

LEAPFROGGING DEVELOPMENT: GETTING TO RESULTS

OVERVIEW

Results-based financing (RBF) offers a bottom-up approach to health system strengthening by focusing on results, rather than inputs. World Bank experience with a range of results-based approaches linking financing to results demonstrates that RBF has the potential to trigger a paradigm shift in service delivery by unlocking bottlenecks, changing financial flows, and empowering front-line providers and communities. This paper focuses on lessons learnt from RBF programs supported through the Health Results Innovation Trust Fund (HRITF), country-level impact of the approach, and how RBF can contribute to GFF goals.

SUMMARY OF FINDINGS

While the knowledge about *what works* and *what doesn't* and *why* is still growing, RBF has clearly shifted the debate to real service delivery issues and offers much potential to speed up progress towards universal coverage of key preventive services. Over the last decade, RBF has been used to improve service delivery results at the front-lines. Without claiming it is a panacea that fits all contexts, solid evidence exists that well designed and implemented RBF programs can increase service coverage and quality of care in various contexts¹. Because of its comprehensive nature, RBF also has the potential for larger health system strengthening, as health facilities and hospitals benefit from autonomy of action, local financing for health services, attention to availability of commodities and goods, motivated human resources, strong governance, community engagement, greater financing efficiencies and strengthened reporting and information systems.

As GFF pushes the boundaries on RMNCAH goals, the learning from the HRITF-supported RBF program is even more relevant and critical today. The GFF offers broader opportunities and a larger potential for health-system reform, as it explicitly focuses on scaled investments and sustainability. As the GFF engages with countries to help them identify main sources of inefficiencies, it can explore the use the results-based approach strategically at various levels of the health system as a mechanism to reduce transaction costs and reliance on external financial resources. This paper suggests it is paramount that the learning on RBF continues as the GFF moves forward.

ACTION REQUESTED

The Investors Group is requested discuss options for using Results Based Financing to strengthen health systems so critical for achieving RMNCAH outcomes.

¹ <https://www.rbfhealth.org/resource/completed-impact-evaluations-and-emerging-lessons-health-results-innovation-trust-fund>

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1. Results are at the core of GFF business proposition

Despite the tremendous progress made in human development, reproductive, maternal, newborn, child and adolescent health (RMNCAH) outcomes continue to hinder many women and children in low and lower middle-income countries (LMIC) from reaching their full human potential.

Without strong health systems, many of the basic RMNCAH services remain inaccessible to populations that need them the most. While communities are left with limited access to quality care and high out-of-pocket expenses, health care facilities grapple with staffing issues, lack of financial resources, inadequate supervision, and shortage of supplies. Not unexpectedly, large segments of the population—especially the poor—are reluctant to seek and/or utilize health services.

Results-based financing (RBF) is a bottom-up approach to strengthening health systems while keeping results a central driving force. A big challenge facing health systems is channeling more resources to front-line services, and primary care in particular. Input-based financing mechanisms that dominate in many LMICs do not readily allow financial flows to the primary care level, often crowded out by secondary and tertiary care and infrastructure and human resources expenses. RBF can therefore serve as a kick-starter for a paradigm shift by changing financial flows, delivering larger resources to primary care facilities, and linking financing to results.

Results at the country level are at the heart of the value statement of the Global Financing Facility. Acknowledging that RBF is not a panacea and comes with its own set of challenges, it is an important approach to delivering on the results agenda of the GFF. Addressing the service delivery challenges will be key to meeting the SDG goals, and each GFF-supported country prioritizes a range of results—from RMNCAH outcomes to strengthened health systems and sustainable financing. In this complex environment, RBF programs can work by making cash payments or financial transfers to national or sub-national governments, managers, providers (government or non-government), or consumers of health services after predefined results have been achieved and independently verified.

This paper aims to provide some early lessons from using results based financing to improve service delivery for better maternal and child health outcomes. It also provides the information on how some GFF countries include the scale up of RBF approaches as part of priorities in the investment cases.

2. Results-based financing: What is this?

Several elements underpin result-based programs (Figure 1), with three of them playing the most important role.

