions (FGD) with operational staff, conducted at least two weeks after QQA and Data Quality Assessment (DQA) exercises, using a semi-structured questionnaire, and,
- Observations by programme staff.

The NU Health Programme: key features

- NU Health focuses on generating and testing evidence on the extent to which RBF is an efficient and effective financing mechanism, compared with more traditional input-based financing (IBF), for improving access to and quality of health care among faith-based, private-not-for-profit health providers (PNFPs)
- NU Health is currently supporting 31 PNFPs, including 21 located in the intervention area in Acholi sub region and ten in the control area in Lango sub region
- Implementation of the RBF and IBF initiatives has been phased in over time with the first batch of facilities (Batch A) commencing activities in September 2012 whilst Batch B commenced in November 2012

Each month participating facilities provide a summary of services delivered, based on a specific listing developed for NU Health: the listing includes key services routinely recorded through the health management information system (HMIS). The data provided is verified externally once every three months for smaller facilities and every month for hospitals.

In addition, a QQA is undertaken by the DHT and the NU Health team, with health facility staff according to a pre-defined checklist. The quality assessment procedure also serves as a supervisory and mentoring activity since feedback is provided on the spot for each area of assessment and means of improvement are discussed together with facility staff. Together, the volume and quality of services provided form the basis for a quarterly performance payment to RBF facilities. The IBF facilities receive an upfront payment equivalent to that of a similar level RBF facility but irrespective of their performance.

All participating RBF and IBF facilities developed a business plan before obtaining NU Health funding. The purpose of the business plan was to help facility staff analyse the benefits and risks, investment and likely returns associated with the new initiative – in this case the funding associated with NU Health. Business plans formed the basis for facilities to plan improvements in service delivery and quality through reinvesting revenues generated through NU Health funding. In order to provide an opportunity for participatory planning and better understanding of the RBF concept, NU Health provided planning guidelines to staff and management of both RBF and IBF facilities prior to implementation (which commenced in September 2012). In health facilities where annual health plans already existed – as was the case for all the participating hospitals and health centre 3s affiliated to Lacor Hospital – business plans were developed with reference to existing plans. Initially, we had adopted a hands-off approach, however, most lower level health facilities required more time and support to internalise the principles and develop their plans.

In this brief we only report on the period covering the baseline and the first quarter of implementation for all facilities. Trends and comparisons for other quarters will be possible as these are completed.

The Findings

Utility of business plans to guide implementation:

Although there was a good sense of understanding of RBF concepts amongst staff and management, this had mostly been gained during the first verification exercise. The size of the health facility and staff turnover affected the level of awareness amongst staff on the purpose and content of facility business plans in both RBF and IBF settings. For example, larger facilities were less likely to involve a higher proportion of staff in the planning process, whereas many smaller facilities with small management teams were reported to have been more inclusive. A high attrition rate and failure to bring all new staff on board quickly, also affected the level of awareness of planning processes in both RBF and IBF facilities. A lack of collective understanding on the business plan purpose and content can impede implementation and is illustrative of the need to continuously update and orient staff on 'new' concepts.

In the first three months of implementation, management and staff gained insights into how they could improve their business plans. RBF facilities tended to focus on improving their quality scores, through for example, increasing human resource levels and improving infrastructure to ensure privacy during consultations. In IBF facilities, additions were typically input items requiring additional funding – such as infrastructure improvements, provision of fuel for the ambulance, increase in staff salaries, renovation of staff housing, and repair of solar panels. In some cases this was because rapid price inflation had led to facilities obtaining fewer commodities than planned in their budgets.

Quality of Care:

The overall quality of care at health facilities is measured using a framework agreed during inception (NU Health, 2012). The overall score is based on the total sum for all areas assessed and is a reflection of the extent to which health facilities have taken steps to comply with indicator standards. Clearly, the quality assessment (QA) tool is starting to drive changes in some health facilities. Table 1 and Figure 1 illustrate that there was an increase in the QQA score at all levels of care in the RBF region as opposed to IBF where this increase was observed at the hospital level only. In the IBF region, there was a decrease in the scores at HC3 and 2.

