Results Based Financing & Universal Health Coverage

Evidence from Northern Uganda

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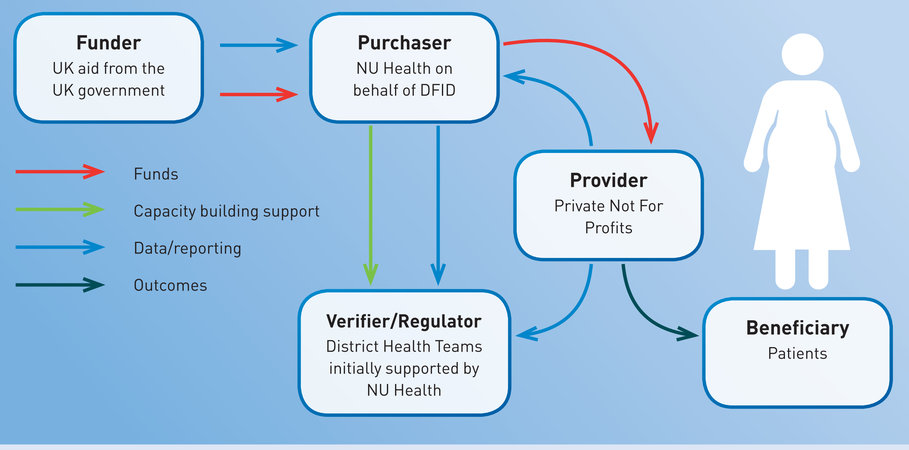
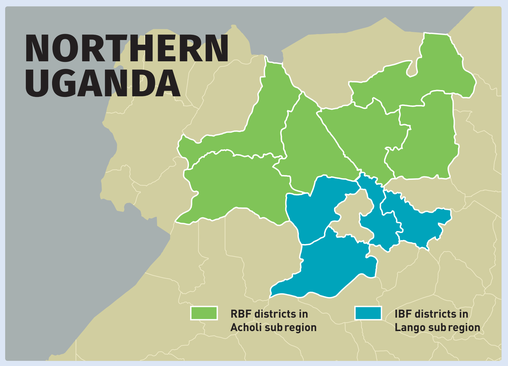
BACKGROUND: Results Based Financing (RBF) has emerged as a key strategy to improving health sector performance. Despite gaps in evidence related to cost effectiveness, systems implications and sustainability of RBF at scale, there is a growing body of evidence that RBF can contribute to improving quality, efficiency and accountability toward Universal Health Coverage. This study explored how this might work with non-state providers in post-conflict Northern Uganda.

RESULTS BASED FINANCING IN A NUTSHELL



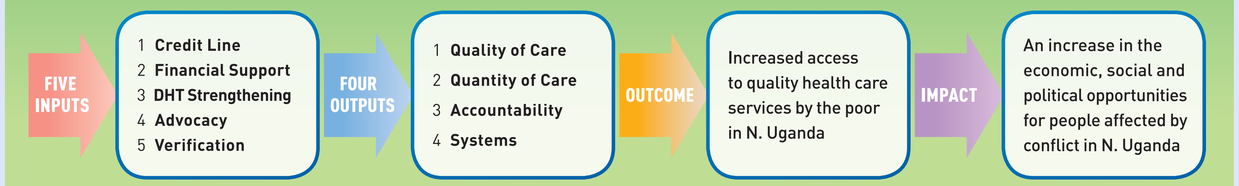
- Financing linked to delivery and verification of predefined results
- Incentives focus on results rather than inputs
- Aims to promote innovation, efficiency and accountability
- RBF is intuitively attractive, but there are major gaps in evidence about how to undertake and assess it



OVERVIEW: Northern Uganda Health (NU Health) was a controlled trial designed to assess the costs and benefits of RBF versus conventional Input Based Financing. Conducted as part of a larger programme of post-conflict systems and institutions reconstruction effort, the study focussed on isolating the main effect of the financing mechanism on health facility performance, controlling for a range of potentially confounding factors.

THEORY OF CHANGE

behind the study design is summarised as follows:



METHODOLOGY: Private-Not-For-Profit health facilities in two districts were enrolled according to key criteria related to facility functionality, staffing and recent performance in each of the two arms of this prospective cohort study.