- **Linking payment to results:** A common feature across all RBF projects is that finances are disbursed upon the delivery of results, as determined by the achievement of measurable and verifiable indicators rather than inputs. Financial incentives are one of the largest elements of the RBF approach, and the results can vary by the level of engagement. For example, at the facility level, results can be reflected by the number of quality-assured deliveries; at the sub-national level—by the number of supervision visits made; at the national level— by the funds allocated for recurrent budgets.
- Providing **autonomy** to define the pathways to achieving these results. Some degree of autonomy is required to ensure that facilities, districts or governments can define the means and pathways to get to the results. For health workers, having the tools to carry out their jobs is in itself an incentive and provision of

health facility autonomy along with some financial autonomy is a key aspect of many facility-based RBF projects. This enables service providers to procure drugs, organize a health facility, clean their surroundings, and make necessary changes and innovations to produce better results.

Figure 1. Linking payments for results



- Putting a premium on **monitoring and verification** of the results to ensure they are accurate. RBF projects support performance improvement through better monitoring, record keeping, and continuous tracking of results. Supervisors make periodic visits, review implementation, fill out checklists, and work with staff to understand bottlenecks to performance. A positive spin-off is the greater contact time between health providers and their supervisors. To mitigate the risk of over-reporting, results need to be independently (counter-) verified which drives up costs of such projects. Many projects are therefore exploring

risk-based verification as a means to target and reduce the need for large-scale verification. Due to strong emphasis on data and continuous monitoring and verification of performance measures, RBF programs also contribute to strengthening of health information systems. In many countries, a cloud dashboard system has been introduced, thus making data entry more accurate and efficient and also making data analysis and management decision-making much more timely and conducive.

3. What has been the impact of RBF?

With over 35 RBF projects supported by the Health Results Innovation Trust Fund² (HRITF), there is a wealth of information continuously building up about the effectiveness of the approach. Some early evidence of the areas where RBF can contribute include the following (see also Table 1).

Improving utilization: Several robust impact evaluations and a large amount of independently verified operational data show that RBF approaches to health delivery can be highly effective and even cost-effective when it comes to improving coverage of targeted services across many aspects of maternal and neonatal health. A synthesis paper that brought together the learning from the first batch of completed impact evaluations has demonstrated that:

- In Rwanda, RBF significantly increased coverage of institutional deliveries, preventive care visits for children, and quality of care. Performance-based incentives also had a statistically significant effect on the weight-for-age of children age 0 to 23 months and on the height-for-age of children age 24 to 49 months (Paulin Basinga 2011).
- In Argentina, Plan Nacer—an ambitious effort to extend maternal and child health services to the poor and underserved—reduced low birth weight by 19 percent, the probability of neonatal mortality by 74 percent, and the probability of stillbirths by 30 percent (Gertler et al 2014).

² The HRITF is a trust fund at the World Bank supported by DFID and Norway to pilot RBF approaches to improve maternal and child health outcomes. A total of US\$498.6Million in grant funding and US\$2.2Billion in IDA funding supports 35 programs in 28 countries.

- In Burundi, a recent impact evaluation of the nationwide program showed that RBF increased the probability of women delivering in an institution by 21 percent, the probability of using antenatal care by 7 percent, and the use of modern family planning services by 5 percent (Igna Bonfrer 2013).
- In Zimbabwe, in the first year of the program, 75 percent of pregnant women delivered safely in a health facility with a skilled birth attendant, up from 50 percent; in addition, child immunization rates nearly doubled from 33 to 62 percent.
- In Zambia, a three-arm evaluation that tested RBF against an enhanced financing-only arm and a pure comparison arm showed that of the nine indicators directly targeted by the RBF program through the incentive structure, some responded to the RBF program, with a broadly similar set also showing improvements under the enhanced financing arm. One of the most important gains in the RBF arm was that the first ANC visit was earlier by two weeks as compared to the two other arms.

Evidence also illustrates that demand-side and supply-side incentives work on different margins and may work best when combined—demand-side incentives can directly increase health-seeking behavior beyond what supply-side incentives can achieve by themselves. Improved quality and outreach by health providers can have an additional indirect impact. For instance, the qualitative work in Afghanistan identified the lack of attention to demand-side considerations as one of the flaws of the RBF pilot implemented there. Early results from the qualitative study in Rwanda also suggest that the involvement of the community health workers was key to the program’s success as they helped create demand for health services by engaging with the communities. In a similar work carried out in Cambodia, performance-based contracting led to quadrupling utilization when there were also vouchers.

