THE QUEST FOR A NATIONAL RESULTS-BASED FINANCING MODEL IN UGANDA: INNOVATION, LEARNING AND BUILDING FROM MULTIPLE PILOTS.

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PRESENTATION OUTLINE

• Introduction and rationale
• Contextual Background
• Methods
• Key findings
• Discussion and conclusions
INTRODUCTION & RATIONALE

• Results-Based Financing (RBF) is considered a means to improve health systems performance toward UHC.
  • RBF links payments to providers or consumers to quantitative or qualitative indicators.

• Limited documentation of how and why design and institutional arrangements of pilots implemented in same national health system evolve.

• A number of RBF initiatives have been implemented in Uganda between 2003-2015 (Lindsay 2010, Nu Health 2014, Ekirapa et al 2011, Okal et al 2013).

• This paper addresses how and why RBF models have changed over time in Uganda and discusses implications for design of national RBF model for Uganda and similar countries.

CONTEXTUAL BACKGROUND

• MOH has overall stewardship
  • Has to work with line ministries.
• Health financing:
  • THE: Government (16%), Donors (45%) & OOPs (36%).
  • User fees abolished in public facilities in 2001
  • Ongoing efforts to start national health insurance system.
  • Government uses budgets to fund public facilities and subsidise in Private not for profit subsector.
• Delivery system has both public and private sector.
  • Each sector contributes 50% of service outputs.
• Significant functionality deficits across building blocks of health system exist.
RESEARCH OBJECTIVES

Overall aim:
This study aimed at documenting and analysing the development process of RBF in Uganda from Jan/2003 to March/2015 and draw lessons for future scaling up and sustaining.

Study objectives:
1. To explore the evolution of RBF policy (2003 – 2015) with focus on 7 RBF schemes, the actors involved, their motivation, cross linkage between schemes (cross learning) and integration into national health policy process.

RESEARCH METHODS

• Case study design as part of WHO funded multi-country study.

• Only Qualitative data collection methods.
  • Desk review
    • Published and unpublished documents on RBF in Uganda.
    • Specific Program reports, grant applications/concepts, policy documents, technical memos.
  • Key informant interviews
    • 39 respondents from Various stakeholder groups.

• Concepts from complex adaptive systems theory used for Comparison and building plausible explanations for the different RBF models over time.
KEY FINDINGS

- Seven (7) major RBF schemes implemented in Ugandan health sector since 2003.
  - 4 supply side schemes.
  - 3 demand side/vouchers.
  - Comparable overlaps between the two categories.

- The designs and institutional arrangements for these schemes evolved in several aspects:
  1. Actors in the pilots.
  2. Population/geographical coverage
  4. Health system integration.

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ACTORS IN SCHEMES

<table>
<thead>
<tr>
<th>Project Feature</th>
<th>Duration</th>
<th>General project design</th>
<th>ACTORS</th>
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<tbody>
<tr>
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<td>Funder</td>
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<td>Supply side schemes</td>
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<tr>
<td></td>
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<td>design, two intervention groups and a control</td>
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<tr>
<td>Cordaid project</td>
<td>2009-2015</td>
<td>Interventional design</td>
<td>Cordaid</td>
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<tr>
<td>NuHealth Project</td>
<td>Sept 2011-2015</td>
<td>Quasi-experiment study (RBF &amp; input based financing)</td>
<td>DFID</td>
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<tr>
<td>Strengthening Decentralisation for Sustainability (SDS)</td>
<td>2010-to date</td>
<td>Intervention design</td>
<td>USAID</td>
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### ACTORS IN SCHEMES

