The political economy of results-based financing:
what can we learn from the experience of the health system in Zimbabwe?

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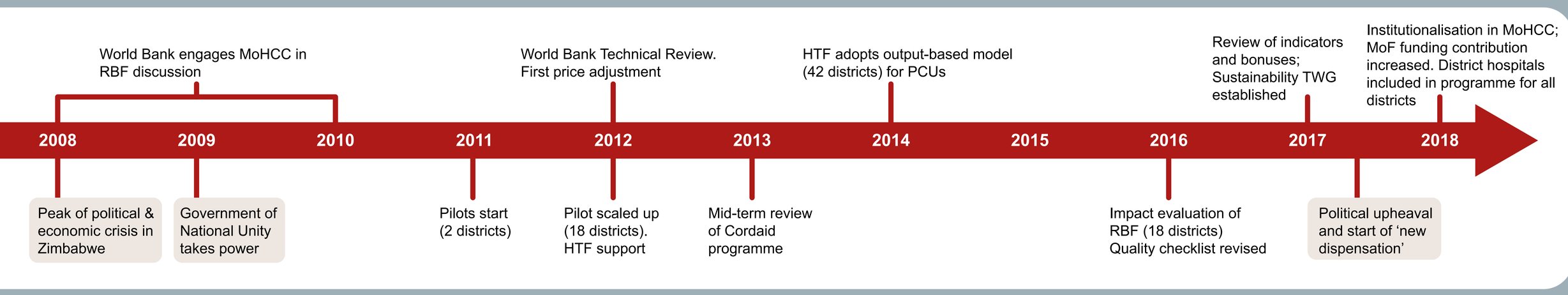
Background and objectives

- Results-based financing (RBF) is **increasingly implemented in low and middle-income settings,** especially fragile and post-crisis/conflict contexts.
- Zimbabwe has one of the **few national RBF programmes in Africa**, rolled out from 2011 with external support.
- Little attention paid to **political economy** of its adoption, adaption and implementation.
- This study examines Zimbabwe's experience, probing how **historical legacies, ideological values and roles and power relationships** have influenced the framing, uptake, implementation and evolution of RBF, and whether RBF has shifted health system power and resources.



Findings

Context

- Adoption driven by crisis-related resource constraints in MoHCC; funding was conditional on RBF mechanism.

> *'There was no scope for negotiation as the Bank could only offer this kind of grant. The health system was very cash strapped […]. There was only one offer on the table. […]'* (National KI)

- MoHCC initially viewed RBF with suspicion – seen as threatening system equity.
- System capacity legacy led to adaptation by MoHCC, ensuring RBF fitted within system; ownership developed over time.
- RBF initially framed as important to staff retention and health system investment; later portrayed as fitting government's earlier (unrealised) Results-Based Management policy.

Actors

- MoHCC and staff were key in the decision to adopt RBF.
- Donors initially divided, but supportive when initial results looked promising.
- MoHCC has veto power. But complexity of RBF design and management means some National Steering Committee members struggle to engage.
- Embedding RBF in system ensured district managers retained roles.

Resource distribution

- Primary health units (PHUs) were main beneficiaries: gained resources and some resource management autonomy, although considerable controls over how RBF funds are spent.
- Hospitals relatively neglected; government funds not forthcoming and RBF focused on primary level.
- Staff at PHUs benefitted from funds, materials and bonuses. But concerns about inappropriate distribution of bonuses.

> *'The work environment improvement and ability to make decisions at their level is what motivated health staff. Rural health workers were also more cognisant of the work they had to do'* (Local KI)

- Patients benefitted from improved drug supply, some infrastructure investments, and the reinforced fee removal for MNCH services.
- Role of Health Centre Committees shifted from resource generation to allocation.
- Managers benefitted from intangible pay-offs from participation (eg training, visits, conferences).
- Funders benefitted from 'demonstration model' of RBF, from relatively rapid and successful scale-up in Zimbabwe.
- Fund holders and implementers gained resources and experience.
- No major changes to health market; small but significant resources added to local public health system; challenging to sustain when external funding is withdrawn in 2018.

> *'The limited funding from the government is one of the main challenges. Health facilities are 100% dependent on RBF'* (Local KI)

- Focus on primary care and essential services was inherently equitable; however, low catchment population facilities (often more remote) cannot earn significant amounts.

Data sources

- 60 project documents (2008-11) reviewed (policies, strategies, documents, manuals, evaluations and academic articles)
- 40 key informant (KI) interviews at national, provincial (2) and district (4) levels with development partners, government officials, implementers, consultants and public bodies in early 2018

Conclusion and reflections

- RBF represented a **small but significant increment in public resources for health in Zimbabwe** (around 5%).
- Due to shortfall in public budget RBF was used as the **main source of funding for non-salary recurrent costs at PHU level**, functioning as a core financing mechanism, not an incentive.
- Its **future role** within the wider health financing landscape remains unclear.
- In the context of **lack of trust** in government, RBF was attractive in enabling funds to reach lower levels of the system.
- RBF simultaneously **passes resources** and (potentially) control to the periphery while using them to **establish control** (using contracts, reporting, verification and sanctions) to direct behaviour.

The study also sheds light on **how political economy analysis may need to be adapted to be usefully applied to FCAS settings**. While political economy in higher income settings often focuses on the role of politics, bureaucratic factions, interest groups and beneficiary organisations in policy development and outcomes, in Zimbabwe these groups are less organised and influential, with individual leadership, donor positions and marginal resources having disproportionate influence.

Further information

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ReBUILD Consortium

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