# Learning from Results Based Financing: The World Bank's Experience in Africa

HEALTH RESULTS INNOVATION TRUST FUND

WORLD BANK GROUP
Health, Nutrition & Population

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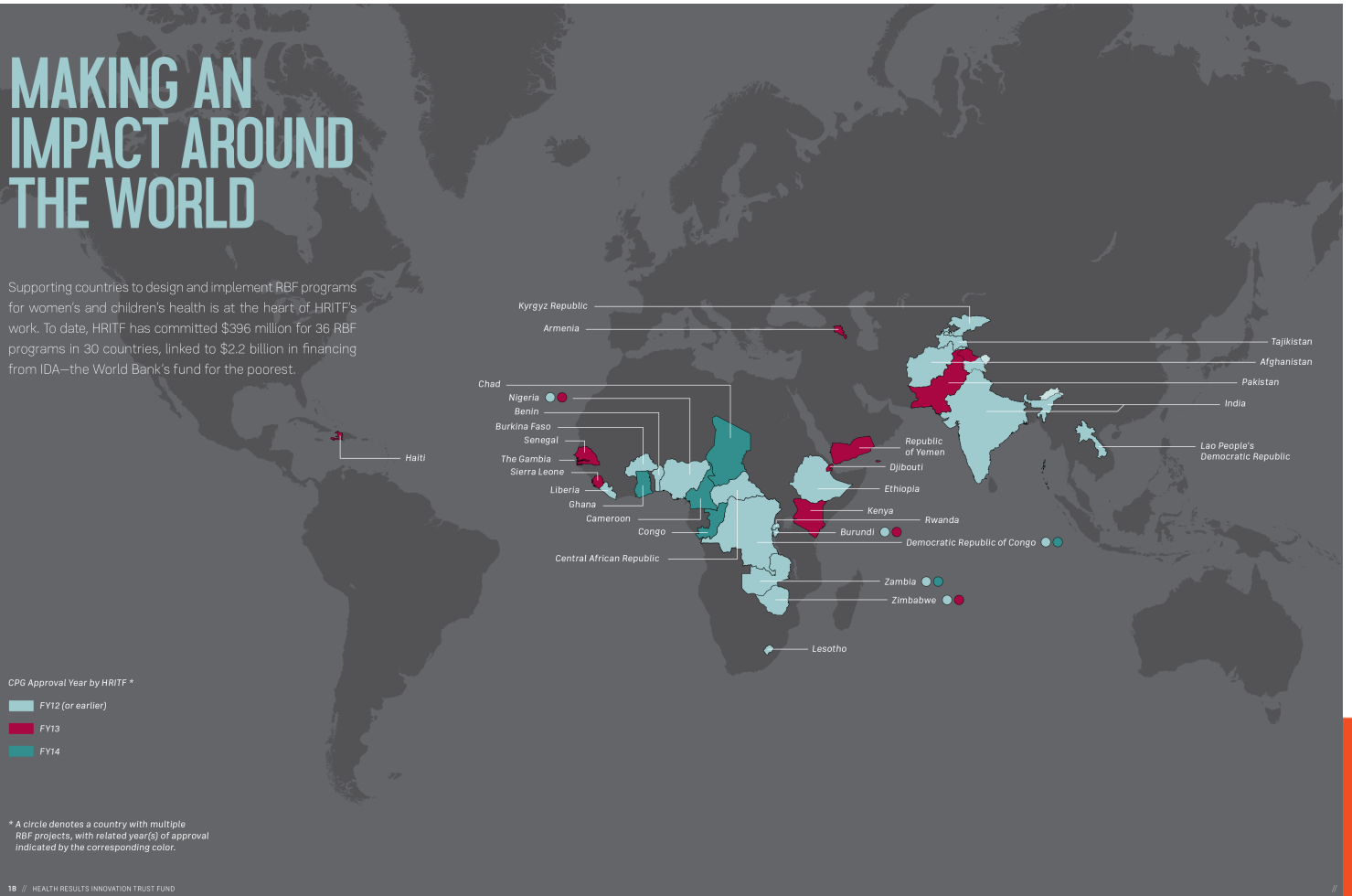
# The RBF Portfolio