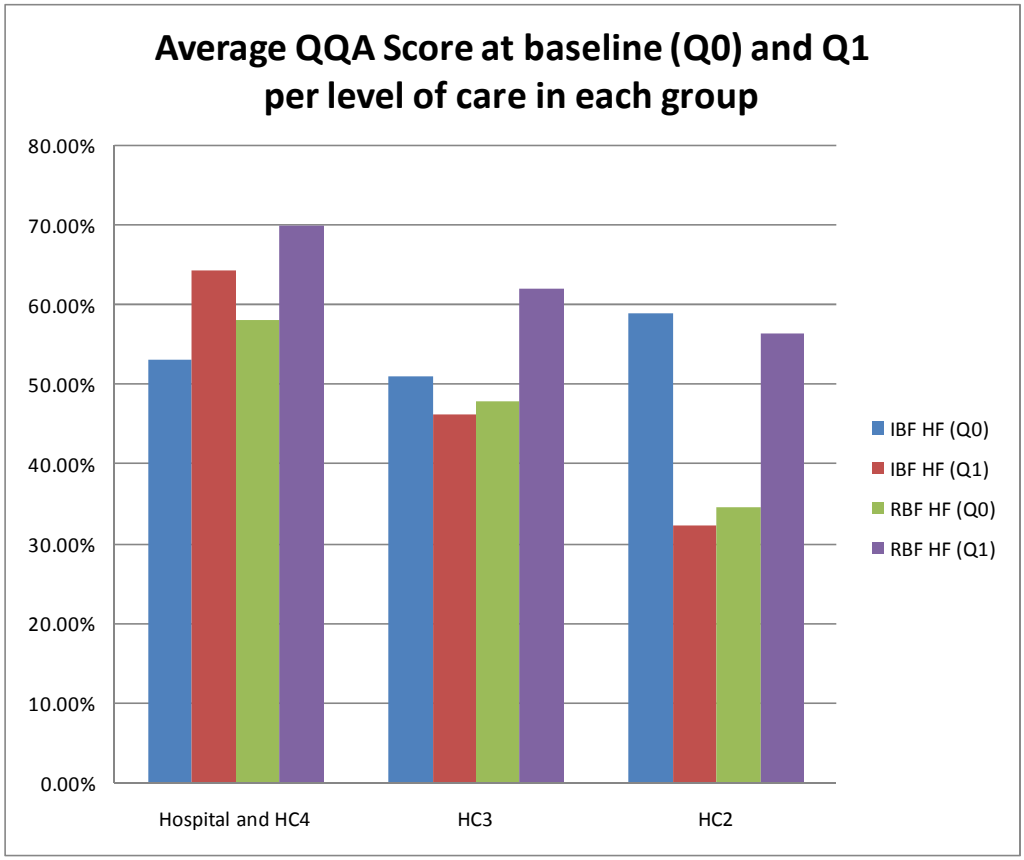
The most likely reason for the higher score in the RBF region at Q1 was the "behavioural response to financial incentives". Conversely, at HC2 and 3 in the IBF region – the decrease is explained as the "lack of investment to date in areas that are specifically focused on during the assessment". It should be noted that all hospitals and HC4 were in the category 1 before implementation and did not need additional investment suggesting that the support supervision and mentoring by itself may have contributed to the observed improvements at this level. Additionally, hospitals and HC4 in both the RBF and IBF regions were quickly able to replace staff lost due to attrition during the mass recruitment in the public sector.

The stricter scoring in Q1 could have contributed to the lower scores observed in the IBF region at HC2 and 3 particularly because the baseline was more lax for this particular set of facilities. However, observation over a longer period will allow us to make more meaningful conclusions.

