Insights for taking Results Based Financing to scale

Key implications for policy makers using RBF approaches: Insights from the Northern Uganda Health programme

There is increasing interest in understanding how Results Based Financing (RBF) can improve efficiency, effectiveness and accountability in programming towards Universal Health Coverage and improved health outcomes at scale. With the Sustainable Development Goals, the UN Secretary General's revised Global Business Plan for Maternal and Child Health, and the World Bank-hosted Global Financing Facility, there is a renewed imperative to achieve better results from health investment, including improved transparency and accountability. While there is a growing body of experience in a range of RBF-related programmes, there remain key gaps in the evidence generated by these. These evidence gaps include how cost-effective programme approaches can be adapted to circumstances of fragility, poor governance and weak systems, where unmet need for reproductive, maternal, newborn and child health services is often greatest.

Key Messages

1) RBF can lead to improvements in **quality of care** for major childhood killers such as malaria, diarrhoea and pneumonia.

2) RBF can significantly improve **data management and reporting**, and lead to better decision making for resource allocation.

3) When **designing an RBF programme**, practitioners should consider factors such as the balance between IBF and RBF and the supply and demand side of RBF, the level of autonomy over fund use, and the means for maintaining effective results verification at scale as well as the requisite financial management.

Response

The NU Health programme (2011-2015) was funded with UK aid from the UK government as part of a package of post-conflict aid aimed at strengthening governance and accountability and reconstructing social systems in Northern Uganda. NU Health was a controlled implementation study to determine the impact, costs and benefits of RBF relative to more conventional Input Based Financing (IBF). The programme provided comparable levels of support to facilities in both arms of the study, aiming to isolate the main effect of the financing modality in terms of quality and quantity of health service provision.

In both modalities, facilities received considerable supervisory support from the District Health Teams and the NU Health programme during results verification (and financial verification in the case of IBF). Both regions received a pre-agreed credit line for the provision of essential medicines from the Joint Medical Store, in line with the facility level and the Ministry of Health defined essential medicines list.

Payments to RBF facilities were directly linked by a pre-agreed formula to reflect the volume and quality of services delivered by the facility. Payment was provided in arrears, was fully flexible and could be spent entirely at the facilities' discretion. IBF facilities received a comparable monthly allowance, independent of service delivery, needing only to submit a reasonable business plan for activities, and provide evidence that spend directly related to the plan.

NU Health focused on generating evidence on RBF and the extent to which it is an efficient and effective financing mechanism for improving health outcomes and accountability from non-state providers. To this end, NU Health supported an RBF intervention group of twenty-one eligible Private-Not-For-Profit facilities (PNFPs) in the Acholi sub-region of Northern Uganda. A comparison group of ten PNFPs in the neighbouring sub-region of Lango received comparable support through more conventional IBF. Capacity building was undertaken with both PNFPs, as providers, and District Health Teams, as regulators and verifiers. Furthermore, intensive data management was undertaken by the programme with external assessment providing further independent verification.

Design of NU Health

The context of Northern Uganda, as well as the focus of the study, shaped the design and implementation of NU Health. In a setting marked by post-conflict fragility, poorly-regulated health markets, and underdeveloped sectoral governance and systems, NU Health made significant investments in strengthening key capacities related to planning and management, monitoring and verification, data management and analysis.

The design of NU Health included extensive stakeholder engagement in the identification of priority health services, agreement around unit cost for services or

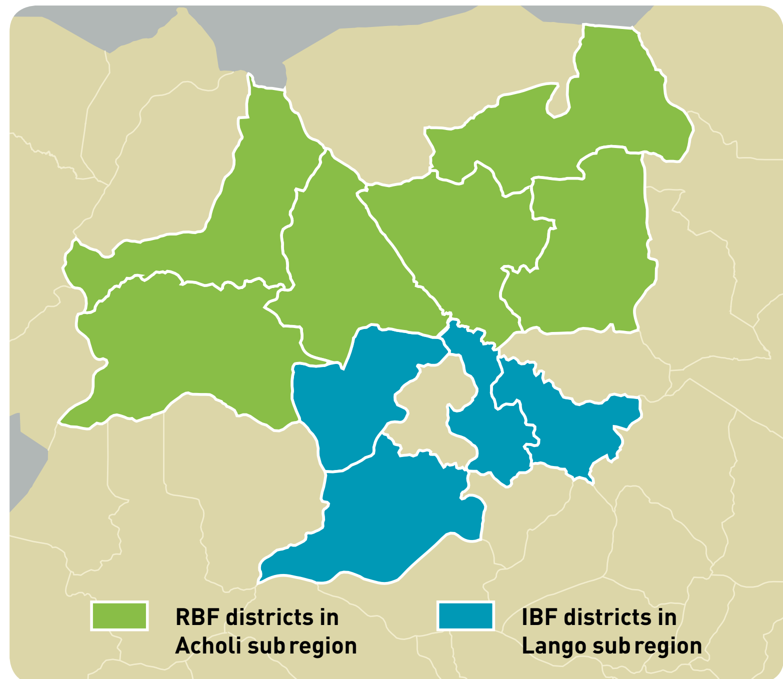
What is Results Based Financing?