Boosting the Quality of Care: RBF provides a sound platform for continuous quality improvement. The Plan-Do-Study-Act (PDSA) cycle, a powerful tool for accelerating quality improvement that RBF promotes, allows health care teams to test changes to processes of care to improve adherence to best practices. Supportive supervision provided by front-line managers includes integrated clinical quality improvement, and data-management capacity-building over time. Managers, front-line health care workers and staff who possess the necessary deep knowledge of their local systems work together to identify and test feasible and sustainable changes to “usual processes” to improve care in their local setting. It has been demonstrated that health worker satisfaction and motivation play an important role. Qualitative studies point also that uncompensated price reductions of RBF services can induce negative effects in motivation among health workers.

Quality is a difficult concept to measure and incentivize and the evidence for RBF’s impact on quality is much more nuanced than that of utilization. Work is underway to test new instruments for measuring quality and experimenting with innovations to bridge the knowledge, ability, and willingness gaps. Having said that, impact evaluation studies³ demonstrate RBF programs have generally had positive and significant effect on the quality of care. Afghanistan, Cameroon, and Zimbabwe studies have shown measurable improvements in structural and processual quality⁴. In addition, the impact evaluation in Zambia found some improvements in structural quality in the RBF arm and somewhat more limited, but positive results on process quality. Health workers in RBF facilities in Afghanistan and Zambia also spent significantly more time during consultations with their patients.

³ <https://www.rbfhealth.org/resource/completed-impact-evaluations-and-emerging-lessons-health-results-innovation-trust-fund>

⁴ Structural quality measures give a sense of a health care provider’s capacity, systems, and processes to provide high-quality care. Process measures indicate what a provider does to maintain or improve health, either for healthy people or for those diagnosed with a health care condition.

Strengthening health systems: RBF relates to all six health systems pillars and, if well designed and implemented, can strengthen all of them. Health facilities and hospitals benefit from autonomy of action, local financing for health services, attention to availability of commodities and goods, motivated human resources, strong governance, community engagement, and strengthening reporting and information systems. These are high-value results since service expansion efforts have been slowed by insufficient health infrastructure and inefficient health systems for decades. (Zeng, Wu et al. 2017). Impact evaluation studies show there is cross-cutting evidence of general health system strengthening in terms of more active monitoring and supervision and more quantifiable involvement with communities. These system-level impacts can have knock-on effects on population-level health outcomes that may extend well beyond the life of the evaluation period.

Enhancing donor alignment: RBF programs have shown that they can be a platform for better in-country harmonization of the implementation of a comprehensive package of key maternal and child health services that respond to country's health priorities. A nationwide RBF program in Burundi offers such a package. The national performance-based financing (PBF) program in the country is the government's implementation mechanism of its free health care basic package. The government contributes almost 45 percent of PBF payments to health facilities through a virtual harmonized pooling system. It allows donors to "pay" for specific indicators, geographical area or the overall program, while maintaining one harmonized system. This has streamlined the scale-up and reduced transaction costs for the government. Interestingly, Burundi has become a leader in using RBF as a platform for harmonizing health financing for maternal and child health services. Some donors choose to partner on an RBF program through a "joint basket" system. In Benin, for example, such a virtual joint basket system is used to manage the PBF programs, which are identical across districts, i.e. same RBF design and interventions managed by the same entity with common procedures. This arrangement allows partners to purchase health results in a geographic area where they may already have a presence. The Ministry of Health managed this system and the partners—the World Bank, the GAVI Alliance, and the GFATM—contributed an equal share for RBF operating costs based on the number of districts in which the joint basket works. The co-financing arrangement has made it possible to scale-up PBF throughout Benin, and from mid-2015 to mid-2017 it was operational in 85 percent of the country's districts (i.e. 29 districts out of the 34 of the country, the remaining 5 districts were also covered by PBF approach funded by the Belgium Cooperation using a slightly different mechanism).

Each of the above cited impact evaluations provide rigorous evidence that can and often have guided the policy discussion within countries. As the evidence of the portfolio of impact evaluations funded by the HRITF grows, it will be important to move from understanding whether and why an RBF scheme has worked in a setting to identifying the contextual factors that drive success on a more general level. Such more systemic evidence will ensure that countries embarking on new RBF schemes can optimally learn from these experiences.