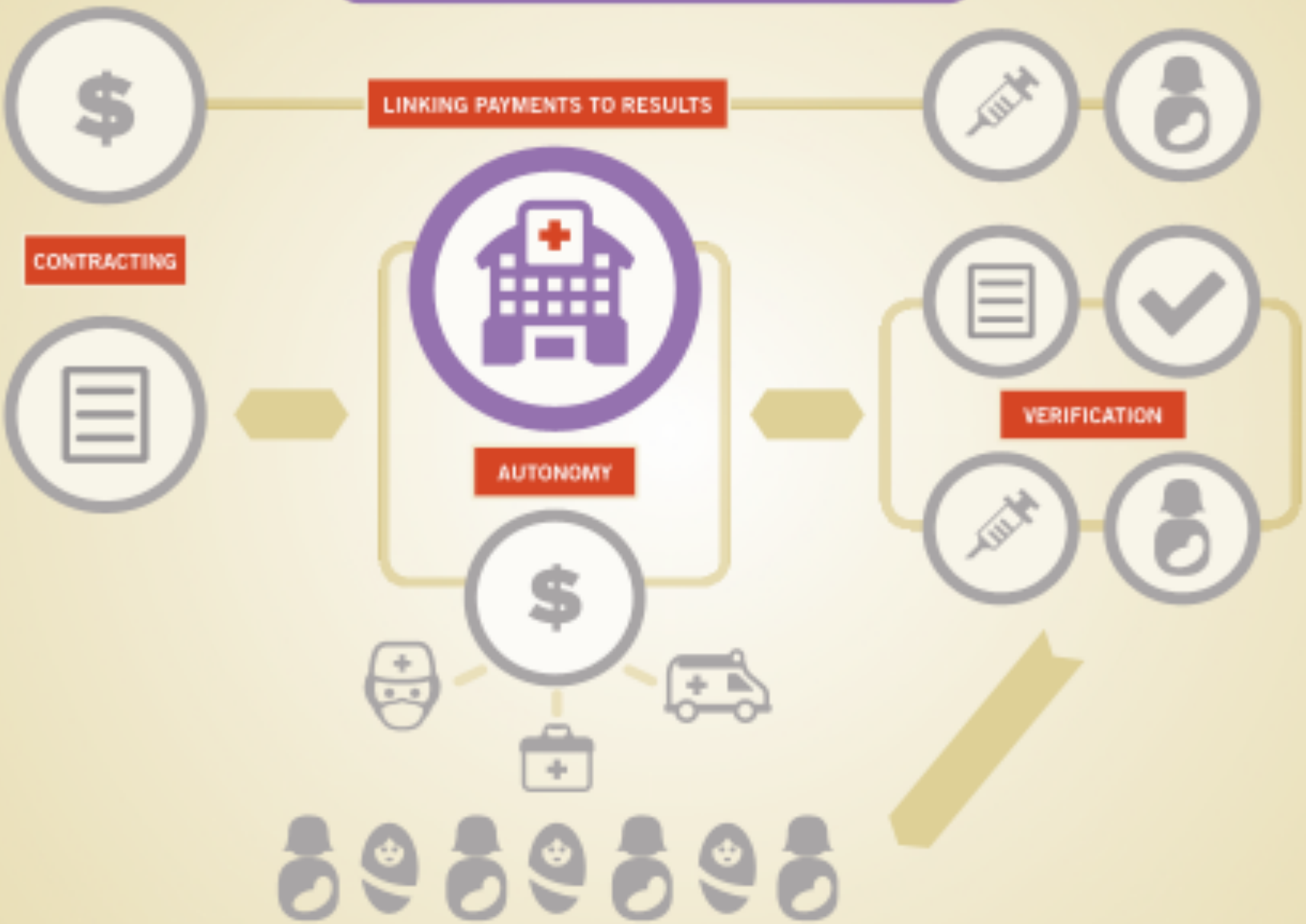
- **30 countries with 36 Country Pilot Grants**
- **HRITF has committed $396 million, linked to $2.2 billion financing from IDA**




## RBF models:

- **Performance Based Financing**
- Vouchers (CCT),
- Community RBF,
- Cash on Delivery

