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Investigating results-based financing as a tool for strategic purchasing: comparing the cases of the Democratic Republic of Congo, Zimbabwe and Uganda

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Introduction

- RBF has proliferated in low and middle-income settings (incl. in fragile, post-crisis/conflict contexts) in the past decade.
- It is often portrayed as a mechanism for strengthening strategic purchasing

> "First and foremost, P4P is a strategic purchasing tool, helping to translate stated priorities into services. [...] Because P4P involves an explicit link between purchasing and benefits, with payment driven by verified data on the use of defined services, it is a form of strategic purchasing"
>
> [Soucat et al, Pay-for-Performance Debate: Not Seeing the Forest for the Trees. *Health Systems and Reforms*, 2017; 3(2):74–79]

- However, few studies have empirically examined how RBF affects prior purchasing arrangements in practice → we looked at the experience of Uganda, Zimbabwe and the DR Congo.

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Study settings

	DRC	Zimbabwe	Uganda
History & fragility features	- Violence and pol. instability since independence. - Underfunded public service provision - Policy vacuum left room for NGO/ donor-led experiments	- Single government since independence - Prolonged economic and pol crisis (peak in 2008) - Resource constraints as trigger for RBF adoption	- Civil war until 1986, continued in the Northern region until 2006 - RBF adopted to improve public services
RBF program-mes & focus of this study	- Since 2005 - Numerous programmes (~7) - Focus: EU-funded *Fonds Europeen de Developpement* (**FED**) (2005-2010); WB-funded *Programme de developpement de services de santé* (**PDSS**) (2017-ongoing)	- Since 2011 - WB-funded (**Cordaid**) pilot, later scaled up - HDF-funded (**Crown Agents**) for national scale up (2014)	- Since 2009 - Numerous programmes - Focus: WB's Saving Mothers, Giving Lives (**SMGL**) (2012-2017); DFID's **NuHealth** (2011-2016); USAID's Strengthening Decentralisation for Sustainability (**SDS**) (2011-2017).

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Methods

- **Comparative case study**:
  - Qualitative
  - Retrospective
- **Data collection**:

	DRC	Zimbabwe	Uganda
Document review	23	60	27
Key informant interviews	9 KIIs (remotely)	40 KIIs	49 KIIs (14 KIIs for this study; 35 KIIs for previous study and re-analyzed)

- **Data analysis**:
  - Thematic coding based on pre-defined list of themes reflecting the functions/key actions included in a framework on strategic purchasing [ReSYST, *What is strategic purchasing for health?*, 2014]
  - Comparative matrix

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Results

Key strategic purchasing actions *by government*

	DRC	Zimbabwe	Uganda
Establish clear frameworks for purchaser(s) and providers	- Weak regulatory capacity - RBF contracts provided clearer rules and regulations, though re. RBF funding only	- Strong regulatory frameworks (e.g., Results Based Management since 2005), but resource-starved. - Only primary level and some indicators covered	- RBF did not radically change regulatory frameworks - Some changes *only for providers/services covered by RBF*
Ensure accountability of purchaser(s)	- EUPs have stronger accountability links with MoH compared to NGO projects - In practice, govt/MOH did not exercise their oversight role	- Parallel system with external purchasers - Accountability of purchasers to funders as well as to govt. - Non-RBF funding through different channels	- RBF operating in parallel - Plans for a national scheme under MoH leadership
Ensure adequate resources mobilised	- OOPs, main source of fund. - RBF mobilised additional resources to decrease UF - Limited success of EUPs in raising/pooling funds	- RBF provided modest but partially additional funds, still significant for primary care providers - Focus on MCH indicators - Donor dependent	- RBF donor funded, with donors working in silos even within the same region - Discussions of a virtual pool but not realised yet
Fill service delivery infrastructure gaps	- Assessments carried out by RBF projects and bonus provided in some cases	- RBF provided some upfront investment, but no major revision of infrastructure planning in relation to needs	- District teams remain responsible for identifying service delivery infrastructure gaps

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Results

Key strategic purchasing actions *in relation to citizens/population served*

	DRC	Zimbabwe	Uganda
Assess needs, preferences, values of the population to specify benefits	- Norms on activity packages existed and RBF worked within them, covering *some services* in the packages - EUPs allowed to revise RBF package – but rarely done in practice	- No consultations on needs, values and preferences - Package defined nationally with no scope for variation at local level	- No consultation with communities - RBF includes services from the minimum package
Inform the population of entitlements **Establish mechanisms for complaints and feedback** **Publicly report on use of resources and performance**	- RBF requires price list to be made public on the facility wall - RBF aimed at improving community participation by strengthening Health Management Committees - Community verification, but delays in data collection and no/little analysis and feedback - IT portal to report performance, but only for RBF indicators and no community verification scores	- RBF requires price list to be made public on the facility wall - RBF helped revive Health Centre Committees: variable results and capacity	- Preexisting mechanisms for feedback (barazas, suggestion boxes, Health Unit Management Committees) - Client satisfaction surveys in some RBF programmes