4. Limitations and challenges

As with any health system reform, there is no one size fits all solution and implementation is key. Not all RBF schemes have produced positive effects and often not all utilization indicators are affected. Learning from both the positive and negative experiences is and will continue to be crucial to identify the enabling factors for successful design and implementation of RBF. One such example is the RBF pilot in Haut Katanga district of the Democratic Republic of the Congo that suffered from implementation problems and therefore did not have any impact on the coverage of essential services. The de facto absence of a credible link between financial resources and performance, because of too late/few verifications and the absence of an appropriate financial penalty for misreporting, led to more volatile and reduced payments in RBF facilities, in turn causing motivation of health workers to decline. Verification is indeed key to RBF, but also increases costs and the workload for staff. As programs mature, technological innovation (online data platforms) and more strategic ways of verifying are likely able to push down these costs and hence improve cost-effectiveness of RBF. Identifying the best practices for

doing so is an important item on the agenda for further research. Also, the fee-for-service incentive structure that is implied by RBF not only risks over-reporting but also over-provision, RBF is often more suitable to increase coverage of preventive services. Careful attention therefore needs to be paid to the integration of different financing mechanisms for different types of care. Argentina's Plan Nacer for example, uses a very innovative combination of fee-for-service and capitation mechanisms that ensures providers are adequately compensated for the entire package of services they are supposed to provide. Such an integration of payment mechanisms will become increasingly important as countries move closer towards Universal Coverage and can extend benefit packages to non-communicable diseases. The potential of RBF as a kick-starter for larger health system reform also has implications for assessing its cost-effectiveness. The current portfolio of cost-effectiveness studies only considers utilization increases (and associated health impacts) as outcomes, which likely is an underestimate of the scheme's true cost-effectiveness if such larger health system impact could be measured and taken into account.

5. Going forward: GFF offers opportunities

Early years of the HRITF focused on testing to which extent and under which conditions RBF can be an effective and efficient driver for better results. Evolving into the GFF, the agenda is focused on the same results but GFF approaches are broader, more comprehensive in using the RBF potential and also more explicitly focused on sustainability. It is therefore paramount that essential lessons are learned and taken forward while at the same time ensuring learning continues as programs move forward. Three most important ways GFF expands the RBF agenda are following.

- **Using RBF strategically at all levels of the health system**

While most of the HRITF-supported projects focused on facility-based RBF, the GFF has expanded the results-based incentive structures to include both regional and national levels.

In Kenya for example, the GFF uses RBF a performance-based approach at the county level with the aim of improving RMNCAH results and the equitable increasing allocation of domestic resources to health. The GFF has supported the development of an RMNCAH Investment Framework, which is implemented through county level annual work plans (AWP), whereby the performance-based payments incentivize counties to allocate funding for health to operationalize these AWP as well as to improve results. The GFF trust fund co-financed IDA project finances the priorities described in the RMNCAH Investment Framework. It aims to improve the quality of AWP by disbursing allocations to a county after the county AWP has been technically appraised with focus on key issues such as equity (e.g. targeting interventions in a sub-county or amongst a population group that has historically been neglected) and efficiency (e.g. implementing evidence-based cost-effective interventions including interventions described in the RMNCAH investment framework). The GFF has also facilitated improved harmonization and coordination of the capacity building support provided through multi-donor funding and coordination from DFID, USAID, and Danida to ensure appropriate capacity building to prepare and implement the AWP and attain the results. An evaluation of such models, as well as further experimentation in other countries will need to demonstrate whether RBF can be a vehicle to help drive the Domestic Resource Agenda in devolved settings.

Mozambique never had a RBF pilot supported by the HRITF, but through the process of developing the Investment Case, the dialogue in the health sector has shifted from focusing on inputs to results. The priorities identified in the IC were translated, by the Ministry of Health (MISAU), to the annual Economic and Social Plan (PES), which is the main annual planning and budget document. The Ministry of Health (MISAU) leads the implementation of the PES, which is funded by domestic and external resources through both input-based and results-based financing.