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<tr>
<th>Project Feature</th>
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<th>General project design</th>
<th>Funder</th>
<th>Fund holding agent</th>
<th>Purchasing agent</th>
<th>Auditing/Verification agents</th>
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<tbody>
<tr>
<td>Demand side/Voucher Schemes</td>
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<tr>
<td>Reproductive Health vouchers Project</td>
<td>July 2006-2011</td>
<td>Intervention study</td>
<td>KfW and the GPOBA-World Bank</td>
<td>MariesStopes (MSU)</td>
<td>MSU</td>
<td>MSU</td>
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<tr>
<td>Safe deliveries Project (SDP)</td>
<td>2009-2011</td>
<td>Quasi-experiment study with intervention and control arms</td>
<td>Bill and Melinda Gates Foundation and WHO-AHPSR</td>
<td>Makerere University School of Public Health (MaKSPH)</td>
<td>MakSPH</td>
<td>MakSPH</td>
</tr>
<tr>
<td>Health Baby / SMGL Voucher Project.</td>
<td>2012-to date</td>
<td>Intervention design</td>
<td>SMGL funded by US Global Health(GHI) and partners including Merck/MSD, the American College of Obstetricians and Gynecologists, Every Mother Counts, ELMA Foundation</td>
<td>MSU</td>
<td>SMGL</td>
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### COVERAGE

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<thead>
<tr>
<th>Project</th>
<th>Population coverage</th>
<th>Service package</th>
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<tbody>
<tr>
<td>Geographical scope</td>
<td>Populations served</td>
<td>Service packages</td>
</tr>
<tr>
<td>Supply side schemes</td>
<td></td>
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<tr>
<td>World Bank Study</td>
<td>115 facilities (68 PNFPs) from five pilot districts distributed in 4 regions</td>
<td>All resident within reach of health facilities</td>
</tr>
<tr>
<td>Cordaid project</td>
<td>Initially 3 districts in east (Jinja, Kamuli &amp; Iganga). Later restricted to Kamuli.</td>
<td>All residents within reach of facilities</td>
</tr>
<tr>
<td>NuHealth Project</td>
<td>31 health centres in 12 northern Uganda districts.</td>
<td>All residents within reach of facilities</td>
</tr>
<tr>
<td>SDS</td>
<td>35 districts initially increased to 50 districts in 2015 across the country.</td>
<td>District councils and Medical bureaux</td>
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<tr>
<td>Demand side/Voucher Schemes</td>
<td></td>
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<tr>
<td>Reproductive Health vouchers Project</td>
<td>Evolved from 4 pilot districts to 20 districts in south western Uganda.</td>
<td>Women for SM. Couples for STI. Poverty grading used to target poorer.</td>
</tr>
<tr>
<td>Safe deliveries Project (SDP)</td>
<td>22 health facilities in 2 districts in Eastern Uganda.</td>
<td>All pregnant women, transport providers used.</td>
</tr>
<tr>
<td>Health Baby / SMGL Voucher Project.</td>
<td>4 districts in Western Uganda but scaled up to 10 included 6 more districts in Northern Uganda</td>
<td>All pregnant women within districts, transport provisions made available.</td>
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</table>
### HEALTH SYSTEMS INTEGRATION

<table>
<thead>
<tr>
<th>Governance</th>
<th>HR system</th>
<th>Medical supplies systems</th>
<th>IMIS</th>
<th>Capacity building (CB)</th>
<th>Social marketing</th>
<th>Transition from pilot</th>
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<tbody>
<tr>
<td><strong>World Bank</strong> Study</td>
<td>World Bank provided oversight; MOH engaged for buy-in.</td>
<td>Local government manages grants and disburse to facilities.</td>
<td>Development of IMIS by World Bank National Committees.</td>
<td>Originally engaged but has not continued engagement.</td>
<td>Not included pilot facility autonomy adopted.</td>
<td>Extended to public facilities after pilot.</td>
</tr>
<tr>
<td><strong>Cordaid project</strong></td>
<td>UMH offered oversight; MOH engaged for buy-in.</td>
<td>DHTs supervise data quality.</td>
<td>MOH engaged for buy-in.</td>
<td>Not applicable.</td>
<td>Closed in 2015.</td>
<td>Not applicable.</td>
</tr>
<tr>
<td><strong>Nahled Health Project</strong></td>
<td>MOH &amp; UMH to oversee project.</td>
<td>MOH engaged for buy-in.</td>
<td>MOH engaged for buy-in.</td>
<td>Not applicable.</td>
<td>Closed in 2015.</td>
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**Reproductive Health vouchers Project**