Results

Key strategic purchasing actions *in relation to providers* (1)

	DRC	Zimbabwe	Uganda
Select (accredit) providers	- Done by health authorities/ regulator, EUPs have limited power in deciding which facilities to contract (limited to type of contract or sub-contracts) and to enforce sanctions	- RBF did not change existing accreditation system - RBF required facilities to meet minimum criteria, incl developing an operational plan, having a bank account and a functioning HCC	- Accreditation bodies preexisted and RBF did not change this.
Establish service agreements/ contracts	- RBF introduced contracts – but rarely enforceable with limited room for sanctions - Contracting done by EUPs, and limited to RBF services/facilities	- RBF introduced contracts – but rarely enforceable with limited room for sanctions - Contracts are limited to services and facilities covered by RBF	(As in Zimbabwe)

Results

Key strategic purchasing actions *in relation to providers* (2)

(cont.)	DRC	Zimbabwe	Uganda
Design, implement, modify provider payment methods to encourage efficiency and quality	- Very little public funding other than (some) salaries - RBF provided additional performance-based funding, but did not alter public/other donors' funding - Some evidence of quality improvements	- Mixed picture in terms of outputs and quality improvements - Focus on MCH services, incl some for which coverage is high - Some quality improvements (e.g., drugs availability)	- Little quality improvements given broader structural challenges.
Establish provider payment rates **Pay providers regularly**	- RBF introduced payment rates for services (not the practice before) - Rates are additional to UF - Rates defined at provincial level, depending on funds available and donors' preferences (FED) - Rates defined centrally and included in Project Manual (PDSS) - Delays in paying providers	- RBF introduced payment rates for services (not the practice before) - Rates defined centrally, focus on MCH and low coverage indicators - Concerns over sustainability of payments (rates have been reduced over time)	- RBF introduced payment rates for services (not the practice before) - Payment methods complex and not well understood - Different schemes have different indicators and rates, depending on funders' preferences and budget - Unilateral decisions often poorly communicated

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Results

Key strategic purchasing actions *in relation to providers* (3)

(cont.)	DRC	Zimbabwe	Uganda
Allocate resources equitably **Strategies to promote equitable access** **Monitor user payment policies**	- Bonus to compensate remote facilities - Extra funds to cover services provided to the very poor (*Equity Funds*), but only hospital services (FED) and for few services (PDSS) - Support to reduce UF and introduce *flat fees* to cross-subsidise between patients - Community verification to monitor UF payments	- Remoteness bonus, but considered too small and failed to compensate facilities with small catchment areas - RBF aimed to remove UF for the services it covered. However, no difference in OOP between control/intervention areas	- No bonus in payment calculation but some initial bonus to remote facilities. - Facilities/districts often chosen as easier to work with, adding to the fragmentation and inequity - Reduction of UF (in PNFP facilities) as a precondition for RBF support
Develop, manage and use information systems to monitor/audit performance and protect against fraud **Supervise providers**	- RBF information system is parallel to HMIS. Plans to ensure integration in the future - Zonal/Provincial teams contracted to ensure supervision	- RBF used HMIS data after having verified and corrected it - Providers have multiple data reporting requirements - RBF brought greater focus on data quality - Little evidence of false claim, risk based verification - Pre-existing well developed and integrated supervision system to which RBF provided funding	- Similar issues of multiple data streams, but HMIS remains main one - Supervision system only partially affected/funded by RBF

In summary

- In relation to government
  - Little change to accountability of purchasers
  - RBF does mobilise additional resources to support entitlements for *some* services
- In relation to population
  - Some improvements in specifying and informing of entitlements
  - Engagement and consultation remains limited
- In relation to providers
  - No impact on providers' accreditation and selection
  - More contractual relations for *some* providers
  - Partial improvements in payment systems, data quality, facility autonomy, equitable strategies

Discussion

- Overall, overoptimistic views of widespread, systemic transformation through RBF are not supported
- However, there are gains in *specific* areas and for a *subset* of services

- **Differences** across cases due to:
  - Nature of RBF programmes (e.g., providers included)
  - Contextual differences (e.g., stronger govt leadership vs. weak institutions)

- **EUPs experience** in DRC as a possible option for extremely fragile settings?
  - High expectations in terms of catalytic role for raising and pooling funds and increasing strategic purchasing
  - In practice, original vision of becoming a joint, integrated pooling and purchasing agency remains unfulfilled

Conclusions

- Possible **reasons** for limited impact
  - RBF viewed and implemented as stand-alone financing mechanisms rather than part of a mixed provider payment system
  - RBF run as pilot/project, not integrated with existing systems → fragmentation and duplication of strategic purchasing actions.
- RBF as a 'first exposure' to strategic purchasing?
  - However, there are a number of outstanding challenges in integrating RBF into health systems, aligning it with other payment mechanisms and PMF, and achieving broader changes in strategic purchasing
- Expectations should be nuanced
  - Focus on expanding areas of potential gain and ensuring better integration and institutionalisation