Research Article

From Scheme to System (Part 1): Notes on Conceptual and Methodological Innovations in the Multicountry Research Program on Scaling Up Results-Based Financing in Health Systems

Bruno Meessen1,*, Zubin Cyrus Shroff2, Por Ir3, and Maryam Bigdeli4
1Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium
2Alliance for Health Policy & Systems Research, Geneva, Switzerland
3National Institute of Public Health, Phnom Penh, Cambodia
4Health System Governance, Policy and Aid Effectiveness, World Health Organization, Geneva, Switzerland

CONTENTS

Introduction
The Research Process: Hypothesis, Core Question, and Methods
Conclusion
References

Abstract—This article presents conceptual and methodological developments made in analyzing the scale up of results-based financing (RBF) as part of a multicountry research program supported by the Alliance for Health Policy and Systems Research. Following a brief overview of the research process, the article proposes a new five-dimensional conceptualization of scale-up (population coverage, service coverage, health system integration, cross-sectoral diffusion, and knowledge expansion) to capture various facets of RBF scale-up. It also presents how Walt and Gilson’s health policy triangle framework was modified to identify the enablers and barriers to scale-up in the country case studies included in this research program. The article then puts forth a four-phase model of scale-up, including phases of generation, adoption, institutionalization, and expansion, developed for the purpose of this research program. The article concludes by providing some lessons learned on the use of the methods and theoretical frameworks developed for this multicountry research program.

INTRODUCTION

Since its initial introduction in Haiti, Cambodia, and Rwanda,1 results-based financing (RBF) has gained in popularity as a strategy to improve the performance of health systems in low- and middle-income countries (LMICs). Significant differences exist among RBF projects, in terms of both design2 and implementation.3

In several countries, RBF has been initiated with the ambition to expand the scheme “to scale,” making it an integral part of the national health system.4 This suggests that RBF projects should be assessed as reforms in the making
rather than as standalone interventions. Some recent experiences indicate that moving beyond pilot projects is not straightforward, as described in the Chad country case study in this issue. National policy makers and aid agencies involved in RBF look for practical guidance. However, most assessments of RBF thus far have been limited to impact evaluation of pilot programs.

Thus, the main objective of the research program called Taking Results-Based Financing from Scheme to System was the generation of policy-relevant learning on scaling up and integrating RBF programs into national health systems, including country case studies. One particular objective was to produce knowledge useful to the many countries still in early phases of RBF policies.

The topic of the scale-up and integration of RBF is understudied. Learning from multiple cases thus required the development of analytical frameworks to allow researchers to categorize data, discern patterns from narrative experiences, and identify common lessons. After providing a brief overview of the research process of the whole program, this article discusses three core conceptual and methodological developments:

1. Defining a multidimensional approach to scale-up allowed the analysis to account for the complexity of a health reform such as RBF, something that previous scale-up frameworks had inadequately addressed.
2. Modifying Walt and Gilson’s health policy triangle framework to make it directly applicable to studying the scaling up of RBF.
3. Delineating a four-phase model of scale-up identifies beginning and end points for the key transitions that an RBF policy undergoes as it moves from pilot phase to integration into the national health system.

Key findings generated through use of these research concepts and methods are discussed in the country case studies in this special issue of *Health Systems & Reform* as well as in the following article by Shroff et al.

**THE RESEARCH PROCESS: HYPOTHESIS, CORE QUESTION, AND METHODS**

Eleven countries were selected for this research program (as described in the introductory article). From the start, the research program endorsed several key directions identified by Gilson et al., including increasing the use of theoretical concepts and analytical frameworks; making methodological choices to allow comparative analyses among countries; and adopting theoretically robust and well-structured approaches to synthesizing findings.

The operating hypothesis was that scaling up RBF entails a sequence of actions that occur in four phases (see below). This hypothesis was mainly grounded in the experience of one of the authors (BM), who has been deeply engaged in scaling up health financing interventions globally over the past 15 years. An early version of this sequential view had been previously applied by three coauthors (IP, BM, and MB) to the national scale-up of an RBF scheme focusing on reaching the poorest in Cambodia.

Each country team examined one common question: what enablers and barriers are encountered during scale-up and integration of an RBF scheme at the country level? Shroff et al. synthesize the findings of the cross-country analysis of this question. Where possible, country teams were also tasked with identifying and studying a second question specific to their national context. The articles by Kiendrebeogo et al. and Sieleunou et al. in this special issue address the country-specific research questions.