# RBF is a health system intervention



# A Conceptual Framework

STRATEGIC PURCHASING

POLITICAL ECONOMY

COMMUNITY

Stakeholder support

Public policies

Institutional capacity

Legal framework

Governance

HEALTH SYSTEM

HEALTH FACILITY

**Key Behavioral Attributes**

- Understanding
- Expectancy
- Valence
- Buy-in
- Perceived fairness

**Program Design & Implementation**

1. Contract with PBF indicators
2. Increased autonomy
3. Performance payment (size and frequency of performance payment, distribution mechanism, individual vs. facility levels, additional resources)
4. Data reporting
5. Capacity building

**Program Design & Implementation**

6. Verification
7. Supervision

**Organizational Changes**

- Improved clarity of priorities **1**, **4**, **5**
- Autonomous facilities allocate resources better through management & leadership response **2**, **5**
- Facilities get paid more/more productive staff **1**, **3**
- Change in trade-off between user fees & number of patients **1**, **3**
- Change in value of being client-friendly **3**
- Improved transparency & accountability **1**, **4**, **6**, **7**
- Use of data for decision-making **1**, **2**, **4**, **6**
- Better prepared facilities (inputs, training, etc.) **3**, **5**, **7**

**Behavioral Changes**

- Improved motivation & morale **2**, **3**
- Improved teamwork & collaboration **1**, **3**
- Improved communication & awareness **1**, **4**, **5**, **6**, **7**
- Improved perceived control **2**, **4**
- Increased demand for knowledge **1**, **2**, **4**

Health system pillars:

(i) Service delivery
(ii) Human resources
(iii) Financing
(iv) Governance
(v) Medicines/ commodities
(vi) Information

