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# 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

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# 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.

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# CONTEXTUAL BACKGROUD

- 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.

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# 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.

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# 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    - Published and unpublished documents on RBF in Uganda.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.

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# 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
  3. Benefit packages.
  4. Health system integration.

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# ACTORS IN SCHEMES

| Project Feature | Duration | General project design | ACTORS | | | |
|---|---|---|---|---|---|---|
| | | | Funder | Fund holding agent | Purchasing agent | Auditing/ Verification agents |
| **Supply side schemes** | | | | | | |
| **World Bank Study** | 2003-2005 | Quasi-experimental design, two intervention groups and a control | CIDA, USAID,BTC | World Bank-Washington | World Bank through local government. | MaKSPH |
| **Cordaid project** | 2009-2015 | Interventional design | Cordaid | Cordaid | Jinja Diocese/Cordaid | Cordaid/DHTS and CBOs |
| **NuHealth Project** | Sept 2011-2015 | Quasi-experiment study (RBF & input based financing) | DFID | Health Partners International (HPI) &Montrose International | HPI & Montrose | NU-Health and District health teams (DHTs) |
| **Strengthening Decentralisation for Sustainability (SDS)** | 2010-to date | Intervention design | USAID | SDS program | Cardno and supported by the Urban Institute (UI),Devis, Infectious Disease Institute (IDI) and Tangaza Cinemas Ltd | SDS + District health teams |

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| | | | Funder | Fund holding agent | Purchasing agent | Auditing/ Verification agents |
| **Demand side/Voucher Schemes** | | | | | | |
| **Reproductive Health vouchers Project** | July 2006-2011 | Intervention study | KfW and the GPOBA-World Bank) | MariesStopes (MSU) | MSU | MSU |
| **Safe deliveries Project (SDP)** | 2009-2011 | Quasi-experiment study with intervention and control arms | Bill and Melinda Gates Foundation and WHO-AHPSR | Makerere University School of Public Health (MaKSPH) | MaKSPH | MakSPH |
| **Health Baby / SMGL Voucher Project.** | 2012-to date | Intervention design | SMGL funded by US Global Health(GHI) and partners including Merck/MSD, the American College of Obstetricians and Gynaecologists, Every Mother Counts, ELMA Foundation | SMGL initiative | Baylor-Uganda, Infectious Disease Institute (IDI),STRIDES for family health, MSU. | Baylor-Uganda, IDI,STRIDES for family health, MSU |

# COVERAGE

| Project | Population coverage | | Service package | |
|---|---|---|---|---|
| | Geographical scope | Populations served | Service packages | Facilities |
| **Supply side schemes** | | | | |
| **World Bank Study** | 118 facilities (68 PNFPs) from **five pilot districts distributed in 4 regions** | All resident within reach of health facilities | Six service priorities (OPD and malaria, immunization, ANC, attended births & FP | Intervention group included **PNFP only**. Public, PFP in control category. |
| **Cordaid project** | **Initially 3 districts in east** ( Jinja, Kamuli & Iganga). Later restricted to Kamuli. | All residents within reach of facilities | Range of services from national package. | Started with PNFP. Extended to public facilities in 2013 |
| **NuHealth Project** | 31 health centres in **12 northern Uganda districts**. | All residents within reach of facilities | Range of services especially maternal and child health services | **PNFP only.** |
| **(SDS)** | **35 districts** initially increased to **50 districts** in 2015 across the country. | District councils and Medical bureaux | **Performance-based grants** to **districts and Medical Bureaux** incentivise governance and management functions. | In regard to health services, the facilities targeted were those with bias to HIV/AIDS and the **PNFP facilities** |
| Demand side/Voucher Schemes | | | | |
| **Reproductive Health vouchers Project** | Evolved from **4 pilot districts** to **20 districts** in **south western** Uganda. | Women for SM. Couples for STI. Poverty grading used to target poorest. | Safe Motherhood (SM) services &STI treatment. | **PFP and PNFP facilities.** Public facilities were referral points |
| **Safe deliveries Project (SDP)** | 22 health facilities in **2 districts** in **Eastern Uganda**. | All pregnant women, transport providers used. | MCH and health system strengthening component to deliver obstetric care services. | **Public, PFP and PNFP facilities** |
| **Health Baby / SMGL Voucher Project.** | **4 districts in Western Uganda** but scaled up to 10( included **6 more districts in Northern Uganda**) | All pregnant women within districts, transport provisions made available. | ANC, delivery & Post Natal care and Health systems strengthening. | **Private and Public facilities** involved. |