To identify enablers and barriers to proceeding through the phases of scale-up, the country teams were guided to use the elements of the Walt and Gilson health policy analysis framework: actors, context, content, and process. A common, yet adaptable, template for the case study design was reviewed and adopted during a protocol development workshop with the country research teams.

The five-dimension conceptual framework for scale-up was adopted as a guide for data collection. Data were collected through document reviews and key informant interviews. Documents included consultant reports, policy documents, and research papers; in-depth interviews of key informants were conducted using semistructured interview questionnaires. Country research teams then produced research reports addressing the two questions and demonstrating the application of conceptual and methodological developments. For each of the 11 country studies, ethical approval was obtained from national ethics review boards; the research program overall was approved by the World Health Organization’s Ethics Review Committee.

**Development 1: A Multidimensional Approach to Scale-Up: Enriching the Description of Complexity**

Our first development was a tool designed to enable enriched documentation and description of the process of scaling up. Scaling up is a complex process that had been previously defined in various ways; for Hartmann and Linn, “scaling up means expanding, adapting and sustaining successful policies, programs or projects in different places and over time to
reach a greater number of people.” ExpandNet defined scaling up health programs in particular as “deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and program development on a lasting basis.”

To assess the success of scaling up complex health reforms such as RBF, country research teams had to identify the key dimensions along which scale-up can occur. Scaling up goes beyond increasing the coverage of an innovation; it also includes making it long-lasting and integrated into policy.

RBF is essentially a payment reform with wide implications for health and public financial management systems. RBF involves significant changes in the incentives that shape the behaviors of actors involved in the delivery of health services. It also entails the involvement of new actors and distribution of new roles. Additionally, implementing RBF at scale necessitates either introducing new institutional arrangements or substantially revising existing institutional arrangements for financing and regulation, among other functions. Spillovers can trigger other systemic changes that positively influence other functions of the health system. For example, RBF can lead to more accurate reporting of routine data through investments in management information systems. Eventually, it is paramount to keep in mind that RBF is not an end in itself: it needs to be designed and implemented to be well aligned with the health system’s goals.

We identified five important dimensions of scale-up for a complex health system intervention such as RBF. Each of these dimensions added to a more complete understanding of the RBF policy under study.

1. Population coverage: Scale-up along this dimension means providing services to more people. This can be achieved in several ways: extending the intervention to new geographical areas; covering more socioeconomic groups (e.g., going from a scheme targeting the poorest 20% to a scheme covering the poorest 40%); removing demographic restrictions (e.g., age, gender); or extending the scheme to other groups (e.g., members of a specific insurance program).

2. Service coverage: Services can be scaled up by increasing the types of services covered by the scheme (e.g., shifting from covering family planning only to providing a package of reproductive health services); increasing the number of facilities; expanding the eligibility criteria in terms of affiliation (e.g., from public facilities only to including private facilities as well); or including additional levels of health facilities (e.g., adding referral hospitals to a program that previously only worked in health centers).

3. Health system integration: This dimension relates to understanding how RBF approaches introduced as pilot projects become incorporated into the routine functioning of the health system, including their incorporation into national health financing strategies or strategic plans. Country teams had flexibility to define integration in their own settings.

4. Cross-sectoral diffusion: This dimension captures changes outside the health sector triggered by RBF and related processes. At both global and country levels, the rapid development of the results-based approaches in the health sector has created momentum for results-based approaches in other sectors.

5. Expansion of knowledge: Scale-up along this dimension refers to development of new understanding; it was included because RBF approaches are relatively new, so there is wide scope for additional learning. Systematically developing new knowledge facilitates the shift from basing new policies and actions on intuition, to articulating hypotheses, and eventually to having rigorous evidence. Another aspect of expansion of knowledge relates to sharing and shifting access to knowledge to different actors. In the case of RBF, this has occurred frequently when knowledge initially held by international consultants is transferred to Ministry of Health staff or when theoretical understanding is replaced by practical experience. Mastery of RBF knowledge allows actors at all levels to revise policies, optimize program benefits, extract powerful features, and abandon any weak aspects.