For the latter, Health Partners, under the leadership of MISAU, have supported the preparation of a joint Disbursement Linked Indicators (DLIs) matrix to operationalize the IC. The joint program will disburse funds based on the achievement of a mix of high and intermediate level results. The DLIs are linked to outputs (increased coverage of institutional deliveries, family planning and, nutrition services) while others are linked to health financing (increases in domestic resources, shifts in resource allocations to priority districts) and health system strengthening (share of staff allocated to primary care, percentage of hospital and health centers meeting performance standards, increase use of civil registration system). Main financiers in the health sector have expressed willingness to contribute to financing the program. The results based approach, using DLIs, is in this case a powerful mechanism to focus on key priorities and have transparency of progress achieved.

- **RBF can substantially reduce transaction costs associated with heavy reliance on external resources for health and improve alignment around the Investment Case**

A key challenge for both strengthening RMNCAH service delivery and health financing in many GFF countries is the high reliance on external (donor) resources. In situations where 30-40 percent of a country's health budget is coming from external sources, often going off-budget, it is difficult for governments to appropriately plan and prioritize. When pooling external resources, or providing on-budget support is not desirable or feasible for many development partners in the short term, RBF can provide a vehicle that kick-starts better alignment and harmonization. Also in situations where other partners do not take RBF based approaches, such alignment is possible by adjusting downward the RBF resources in those settings where providers also benefit from input based support.

In the Democratic Republic of the Congo, RBF has proven to be such a strategic tool that has led several partners to come together and create a platform around a set of common goals. GFF's overarching umbrella at the global level has enabled this harmonization philosophy to be translated into an even stronger and more efficient national coordination. With the Universal Health Coverage vision as the end game, six key strategic partners have pledged to work together on the ground, moving from engagement to operationalizing this alignment. While service delivery through RBF at facility level is at the core of such alignment, convergence of efforts also target supply chain, public finance management, and human resources for health, thus supporting a comprehensive health system reform at all levels. The harmonization process required adopting common tools such as strategic purchasing manuals; performance frameworks, financial management manuals, information systems, and finding synergies and complementarities in the procurement and distribution of commodities. The next step is to further align implementation through the various stakeholders and conduct joint field visits as well as define next steps for further consolidation and unification.

- **RBF has the potential to kick start sustainable health system reform**

Smart, Scaled, and Sustainable financing is at the core of the GFF. While RBF has the potential to drive system-wide reform through improved accountability, data management, and building capacity in strategic purchasing, it has not yet realized its potential as much as it could. HRITF experience revealed that for RBF to drive sustainable reform, buy-in from key stakeholders, including Ministries of Finance and donors should be sought very early in the process. The GFF approach explicitly seeks such buy-in by supporting the development and implementation of a Health Financing Strategy that lays out key strategic objectives for the short, medium and long term and bridges discussions on service delivery with sustainable financing. The GFF health financing agenda is one of increasing domestic resources for health of mothers and children and making sure that scarce resources are used in the most efficient way. RBF programs can contribute to both aspects of this agenda – they allow channeling more resources to primary care while ensuring these resources are only spent on the most cost-effective services. At the same time, RBF functions as a tool for building capacity on purchasing, verification, and financial

management at the local level – capacity that is essential for any larger national reform to be properly implemented.

In Sierra Leone, the GFF will be supporting an agenda of capacity building and integration of RBF into a larger health financing context. Since 2011, Sierra Leone has been implementing an RBF scheme as part of the World Bank-supported Reproductive and Child Health Project. The RBF funds that were channeled to primary care facilities have been key to redistribute public resources to the frontline services in rural areas. RBF implementation has not gone without challenges, most notably the payment delays caused by a very high number of contracted facilities. Current funding for RBF implementation has come to an end, but as RBF is the only source of disposable funding at the facility level and therefore important for the effective implementation of the Free Health Care Initiative, there is interest within the government to improve and sustain the RBF approach. At the same time, Sierra Leone has ambitious plans to roll out the Sierra Leone Social Health Insurance Scheme (SLeSHI). Recognizing that RBF can only be sustained if it is made more effective and better integrated in the overall health financing system, and that SLeSHI will need to build capacity in its function of a strategic purchaser, the GFF is supporting a redesigned RBF pilot while at the same time pursuing an agenda of integration between SLeSHI and RBF. Through continuous engagement and technical support, the GFF is contributing to developing a roadmap that lays out how RBF can lay the foundation for strategic purchasing within SLeSHI.