Geography/ remoteness

Cultural values, attitudes & perceptions

Socioeconomic Status

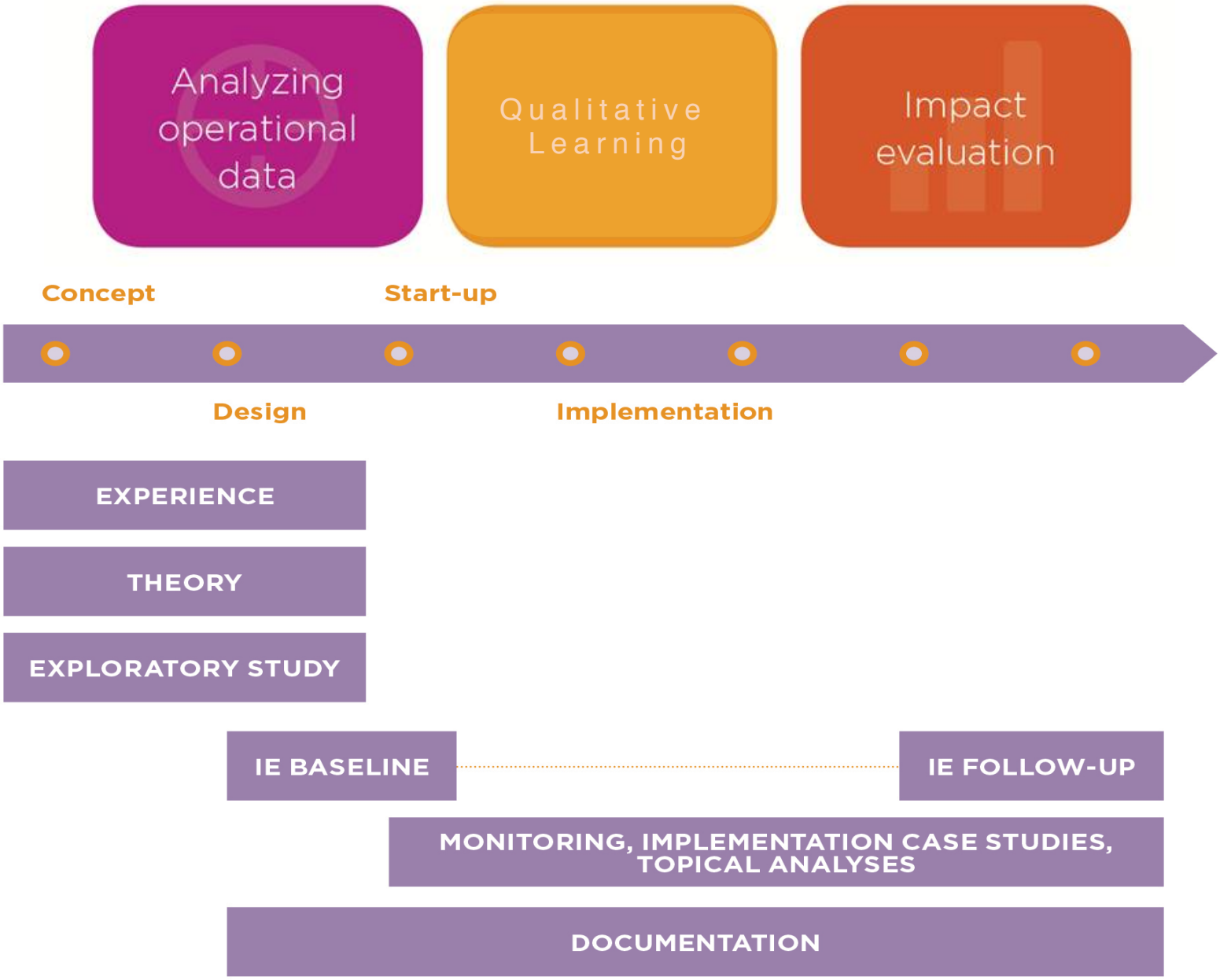
Demand for services

IMPROVED AVAILABILITY & QUALITY OF SERVICE DELIVERY

Health service utilization

IMPROVED HEALTH OUTCOMES

# Learning from Implementation

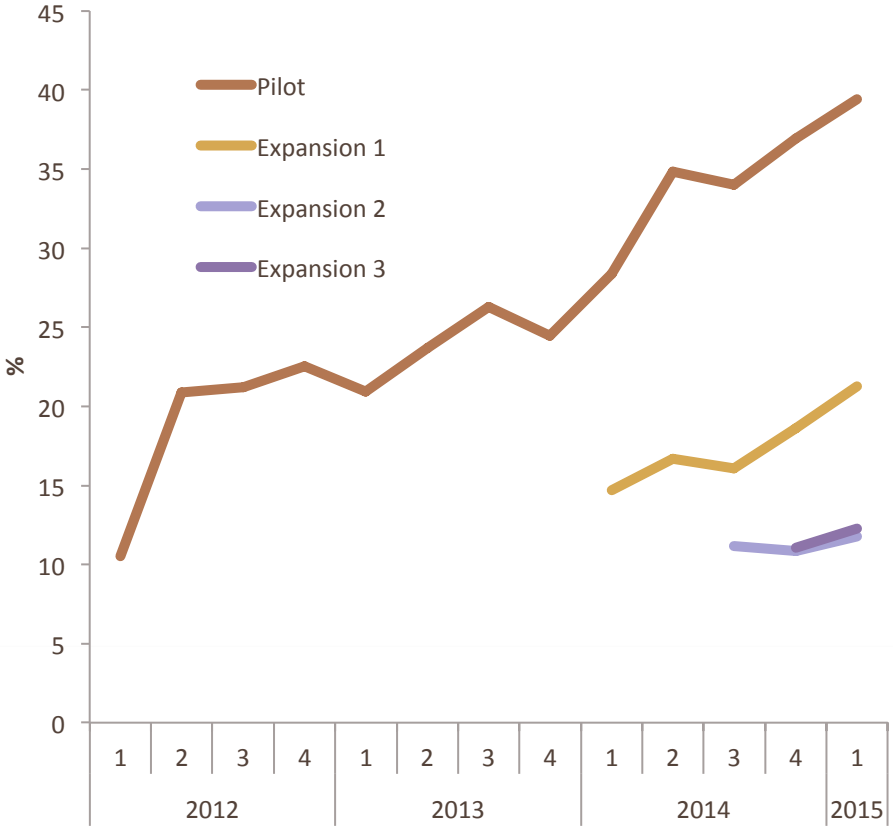


# Tracking Operational Data in Nigeria

Nigeria

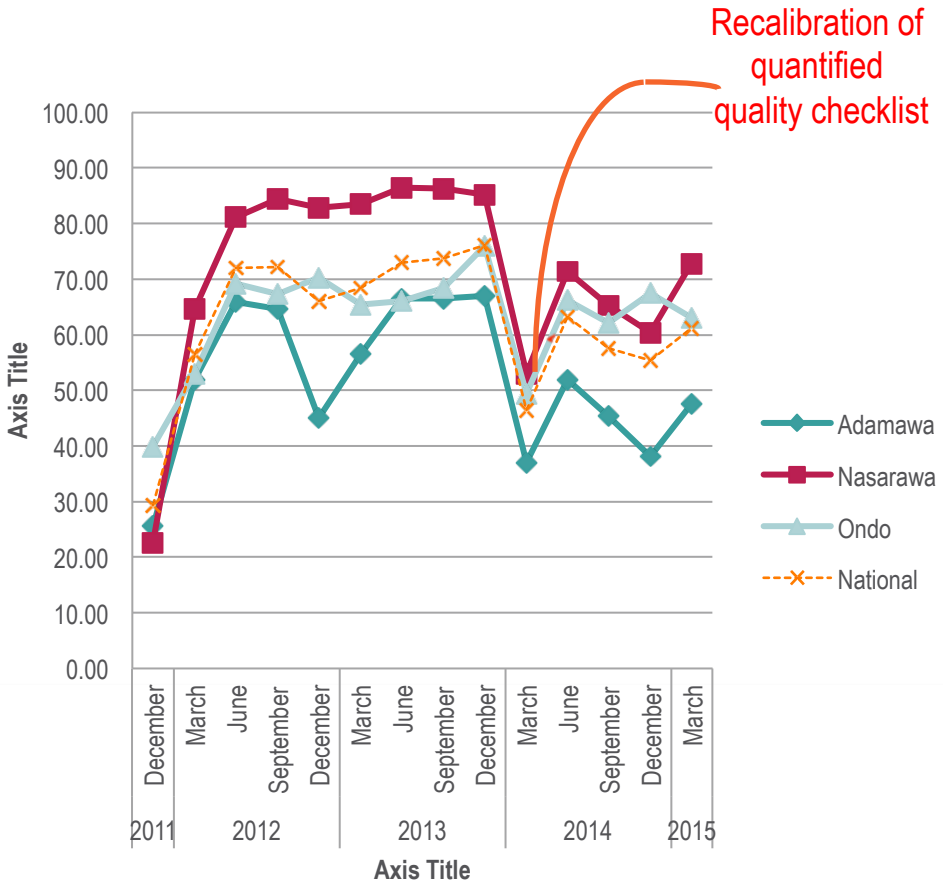
## COVERAGE OF INSTITUTIONAL DELIVERY

**Coverage increases sustained over phases**




## QUALITY OF CARE

**Dynamic quality measures improve outcomes**



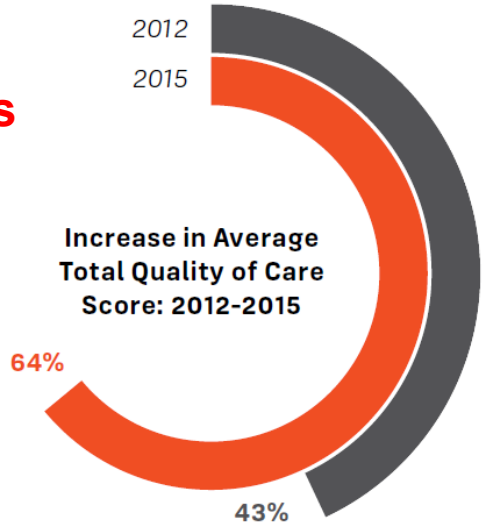
Cameroon

# Qualitative Learning

**Respondents included health care providers and administrative/regulatory bodies**

**Qualitative Component of IE included:**

- In-depth interviews
- Focus groups discussions




**Results:**

- Average total quality of care score increased from 43% to 64% between 2012 and 2015
- Service providers and regulatory agents have a strong desire for the PBF program to continue
- Increased collaboration among the various stakeholders
- Enhanced transparency and accountability in resource management
- Increased satisfaction among both providers and patients

# Rwanda



- **PBF at the health facility level was scaled up nationally in 2008**

- **Community PBF (Second Generation)**
  - Since 2009, Community Health Workers (CHWs) were paid for reporting on health indicators in their communities
  - Additional components were added through the Community Performance-Based Financing Program in order to promote targeted services.