Links exist among the dimensions. For instance, population coverage can be expanded by including more facilities within the scheme. Similarly, extending the RBF scheme to hospitals requires adding new types of services and indicators, which can increase the pressure for more synergies with the health information system. Finding the right fit between RBF and other mechanisms for the continuous improvement of quality of care (health system integration) requires more research (knowledge) in this area.

Each country team produced a detailed timeline of the RBF policy evolution, mapping scale-up along the five dimensions. This allowed a visualization of progress of the RBF scheme along the various dimensions, a first step to organizing the analysis at the country level. We found that each dimension was distinct enough to generate its own rich description, while contributing to more complete understanding of RBF policy scale-up.
Development 2: A Framework to Map Enabling and Hindering Factors

The second methodological development was the application of a framework to account more systematically for key enabling factors and barriers faced in bringing RBF to scale.

As mentioned previously, most previous scientific attention to RBF focused on assessing the impact of programs on health outcomes and outputs. However, the processes and factors that enabled or hindered scaling up and integration of programs into national health systems had not been thoroughly explored. This kind of understanding is, however, vitally important for policy makers and funders in charge of designing, implementing, and integrating RBF programs into national health systems.

Given this emphasis on policy processes, as well as the need for an analytical framework relevant across diverse settings, the research team decided to use Walt and Gilson’s health policy analysis framework. This framework proposes that four elements are central to analysis: actors, processes, content, and context. It does not theorize about how they interact but offers a way to organize data.

The country teams were recommended to use the framework as discussed in the following sub-sections.

Identifying the Key Actors, including How They Operate and Interact

Actors lie at the center of the Walt and Gilson policy analysis framework, as well as in literature on scaling up. Reflecting this, actors involved in the RBF scaling-up process had to receive particular attention in each county study. Policy actors include individuals, groups of individuals, organizations (including international aid agencies, private firms, and civil society organizations), state agencies and bureaus, or governments.

Our hypothesis was that successful scale-up of complex policy processes entails contributions from a series of actors, whose importance varies at different times during the development of the policy. Policy is transmitted among actors involved in different levels of the policy process through various types of transactions. Different “currencies,” such as evidence, funding, symbolic power, social recognition, or official endorsement, are used to obtain buy-in or agreement from different actors, especially those who are key for the policy to move to a more advanced status.

Policy Content: Double Attention

The actual content of the policy is the second element of the Walt and Gilson triangle; it proved of particular importance to our analysis.

On the one hand, the content—the scheme in which financing is determined by results—is the “object” undergoing scale-up. For RBF, design features and institutional arrangements include, among others, objectives; target population or beneficiaries and methods to identify them; benefit package; health service providers; contractual arrangements; incentivized outputs/indicators; management structure; commissioning/funding agencies; and monitoring and evaluation frameworks. The design of a specific RBF program influences its effectiveness, efficiency, and ability to deliver equity.

On the other hand, content is also a key factor that can either enable or impede scale-up. Arrangements that are very complex are often difficult to take to scale. Overly complex or ambitious schemes may fail and, in so doing, can discredit an entire approach. Thinking about scalability of the solution from the pilot stage has been reported as a key enabling factor for successful scale-up.

Scaling up RBF into a systemic intervention may therefore require a transformation of the content. RBF can be configured in many ways. This malleability can certainly be seen as a strength. In many countries, adaptations are done to ensure the best fit with the context, the needs, and the preferences of local actors. However, it can also be a weakness, because it creates opportunities for flawed designs. In order to mitigate the risk of flawed program design, RBF champions have compiled a set of principles underlying what they consider a good RBF scheme design.

Research teams examined various factors underlying evolution of RBF schemes: available scientific evidence utilized (at national and international levels); the influence of specific actors such as international consultants, aid partners, and ministries on policy content; the financial resources available to fund a particular design; instances of altering the policy in order to allow rapid scale-up or ensure buy-in from a key stakeholder; any larger reform vision underlying the RBF program; the need to find the right fit with concurrent policy initiatives or procedures already in place; and the expansion of the range of health problems the RBF program is assigned to tackle (e.g., introduction of indicators to address noncommunicable diseases). The Cambodian case study provides a good example of content being transformed through a long scale-up and integration process.