| District leadership provided oversight. | Facilities determine how funds are utilised. | No direct benefits to health workers. | Public facilities received supplies from NMS while PNP facilities procure supplies from IMS. | Separate reporting requirements for project work. | Training in program uptake; standard operating procedures (SOPs); provided Voucher distributor; Radio talk show; community engagement dialogues. | From 4 pilot districts for STI in 2006 to 20 districts for SM. |

**Safe deliveries Project (SDF)**

| National dialogue continued but MOH has no active role. | Facility management structures decide on fund utilisation. | No direct benefits to health workers. | Public facilities received supplies from IMS and accredited pharmacies. | Adopted IMIS. | Provided some supplies for obstetric care and training of staff. | Successful pilot informed international programme: New activities to build sustainability introduced. |

**Health Baby SMGHL Voucher Project**

| National dialogue continued but MOH has no active role. | Facility management structures decide on fund utilisation. | DHTs supervise and collaborate in service delivery. | Public facilities received supplies from IMS and accredited pharmacies. | Use IMIS and additional project verification tools. | Support districts in development of plans and implementation arrangements. | Free-phase informal 2nd phase. |

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SUMMARY OF OBSERVATIONS AMONG SCHEMES

• Actors:
  • Mainly external funding sources.
  • NGOs & business entities still play prominent roles especially in demand side schemes
  • Progressively government agencies involved but more at the sub national level structures.

• Population coverage
  • Almost all regions have had schemes but bias towards the western region of the country.
  • NO systematic progression across the schemes over time.
  • Expansion, contraction and termination of individual schemes noted.

• Service packages:
  • Demand side schemes offered majorly maternal and child health services
  • Supply side schemes provided wider (but limited) service packages.
  • Packages of services were designed to address MDGs donor concerns and less from service needs in the communities.

• Health systems integration:
  • Mainly private sector facilities involved but recent adjustments to expand to Public facilities noted:
    – Vulnerability of Public Not for profit sector to financial constraints.
    – Mechanism to operationalise the PPPH approach.
    – Compatibility of vouchers with business model of private sector.
  • Regarding alignment with governance structures, RBF has worked closely with districts bypassing the national level.

SDS targets mainly governance and management functions at districts.
EXPLAINING THE EVOLUTION & IMPLICATIONS FOR NATIONAL MODEL

• Explanations:
  1. Progressive learning across schemes and time is major driver of changes in models.
  2. Modifications of designs were efforts to adopt what works well and circumvent health systems barriers in Uganda.
  3. Lessons have been learnt on use of resources, information systems and governance of RBF approaches BUT …..

• Policy level challenges still remain obstacle to national RBF model.
  1. Decision space and Practicality of autonomy of facilities.
  2. Conflict of selling vouchers vs free health care policy of government.
  3. Design of Governance structures and decision making in government.
  4. Harmonization of stakeholders interests and loss of control over resource allocations.
  5. Reforming public sector budgeting and HR systems to align with RBF.
  6. Determining the Actual cost of implementation.

DISCUSSIONS & CONCLUSION

• Cross learning had been documented.
• Change in design and implementation of various models over time demonstrates efforts to design a model appropriate for Uganda.
• Progressive learning is important for implementation of complex interventions like RBF.
• We advise that:
  1. Uganda and similar countries should customize RBF designs to fit their systems configurations.
  2. Desist importing “best practices” from other contexts.
ACKNOWLEDGEMENTS

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- Technical Support team for Taking Results-based Financing from Schemes to System program (ITM led by Prof Bruno Meessen).