Table 1: Differences in QQA scores between Q0 and Q1 in the IBF and RBF regions

Average QQA Score at baseline (Q0) and Q1 per level of care in each group						
Level	IBF HF (Q0)	IBF HF (Q1)	Difference	RBF HF (Q0)	RBF HF (Q1)	Difference
Hospital and HC4	53.08%	64.28%	+11.2%	57.99%	69.90%	+11.91%
HC3	50.91%	46.13%	-4.78%	47.87%	61.94%	+14.07%
HC2	58.90%	32.41%	-26.49%	34.64%	56.40%	+21.76%

Figure 1: Average QQA Score at Baseline (Q0) and Q1 per level of care in each group



(a) Availability of essential drugs, health supplies and equipment

According to the pharmaceutical baseline assessment undertaken in the 31 supported PNFP facilities in September 2012 (NU Health 2012), the average availability of a basket of 18 Essential Medicines and Health Supplies (EMHS) for both RBF and IBF facilities on the day of the survey was 63%. The lower level facilities in both categories recorded poor availability whereas the hospitals had better availability recording more than 80% on the day of the survey (see table 2). Availability of the 6 tracer items was 55%. Only 6% of facilities had all 6 tracer medicines in stock on the day of the survey. The overall availability for Artemisinin Combination Therapy (ACT) and Depo Provera was low in the previous six months. ACT was only available a third of the time and Oral Rehydration Solutions (ORS) half the time in HC2s. The availability of three key medicines related to emergency obstetric care (Ergometrine, Oxytocin and Magnesium Sulphate) was low at only around 10% at HC3 and HC4 level and about 33% at all the surveyed hospitals.

Table 2: Availability of a basket of medicines

PNFP FACILITY (RBF)	% AVAILABILITY (SEPT 2012)	PNFP FACILITY (IBF)	% AVAILABILITY (SEPT 2012)
KITGUM ARCHDECONRY HC2	50	ADUKU HC2	61
ALL SAINTS HC2	78	ST FRANCIS AKIA HC2	39
NEWLIFE MEDICAL CENTRE HC 2	72	BOROBORO HC3	50
LIGHT RAY UGANDA HC2	28	AMUCA SDA HC3	39
ST PHILIP HC2	61	MINAKULU HC3	28
WII ANAKA HC2	50	ICEME HC3	83
ST LUKE HC2	44	NGETTA HC3	N/A
KARIN MEDICAL CENTRE2	N/A	ALANYI HC3	83
ST PETERS AWERE HC2	72	PAG HEALTH UNIT HC4	94
COMBONI SAMARITANS HC2	50	POPE PAUL ABER HOSPITAL	89
ST MAURITZ HC2	67	**AVERAGE**	**63**
ST JOSEPHS MINAKULU HC2	72		
ST MONICA HC2	61		
SOS CHILDREN'S VILLAGE HC2	72		
ST JANANI LIRA PALWO HC2	39		
LACOR AMURU HC3	78		
LACOR PABBO HC3	67		
LACOR OPIT HC3	56		
LACOR HOSPITAL	89		
ST. JOSEPHS KITGUM HOSPITAL	89		
KALONGO HOSPITAL	72		
AVERAGE	**63**		

With regard to stock outs, RBF health facilities registered more days out of stock of the basket of 20 medicines compared to those in the IBF category (see table 3).

Table 3: Days out of stock for a basket of EMHS

CATEGORY	AVERAGE DAYS OUT OF STOCK	% AVAILABILITY ON THE DAY OF SURVEY
RBF	82	60
IBF	58	57

After three months of implementation, management staff at both RBF and IBF facilities reported that with the provision of medicines through the credit line, there have hardly been any stock-outs of medicine. It was also perceived that the constant availability of medicines had boosted patient confidence and increased the numbers attending care at the facility. A quantitative pharmaceutical audit will be conducted in September 2013 and compared to the one taken last year to confirm that the level of availability of medicines has improved. Data from the detailed audit will enable us to make before and after comparisons at health facility level. An equal availability of medicines in both the RBF and IBF regions “levels out the playing ground” for both RBF and IBF and rules it out as a factor that might influence any observed differences in the quality and/or volume of services.