Context Is Critical

Gilson and Raphaely describe the importance of the political, social, and economic contexts in which a policy is contextualized, designed, implemented, and scaled up. Categorizing contextual factors can be done in various ways; in this
research program, contextual factors examined included the larger global development and health context, the national context outside the health sector, and the national health sector context. Global contextual elements included the Millennium Development Goals, Universal Health Coverage Agenda, and the special interest of key actors (including the Norwegian Government, USAID, and the World Bank) in supporting RBF programs.

At the national level, contextual factors of potential importance outside the health sector included macroeconomic, developmental, and governance conditions; the political system; and the role of aid agencies. Within the health sector, contextual factors of importance included the architecture and constraints of each building block of the health system, especially the governance and financing blocks.

**Focus on Processes**

Processes relate to actions taken or not taken by actors that affect the policy. Concerning processes, our research was carried out in two steps. First, the scale-up process was examined at the country level through the development of the case studies. A key step in the study of the policy process was the development of a timeline by each country team. It allowed elaborating the process of RBF scale-up along its five dimensions and the production for each country of a “thick” description of the scale-up process.37 For country teams, creating the detailed timeline facilitated the organization, visualization, and triangulation of information collected from key informants and document review. These data were triangulated with a description of the multidimensional evolution of RBF (the content) and mapping and relating actions taken by stakeholders in this process. From all of this, the teams built up the narrative of the case study. The analytical review then utilized the case studies for the cross-country analysis.

**Development 3: Identification of Four Phases of Scale-Up**

The country timelines and case study reports were reviewed to test whether common phases in the scale-up of an RBF scheme could be defined. We identified pivotal points and transitions at which an RBF scheme gains a more advanced policy status; these were distilled into a four-phase model of scale-up and integration (Figure 1). We also identified how these phases relate to the five dimensions of scale-up.

**Phase 1: Generation**

The first phase, generation, encompasses every aspect of moving from an idea to the establishment of one or more RBF pilot projects that demonstrate the feasibility of the idea. The end point, a measure of success at this phase, is proof of concept. At this point, implementers can say, “This (policy) works here (in this context) and we (actors) learned how to do it (process).” This first phase is associated with progress on three dimensions: knowledge, population coverage, and service coverage.

**Phase 2: Adoption**

Adoption refers to the phase in which RBF transitions from a pilot project to a program, defined as having an organizational structure endowed and mandated by the national authorities to realize the declared ambition to expand the benefits of the specific strategy (in this case, RBF) to a larger population. Yet the RBF scheme usually remains a parallel entity whose financial resources are not part of the national operating budget.

For an RBF scheme, adoption includes a unified, coherent, and identifiable set of institutional arrangements to (1) facilitate the transfer of resources to service providers and (2) verify that agreed-upon results in terms of services delivered have been achieved. Key deliverables in this phase include, among others, contracts, guidelines, job descriptions, and management tools to administer the RBF scheme. This phase, also frequently called roll-out, entails making significant progress on the two dimensions of population and service coverage.

Adoption also requires the development of a critical mass of national-level experts who are conversant with the technical aspects of RBF and commitment of financial resources. By the end of this phase there is typically a central body, agency, or task force managing a single national scheme; this

![FIGURE 1. The Four Phases of Scale-Up](image)
is particularly key when several pilot experiments have to be harmonized. Significant progress is also seen in this phase along the knowledge dimension (in terms of both the number of trained experts at the national level and in the depth of their expertise).

**Phase 3: Institutionalization**

Institutionalization occurs when RBF moves from a program to national policy; this is often enabled by national resources, including commitment from the Ministry of Finance. In the institutionalization phase, the RBF scheme becomes an integral part of the country’s health financing policy, is inscribed in national strategic documents and decrees, and has a stated objective to cover the whole country.

This phase is characterized by significant progress on the dimension of health system integration, leading to the emergence of new knowledge to handle related complex issues, such as how to adapt to public finance procedures, synergize with the health information system, interact with medicine supply chains, and harmonize with quality assurance or human resource policies. By the end of this phase, the RBF arrangement is a central part of provider payment mechanisms in the whole country and contributes in a coherent manner to the main objectives of the Ministry of Health; for example, universal health coverage.