# HEALTH SYSTEMS INTEGRATION

| | Governance | | | HR system | Medical supplies systems | HMIS | Capacity building (CB) | Social marketing | Transition from pilot |
|---|---|---|---|---|---|---|---|---|---|
| | National | Within district | Facility level | | | | | | |
| **World Bank Study** | World Bank provided over all stewardship. MOH marginally involved. | Local government manage grants and disburse to facilities | Intervention facilities had autonomy on utilisation of bonuses | Some facilities shared bonuses with staff. | PNFP facilities procured supplies from Joint medical Stores (JMS) | Adopted HMIS data | One sensitisation workshop of district and facility managers. Health workers not trained. | Not included | Failed beyond pilot but facility autonomy adopted by MoH. |
| **Cordaid project** | UCMB offered oversight; MOH engaged for buy-in. | DHTs supervise data quality | Guidelines on splitting funds (60% into operation & 40%) into bonus. | 40% of funds received were spent on staff | PNFP facilities procured supplies from JMS. Public facilities received autonomy to get supplies outside NMS. Purchase form local Pharmacies. | Adopted HMIS but developed computerised systems. Also had additional Community based verification done by CBOs. | CB for district health management teams | Community based organisations as verifiers. | Extended to public facilities after pilot |
| **NuHealth Project** | MOH & UCMB to small extent engaged. | DHTs perform data quality, output audits. Annual Regional stakeholder meetings. | In RBF arm-facilities had autonomy on fund utilisation based on business plans | In RBF, some facilities gave bonuses to staff | PNFP facilities procured supplies from JMS | Use HMIS but have additional verification/audit tools. Developed computerised systems. | Support districts in: Staff recruitment; Essential medicines Business planning. Support supervision | Not applicable | Closed in Mid-2015 |
| **Strengthening (SDS)** | Within Ministry of Local government but has Intersectoral Committees. | Extended districts health management committees. District Based Technical Assistance (DBTA) partners support districts | Health facility management structures follow guidelines. | No direct funds to staff | Public facilities receive supplies from NMS while PNFP facilities procure supplies from JMS. | Verification tools used designed for the project. | Support districts in development of plans and implementation arrangements. | Not applicable | Started with seed grants in 2012. Introduced performance grants (2014) and innovation grant (2015). |


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| | Governance | | | HR system | Medical supplies systems | HMIS | Capacity building (CB) | Social marketing | Transition from pilot |
|---|---|---|---|---|---|---|---|---|---|
| | National | Within district | Facility level | | | | | | |
| **Reproductive Health vouchers Project** | WB office played oversight role. MOH had no active role. | District leadership provided oversight. | Facilities determine how funds are utilised | No direct benefit to health workers | PNFP facilities received supplies from JMS. Private facilities were allowed to procure supplies from accredited pharmacies. | Separate reporting registers for project work | Training in program uptake. Standard operating procedures (SoPs) provided | Voucher distributors; Radio talk shows.@ voucher at 3000shs. | From 4 pilot districts for STI in 2006 to 20 districts for SM. |
| **Safe deliveries Project (SDP)** | National dialogue conducted but MOH has no active role | Stakeholder engagement throughout the project | Facility management structures decide on fund utilisation | No direct benefits to health workers | Public facilities procured supplies from National Medical Stores (JMS). PNFP received supplies from JMS | Adopted HMIS | Provided some supplies for obstetric care and trainings of staff | Community engagement dialogues held. Transport providers used. | Successful pilot informed intervention phase. New activities to build sustainability introduced. |
| **Health Baby / SMGL Voucher Project.** | MoH, professional bodies are informed | DHTs supervise and collaborate in service delivery | Facility management structure decide on fund utilisation | Bonuses to staff | Private facilities procure supplies from JMS and accredited pharmacies and private facilities recive supplies from NMS | Use HMIS and additional project verification tools | Support districts in development of plans and implementation arrangements. Facility investments are supported. | community structures promote vouchers. | First phase informed 2nd phase |

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## SUMMARY OF OBSERVATIONS AMONG SCHEMES

- Actors:
  - Mainly external funding sources.
  - NGOs & bussiness 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.

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## SUMMARY OF OBSERVATIONS AMONG SCHEMES

- 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.

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# 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 cicurmvent 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.

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# 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.

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