During the inception period health facilities (HF) were classified as either Category 1 or 2 dependent on capacity. One measurement was on whether they had access to basic essential equipment. All those in category 1 (9 RBF HF and 5 IBF HF) had no serious equipment gaps. All health facilities in category 2 were supplied with basic essential equipment that was identified as missing before implementation. This meant that no participating health facilities lacked basic essential equipment at the start of implementation.

Meanwhile, the routine monitoring and data verification systems indicate a higher volume of service delivery. For example **Figure 2** illustrates that for the nine RBF health facilities that have completed a second quarter of implementation, a higher volume of services have been provided in the subsequent quarter in six out of nine facilities. The 'decline' in verified numbers in most cases is related to poor documentation and may not necessarily reflect a decrease in the actual volume of services provided across the 16 indicators. This is particularly obvious for the IBF facilities (**Figure 3**) and in this case the apparent decline in the volume of services is also related to a stricter assessment in the IBF region during the second quarter. A more substantive assessment will be undertaken in later months, comparing volume of services between the current and subsequent years.

Figure 2: Service Delivery Numbers for 9 RBF Health Facilities

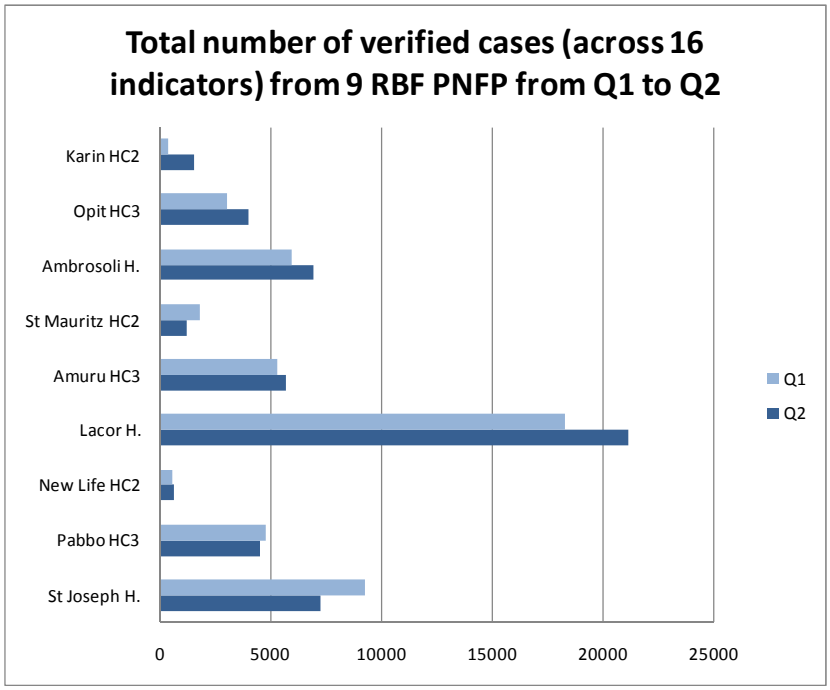
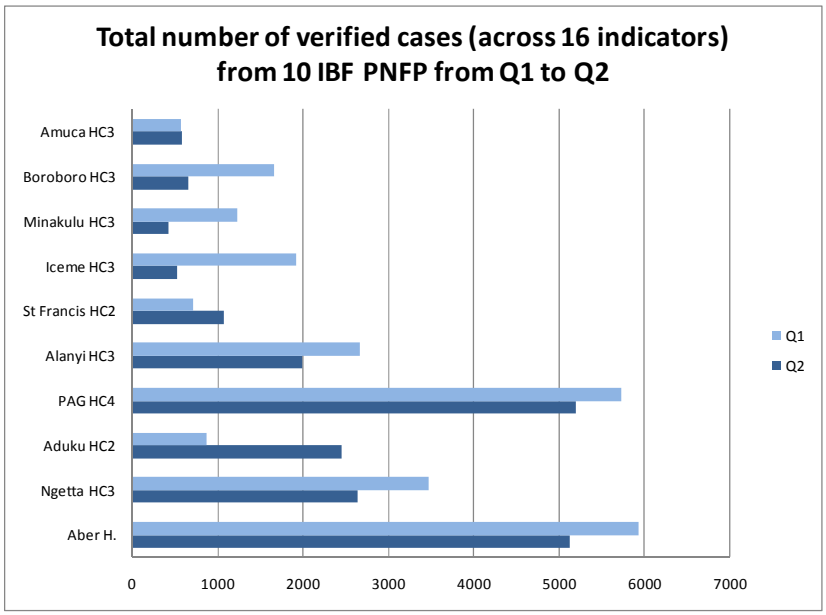