**Phase 4: Expansion**

The fourth and final phase in our model refers to RBF’s transition to key principles that inform the design and implementation of public policy in general, including in areas and sectors beyond health. RBF can inspire further reforms in the health sector, such as spurring strategic purchasing, data for decision making, or accreditation processes. Outside the health sector, RBF principles are also considered relevant, such as paying for results and provider autonomy in other public services such as education. Lateral thinking is enabled by the expansion of national-level knowledge on RBF and the experience of integrating it within the health system. This phase marks significant progress on the cross-sectoral diffusion dimension.

The proposed four phases are not necessarily clear-cut; there is continuity and often overlap. The stories documented in the country case studies ultimately revealed similar lessons, despite individual variations.

Piloting RBF is key for finding a design effective in the local context; moving from a pilot to a full program requires focusing attention on the operational challenges raised by the roll-out of the scheme. Most countries did try to anticipate institutionalization during the generation and adoption phases but only addressed the complexity of institutionalization once RBF had been validated as a potentially strong policy. In this set of countries, we observed little expansion where the RBF idea had not acquired a strong national status in the health sector.

**Lessons on Concepts and Methods in the Research Program**

RBF is a complex health system intervention that can substantially reshape health systems in LMICs. Challenges for its scale-up are specific; they are, for instance, quite different from those that were encountered in those countries that removed user fees a decade ago. The number of countries adopting RBF creates pressure for learning fast. It is thus useful to share three broad lessons on frameworks and methods learned through the process of developing and supporting this program of research. We believe that they will be useful to those interested in studying scale-up and policy processes across multiple countries.

First, the multidimensional conceptualization of scale-up proved extremely useful to teams for categorizing their thoughts and ensuring comprehensiveness in their interview guides. However, teams struggled to measure progress along the five dimensions in precise ways. In particular, health system integration, knowledge expansion, and cross-sector diffusion are difficult to measure quantitatively. Further methodological innovations to address this gap would be welcome.

A second lesson relates to analysis of policy processes. Though the Walt and Gilson policy triangle is a useful framework for identifying and categorizing factors underlying the evolution of policies, it provides little guidance on causal analysis. Several country teams complemented this framework with political science theories or alternative frameworks to answer their specific research questions, as exemplified by the case studies in this special issue from Cameroon and Chad.

Third, the four-phase model of scale-up proved useful but still requires additional scientific validation. Such a sequential approach has also been proposed by researchers working on social innovation in high-income countries. As the number of countries adopting RBF programs grows, opportunities abound for further honing of the model. A key question for policy makers and funders is the extent to which following this sequential progression is necessary for an RBF reform to succeed, in terms of both outcomes as well as any systemic transformative spillover effects. The extent to which these four phases also apply to the scale-up of other health system interventions is also an open question.
CONCLUSION

In this article, we have presented the core concepts and methods developed for the multicountry research program Taking Results-Based Financing from Scheme to System. Examining RBF policy in the process of development required an elaboration of Walt and Gilson’s triangle framework. We have developed a conceptual understanding in which the scale-up of a health intervention is a phenomenon taking place on five dimensions. We also identified four phases in the process of moving RBF from just an idea to a health system reform. Although RBF begins as a payment reform, it ultimately has wider influences on the health and development sectors.

The case studies and the iterative conceptual and methodological reflections in this research program have enhanced our understanding of RBF development. We hope that those scaling up similar scientific and operational endeavors in health care financing will benefit from our observations.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

Zubin Cyrus Shroff is a staff members of the Alliance for Health Policy and Systems Research, WHO. Maryam Bigdeli is a former staff member of the Alliance for Health Policy and Systems Research, WHO. The authors are themselves alone responsible for the views expressed in the article, which do not necessarily represent the views, decisions, or policies of the World Health Organization.

Bruno Meessen contributed to the emergence of PBF as a global health policy, through technical assistance, research, and knowledge management. He is the lead facilitator of the PBF Community of Practice. He holds minority shares in Blue Square, a Belgian/Burundian firm developing software solutions for countries implementing PBF solutions.

ACKNOWLEDGMENTS

We express our gratitude to participants from all of the country research teams whose active engagement greatly facilitated the development of the innovations underlying this article. We also thank the reviewers for their comments, which greatly improved the article, and Michael Reich and Anya Levy Guyer for their extensive efforts in editing the revised version of the article.

FUNDING

This research was supported by the Alliance for Health Policy and Systems Research with funding from Norad.

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