CONCLUSIONS

The first phase of RBF was dedicated to building up an evidence base. While the knowledge about *what works* and *what doesn't* and *why* is still growing, it can be concluded that RBF has clearly shifted the debate to real service delivery issues and offers much potential to speed up progress towards universal coverage of key preventive services. Over the last decade, RBF has been used to improve service delivery results at the front-lines. While incentives are an important driving force for results, the importance of transparency, strengthening of management and supportive supervision should not be underestimated. Owing to its comprehensive nature, RBF has the potential for larger health system strengthening, for example, by facilitating greater decision-making to sub-national levels by passing funds directly to the front lines, putting a premium on monitoring, supervision and evidence-based decision making, and by combining supply- and demand-side interventions. RBF has mandated the need to prioritize RMNCAH services, make critical choices, and sustain the results.

This mandate has now been taken up by the GFF. The health financing agenda of the GFF is to a large extent a Universal Health Coverage agenda, one to which RBF can very much contribute. While it is widely accepted that for countries to move closer towards Universal Health Coverage, a larger share of the health budget will need to be publicly (pre-)financed and spent on primary care, implementing such reforms can be politically and practically challenging. RBF can provide a practical entry point for such discussions and it ensures that only the most cost-effective services are purchased. The Smart, Scaled, and Sustainable financing that the GFF calls for, will however require addressing sustainability issues that initial RBF programs have encountered and ensure they are linked to a longer-term Health Financing strategy. The learning agenda on RBF should therefore continue, but move from trying to answer the question of whether RBF works to the questions of *when, where, how, at what cost* and *how to scale up*. Rather than impact evaluations, implementation research will be key for this continued learning agenda to ensure that evidence is generated in real-time and highly context specific.

Table 1. Impact of results-based financing (from draft mid-term evaluation of HRITF, 2017)

Country	Impact on utilization and coverage	Impact on quality	Impact on health workers
Argentina 1	IE 1: increase in number of antenatal visits; 24.7% increase in tetanus vaccination coverage.	Reduction in in-hospital neonatal mortality	None identified.
Afghanistan 1 Afghanistan 2	There were no significant changes in any of the targeted indicators.	The intervention health facilities had a statistically significant higher performance on engagement of community in decision-making, staff received training, equipment functionality, health facility management functionality, pharmaceuticals and vaccines availability; more time was spent with clients	Positive impact on health worker satisfaction.
Cameroon	There was an increase in child immunization and in maternal immunization against tetanus and improvements in coverage of family planning, but not for others, such as antenatal care visits and facility-based deliveries. The difference between the RBF and additional financing group were not significant.	A significant impact on the availability of essential inputs and equipment, qualified health workers, and increased satisfaction among patients and providers	Greater staff satisfaction.
DRC Haut Katanga	There was no measurable impact on increase in utilization.	No impact on patients' perceived quality of care. Reduced levels of equipment and supplies in the treatment facilities.	Staff in RBF facilities showed lower attendance levels than the control following the intervention and had lower satisfaction rates. 34% more workers in the RBF group attached importance to remuneration.
Rwanda 1	A 23% increase in institutional deliveries and a 56% increase in preventive care for young children. No increase in women completing 4 PNC visits, or in full child immunization.	Increased quality of prenatal care	Evidence that the use of incentivized quality indicators led to improved quality of care.
Zambia 1	Institutional deliveries increased by 13 percentage points and skilled birth attendance increased by 10 percentage points; however, the enhanced financing arm (with no RBF) showed higher rates of increase for each at 17.5 percentage points and 14.2 percentage points respectively.	Improvement in equipment and supplies, and some aspects of care quality; comparison groups showed greater improvements than treatment groups for other care quality indicators.	No impact on health worker satisfaction and motivation.
Zimbabwe	There was a general increase in RBF and control facilities in health service utilization. Key indicators such as skilled provider deliveries, institutional deliveries and deliveries by caesarean sections improved at a faster rate in RBF facilities.	Mixed results for quality indicators; no significant increase in quality of equipment and supplies; no increase relative to control for client satisfaction.	Mixed effects on health worker motivation.