Figure 3: Service Delivery Numbers for 10 IBF Health Facilities



(b) Skilled human resources

Health facilities were required to have the basic minimum of Ministry of Health staffing norms for level of care before they could qualify for programme support. Therefore all health facilities had the minimum of staffing at the start of implementation in both RBF and IBF settings. Staff numbers are routinely checked during the quarterly verification and so far all but one health facility have maintained sufficient staff numbers. Failure to maintain staff numbers constitutes a breach of contract and currently the affected facility has been suspended on this basis.

During the first quarter of implementation, the most commonly cited cause of attrition was the recent mass recruitment drive by government. Government employment is perceived to be more attractive than in the PNFP sector for a number of reasons including higher pay (the recently advertised government posts have a 30% salary increase); lower volume of work; greater job security; and more opportunities for further training. The perceived benefits of employment in the public sector are a real risk for attrition in the PNFP sector and may confound the RBF experiment. Other reasons for attrition were poor QQA scores, for example, it was reported that some staff were fired or forced to resign as a result of poor performance in the first verification exercise where the score was much lower than the baseline. Overall, most of the staff that left were replaced and in some cases numbers increased to include cadres required to undertake a wider scope of activities.

Similarly, staff availability at IBF facilities was subject to the same mass recruitment drive in the public sector. Additional reasons contributing to attrition in the IBF sub-region included personal reasons such as further studies and disciplinary issues for cases of patient harassment and mishandling of funds.

(c) Motivation of providers

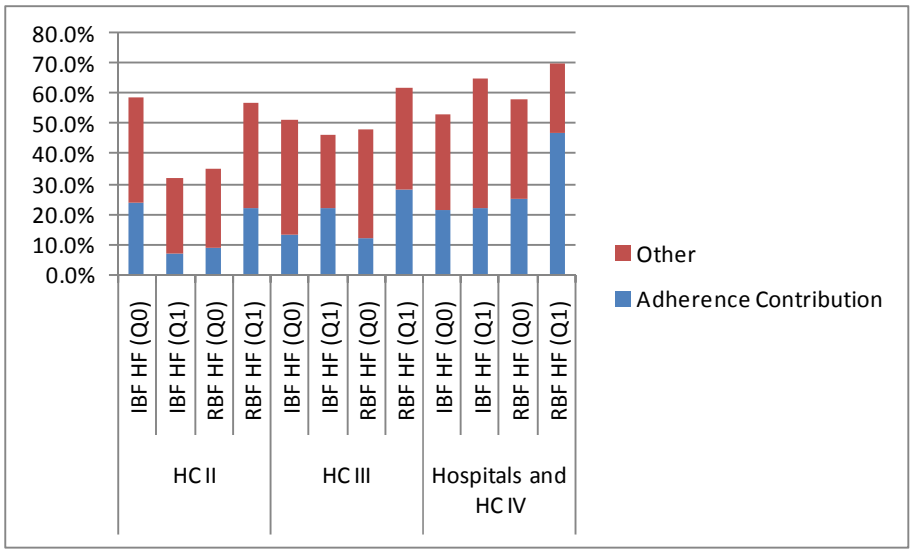
Programme support offers both RBF and IBF health facilities the opportunity to match salaries in the public sector should they choose to do so. In the first three months of implementation, the majority of health facilities have opted not to increase staff remuneration pointing out that programme support is just sufficient to enable them to existing costs such as salaries and other health system inputs. Those few health facilities in both RBF and IBF settings that have increased salaries have not yet matched scales in the public sector. Non-monetary incentives such as meals and learning opportunities are appreciated, but overall it seems that unless public sector salaries can be matched, attrition to the public sector will remain a real threat.