Results based financing is an approach to financing health or other social services whereby payment is based on delivery of results, whether in terms of the quality, quantity or both.

The objective of RBF is to improve service impact by linking payment to pre-agreed targets and incentivising increased efficiency and quality outputs. RBF models are driven by the principle that if financial incentives are clearly linked to pre-determined service targets, providers will find more effective and efficient ways of delivering those services to generate more revenue, cut costs or both. It encourages a shift in the way in which individuals, communities or government entities make best use of the strengths and resources within the system in which they operate. RBF provides flexibility for actors to draw on the potential of these systems, deliver innovative results, and ultimately drive improved quality of services. In essence, RBF moves from a model in which actors are 'assumed' to deliver given the right inputs, to one where they 'drive' delivery for themselves. Providers of RBF also need to shift how they think about financing service delivery.

RBF has evolved over the last decade. It includes a broader set of approaches including 'output based financing', 'cash on delivery' and 'conditional cash transfers'. It includes both supply and demand side models. The NU Health model followed an RBF approach that linked health facility financing to the quality and quantity of health services provided.

RBF and IBF Districts in Northern Uganda



service improvements with providers, and results verification. It also entailed building business planning capacity in both RBF and IBF facilities, and segregating responsibilities between funders, regulators and providers of health services. The design aimed to achieve comparability of support for RBF and IBF facilities, in order to isolate the main effects of the financing modality.

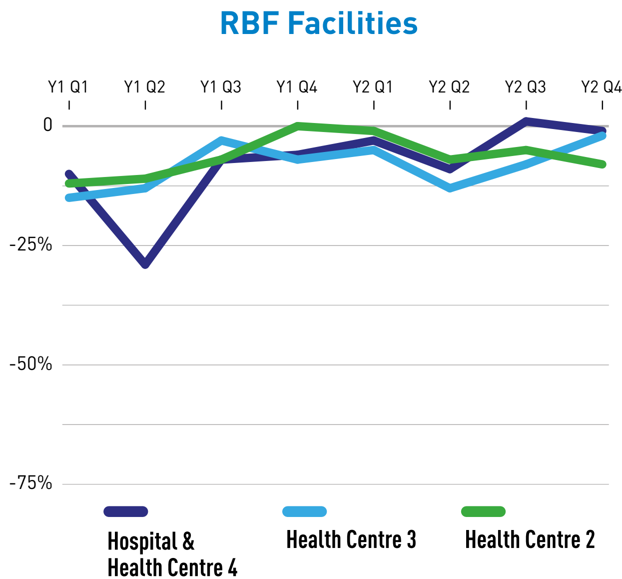
Results

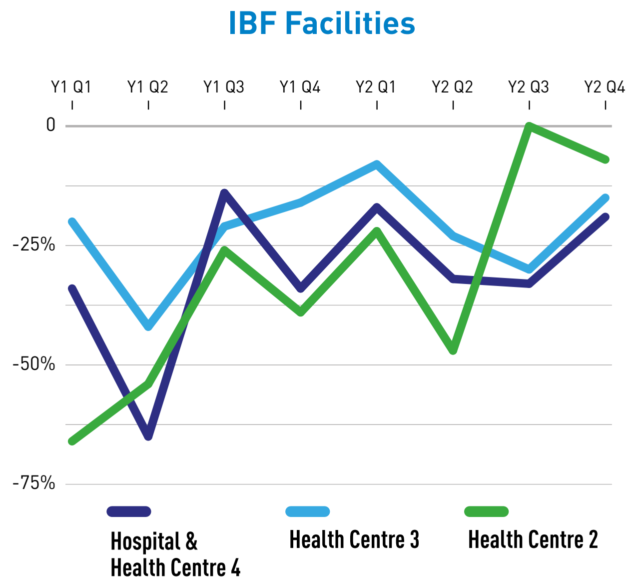
This policy brief outlines some of the major insights from the NU Health programme, but is not meant to be exhaustive. A companion 'Insights Report' and accompanying technical annex aim to contribute further to the growing body of evidence related to RBF, the determinants of its effectiveness, and how stakeholders – providers and putative beneficiaries – have come to receive it. In addition, an independent impact evaluation articulates the detailed effects on service delivery and certain health outcomes, and an associated qualitative review examines the impact of different financing methods on incentives and behaviour of facility managers.

The drivers of success at facility level revolved around clarity of roles and responsibilities, the predictability of support, and the reliability of service delivery from both the financing and verification partners. Facilities required support in planning and data management, as well as regularity in both provision of medical supplies and financing in order to demonstrate to communities that quality services would be available. District Health Teams (DHTs) required support in both clinical and financial assessment, as well as the means to provide regular verification.