- **The IE evaluated the impact of 2 interventions that were added to the scheme:**
  1. Performance incentives for CHW cooperatives
  2. Demand-side in-kind incentives

- **Qualitative study in progress**

# Second generation IE: Cooperatives & In-Kind Incentives

## Performance Incentives for Coop

- **No impact of incentives to CHW cooperative on targeted indicators, CHW behaviors and CHW motivation.**
- **Potential reasons for lack of impact**
  - Incentives were too low
  - Collective reward but individual effort
  - Pay-for-reporting could have already oriented the CHWs towards targeted indicators
  - Limited scope given the many supply-side programs targeting the same indicators

## Demand-side in-kind Incentives

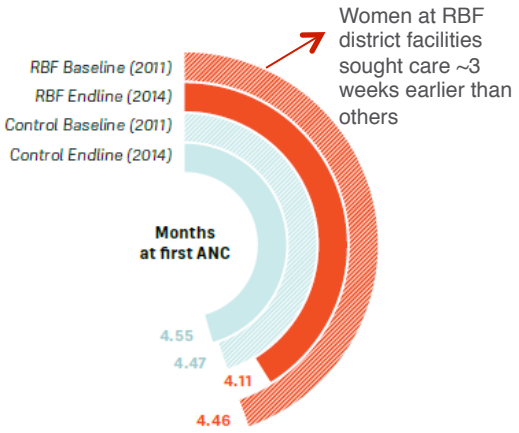
- **The demand-side in-kind incentives caused an increase in timely ANC and PNC services**
- **Despite some challenges in procurement frequent stock outs**
- **Although some health centers independently implemented their own demand-side incentives strategies to promote utilization**
- **Although program ended before end-line data collection**
- **Consistent with findings in other countries**

# Study Design

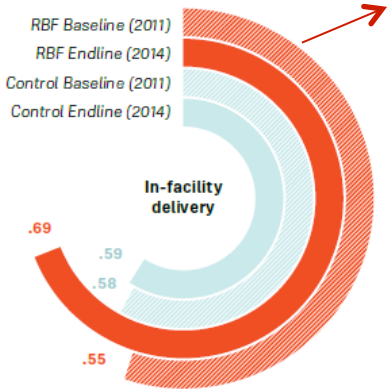
Zambia

**30 districts triplet-matched on key health systems and outcome indicators and randomly allocated to 3 arms:**

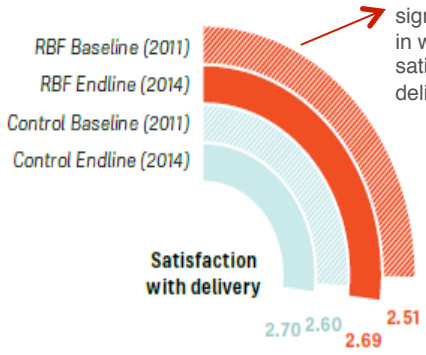
| 10 RBF Intervention Districts (RBF) | 10 Input-Based Financing Districts (C1) | 10 Pure Control Districts (C2) |
|---|---|---|




Women at RBF district facilities sought care ~3 weeks earlier than others




Rate of in-facility deliveries increased by ~13% in RBF districts




No statistically significant increase in women's satisfaction with delivery

Zambia

# Key Findings

- **Sizable gains in some key coverage indicators:**
  - in-facility delivery rate, earlier presentation for ANC care, maintenance of immunization coverage
- **RBF facilities report**
  - higher availability of equipment
  - higher autonomy
  - more satisfied staff
- **Enhanced financing: during implementation, C1 received funds but not to the level of RBF districts – roughly half as much – and were restricted in fund use**
  - No incentives to individual workers, only facility strengthening
- **Preliminary analysis suggests some gains from enhanced financing**
  - Large gain in in-facility delivery rate as well as gains in client satisfaction, some ANC process measures, and FP outreach
  - No change in other coverage indicators – vaccination, any ANC
  - Cost effectiveness analysis to compare the two financing modes is underway

# Key Learnings from Experience

## Data is vital and could be better mined

## Keep quality measures dynamic
Continuous Quality Improvement (CQI)

## Match demand and supply
(Nigeria LGAs Barriers: Transportation Challenges, variable & unpredictable fees for Services and Drugs, Social and cultural Barriers)

## Results measurement and verification itself bring changes

## Strong implementation support is important

## Complex interplay of issues
(autonomy, supervision, accountability)