An additional point is that, although actual workload varies considerably amongst PNFPs, there is a risk that the focus of NU Health on increasing the volume and quality of services will reduce motivation of staff and provoke further departures. This may be exacerbated by the specific requirements in the programme for routine compliance with standard clinical protocols, data reporting and verification which necessitate correct filling of a range of registers and related documents. These should be normal tasks of health staff but currently are not always followed. It will be important for the NU Health team to encourage DHTs and facility management to handle this risk of perceived, and sometimes actual, increased workload. One way this can be addressed is to ensure appropriate compensation for staff; however, it is not the responsibility of NU Health to advocate for this as the facilities have relative autonomy in deciding how to use additional funds received.

(d) Prescription habits/adherence to protocols

The NU Health QQA framework directly assesses compliance to standard prescription practices and management protocols for the management of malaria, pneumonia, diarrhoea, antibiotic use at OPD consultations, and deliveries. These scores contribute up to 50% of the total quality score. Since a health facility may obtain a significant portion of the total score from other areas in the QQA score sheet, there is not always an automatic correlation between overall quality performance and compliance to good prescription practices and management protocols. Figure 4 shows the relative contribution of protocol adherence to the overall quality score. In general, there has been an increase in the relative contribution of adherence to the overall quality score from baseline (Q0) and Q1 apart for HC II in the IBF sub-region, where a drop was observed, and for hospitals and HC4 in the IBF sub-region, where there was no marked change. Improvements in the adherence contribution in the RBF health facilities could be attributed to the overall response to the monetary incentives. The supervision and mentoring provided to clinical staff during the QQA may have played a role in improving the adherence contribution in IBF Health Facilities since these are not directly incentivised. For example, the relative contribution of adherence increased at HC3 in the IBF areas even when the overall score dropped. A clinical audit on selected specific areas under maternal and child health will provide more in depth information. This audit is planned for September 2013.

Figure 4: Relative contribution of protocol adherence to overall quality score



Conclusion

NU Health has now been operational in health facilities in intervention (RBF) and control (IBF) areas for nine and six months respectively. Consultations with health facility staff and preliminary analysis of service delivery data reveal that early experiences are generally positive. Health care providers feel increasingly involved in the process of developing and implementing business plans designed to increase service provision and improve the quality of care. This process appears to be generating change, with the main difference between RBF and IBF facilities at this relatively early stage, being a higher increase in quality scores in RBF facilities. The improved availability of essential medicines and supplies in both the RBF and IBF facilities together with more skilled staff are likely to be contributing factors to increasing quality and volume of services, but results based incentives in the RBF facilities appear to be driving greater change. However, the comparative gains made in RBF facilities may be short-term effects of targeted interventions against specific indicators. The more general improvements being implemented in IBF facilities may result in less immediately realisable, but longer term changes in health service delivery. In conclusion, different trends may be observed as more data is collected allowing analysis of longer term change.

There are challenges in retaining skilled staff in PNFP facilities where competition is currently high from the public sector. At the same time, PNFPs contribute significantly to health service delivery and are generally highly appreciated for their quality and client orientation. It remains to be seen if the RBF model will continue to stimulate greater positive change and will result in sustained differences in comparison to those facilities funded through a traditional IBF mechanism. A critical factor is likely to be the ability of PNFP management to use the additional funding wisely so that staff are adequately motivated.

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List of resources

1. Africa Health Forum 2013: Finance and Capacity for Results. The World Bank
2. Evaluation of the Health Results Innovation Trust Fund, Norad, June 2012
3. Hitting the Target? Evaluating the Effectiveness of Results-Based Approaches to Aid. Eurodad, September 2012
4. NU Health Quality Assessment Tool, October 2012
5. NU Health Pharmaceutical Baseline Assessment, September 2012

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