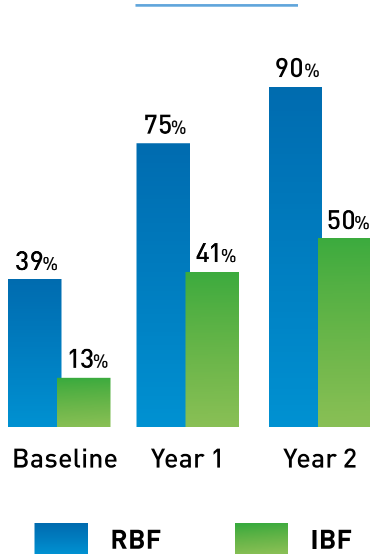
Facility-level governance – Management was a major driver in increased quality of service delivery, with the dynamics of decision making between the facility owner and the staff often impacting significantly on the effectiveness of the investment. While this could not directly be attributed to the size of the facility, higher level facilities tended to have stronger governance boards and clearer distinctions between governance and management. In lower level facilities this distinction, and its resultant control function, was often

Relative Discrepancy Rates Over Time (indicating standards of data management and reporting)

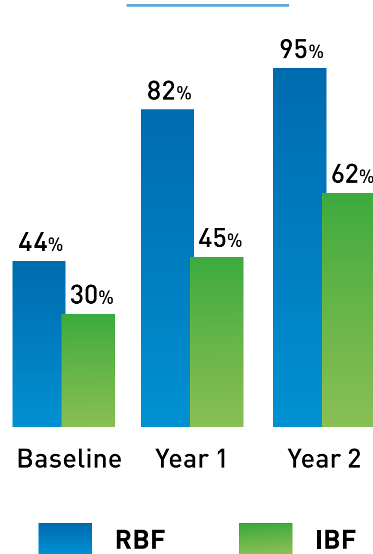




% of Pneumonia cases correctly treated in RBF and IBF facilities



% of Diarrhoea cases correctly treated in RBF and IBF facilities



Source: NU Health Lessons Learned Report 2, March 2015 http://resources.healthpartners-int.co.uk/resource/nu-health-lessons-learned-report-ii-2015/
Year 1 = oct 2012 to Sept 2013; Year 2 = Oct 2013 to Sept 2014

compromised. Higher level PNFPs often had a broader funding base or more established income generation mechanisms, which provided additional scope to invest in service improvements.

Data management and reporting improved significantly in the RBF facilities relative to the IBF facilities, during the life of the programme. The emphasis on data and monitoring, which effectively incentivised better reporting, benefitted both the facility and district. Moreover, through improved data quality, it also demonstrated significant potential for improved Health Management Information System integrity and better decision-making for resource allocation.

Quality of care for many conditions improved more in the RBF facilities compared to the IBF facilities. Quality scores were higher in absolute terms in the RBF facilities. Clinical audits demonstrated significant improvement in quality of care for major childhood killers such as malaria, diarrhoea and pneumonia requiring relatively straightforward clinical management. Those requiring more complex management saw less improvement.

The reliable availability of essential medicines in both RBF and IBF facilities was associated with increased care/service utilisation overall, but with a more pronounced increase in the RBF facilities.

Implications and Recommendations

While the evidence generated through NU Health does not support a particular design for taking RBF to scale, it does have implications for decision making on how to take RBF to scale, particularly in fragile or post-conflict settings.

Key decision points for policy makers contemplating a move to an RBF approach include review of the following design aspects:

Issue	Insights or Recommendations
The balance between RBF and IBF	Provision of a reliable supply of essential medical supplies was associated with increased provision of services in both the IBF and RBF facilities. Careful consideration is needed to define which aspects of core financing are provided on an input basis versus those which are linked to results and incentivised performance.
The balance between supply and demand side RBF	NU Health focused on generating evidence about how provider payment or supply side RBF influenced service provision. However, there is also growing evidence on how the inclusion of demand side RBF, such as emergency health transport vouchers, can further increase service use by overcoming financial barriers and incentivising patient/guardian behaviour.
The means and resources for maintaining effective results verification at scale	NU Health entailed results verification processes far more intense than one would expect in a 'normal operational programme.' However, in any RBF programme the verification of results does require a larger investment of resources than what is often allocated to routine health service oversight. DHTs in this context clearly need capacity strengthening to fulfil the verification function. They also need to have allocated budget to undertake facility verification and supportive supervision.
The level of autonomy over fund use with RBF	Although NU Health had a 'hands off' policy on how facilities used RBF financing, one would expect some guidance on fund use with RBF introduction at scale. Maintaining a level of autonomy by facilities over how they use funds is critical to RBF
The reliability of medical supplies and financial flows	Stakeholders were clear that with NU Health, the reliability of medical supplies and financial flows was important in building confidence – among providers as well as consumers. Finding ways to ensure this reliability with programmes in the public sector and at scale will likely require significant strengthening of institutions, systems and individuals, as will effective implementation of accurate and intensive results monitoring.
Ensuring the requisite financial management	Beyond the NU Health 'hands-off' approach to RBF, it is imperative that stronger public financial management is in place both to manage risk and ensure accountability.

Conclusion

NU Health has generated evidence on the main effects of RBF in terms of improved quality of care and better reporting relative to IBF, contributing to the discourse on how to improve efficiency, effectiveness and accountability in health, particularly when working with non-state providers. NU Health also shed light on the range of systems strengthening needs in settings marked by post-conflict fragility, poorly-regulated health markets, and underdeveloped sectoral governance and systems.

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