Data management rested on quarterly verification of reported results, including assessment of reporting quality, quality of care, and quality of data. Satellite studies were undertaken related to validity of mobile phones for assessing service verification and perceptions of quality of care and the outcomes associated with the use of partograph during complicated labour, *inter alia*.

Intervention inputs were controlled to isolate the financing mechanism main effect. These included:

Credit Lines

Credit lines to ensure stable supply of essential medicines

Financial Support

Financing to ensure staff were paid and basic facility services functioning

DHT Strengthening

District Health Team Capacity Strengthening to enable supportive supervision and results verification

Advocacy

Advocacy to ensure awareness of the study, the relevance of its inquiry and an appetite for its evidence

Verification

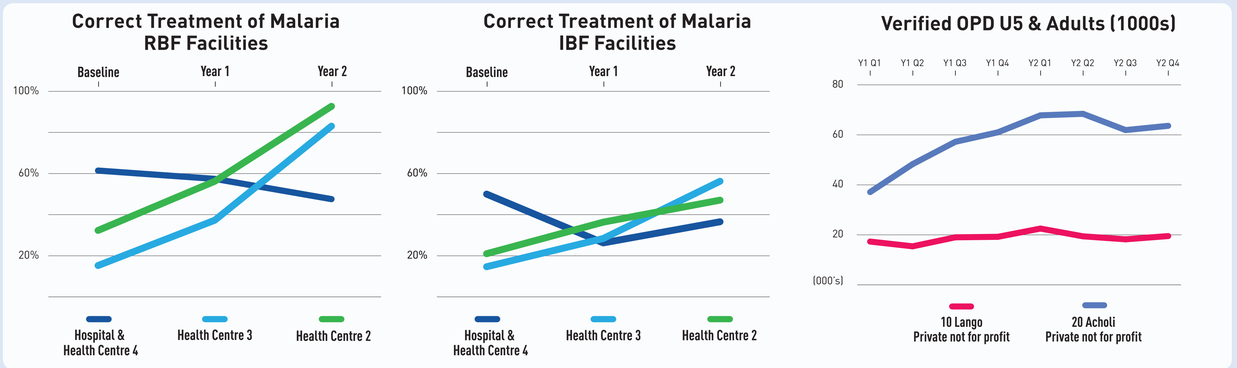
Technical assistance related to verification of results, including clinical and financial analysis and bio-statistics

RESULTS: NU Health generated rich, multi-dimensional data related to innovative practice in health systems development. In particular, there were significant improvements in a range of key indicators in the RBF facilities relative to the IBF facilities.

Overall, in RBF versus IBF, a child was:

- Three times more likely to be treated correctly for malaria (OR 3.15; CI 2.13-4.65)
- Over six times more likely to be treated correctly for pneumonia (OR 6.63 CI 3.34-13.17)
- Over eight times more likely to be treated correctly for diarrhoea (OR 8.34 CI 4.95-14.08)

The main effect in terms of quality of care was differentiated by level of institution. The strongest improvements were observed in lower level facilities. Indicators related to both utilisation and supply of essential medicines similarly showed the most improvement in the lower level facilities in the RBF arm relative to the IBF arm.



Source: NU Health Lesson Learned Report 2, March 2015, http://resources.healthpartners-int.co.uk/resource/nu-health-lessons-learned-report-ii-2015/

INTERPRETATION & IMPLICATIONS: Lower level facilities are the front line of Primary Health Care and Universal Health Coverage. They tend to be widely distributed at the community level and more accessible than higher level facilities and hospitals. In a setting where even the higher level facilities were not satisfactory in their performance, these lower level facilities were functioning poorly in terms of quality and quantity of service provision at baseline.

With the introduction of more predictable health system support and the incentive-verification system provided by RBF, front-line staff were able to improve both the quality and quantity of health services in these lower level facilities. The findings of this study support the assertion that by increasing access to and utilisation of better quality services, RBF can contribute to improving health system performance and achieving Universal Health Coverage.

> *"NU Health was the best programme I've seen here yet. Our facilities were rewarded for good work (or not rewarded when they were doing a bad job!) rather than just given money. Also the money went directly to the facilities rather than being filtered through intermediaries....[with] evidence of better quality prescribing, increased services offered, and increased patient numbers."*
>
> DR NICOLAS LAING, HEALTH CO-ORDINATOR FOR THE DIOCESE OF NORTHERN UGANDA

NU Health was jointly managed by:

Health Partners INTERNATIONAL

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