Commentary

Taking Results-Based Financing from Scheme to System

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INTRODUCTION

Over the last 15 years, a growing number of low- and middle-income countries (LMICs) have adopted results-based financing (RBF) approaches for their health sectors. This special issue presents key findings from the research program “Taking Results-Based Financing from Scheme to System.” The issue includes four case studies on RBF in LMICs and three cross-cutting articles—one on reframing RBF and two on scaling RBF up from projects and schemes to its integration into national health systems.

RBF consists of purchasing mechanisms that link payments (to either producers or consumers) to process or output measures that serve as indicators of, or as proxies for, improved health outcomes. These measures may be either qualitative or quantitative.1,2 RBF schemes have been implemented as standalone pilot projects in various settings, with accompanying research mainly focused on measuring the impact of pilot interventions. The Health Results Innovation Trust Fund based at the World Bank has been a key driving force in this endeavor.3,4

Despite the potential for RBF to have sector-wide impact, relatively little attention has been paid to understanding how RBF approaches have been implemented and rolled out or to their contribution to strengthening health systems. A few noteworthy exceptions exist.7-10 This special issue seeks to help fill this gap.

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PROGRAM OF RESEARCH

To address the gap in knowledge, the Alliance for Health Policy and Systems Research, with support from the Norwegian development agency Norad and in collaboration with the World Health Organization (WHO) Department of Health Governance and Financing, conducted a multicountry research program focused on to what extent, how, and why countries have moved towards using RBF approaches in national health systems.2

A call was issued in April 2014 for researchers from LMICs to submit proposals to analyze country experiences in transitioning RBF from pilot projects and schemes to approaches integrated with the health system.2 In June 2014, 11 country research teams were selected for support under the program to investigate policy processes related to the scale-up and integration of RBF schemes: Armenia, Burundi, Cambodia, Cameroon, Chad, Kenya, Mozambique, Macedonia, Rwanda, Tanzania, and Uganda. The Institute of Tropical Medicine, Antwerp, provided technical support for the research program. Details on the research process and the findings from comparative analysis are provided in two articles in this special issue.11,12 The empirical articles in this special issue on RBF are likewise based on the research program.

EXAMINING RBF AS HEALTH SYSTEM POLICIES IN DEVELOPMENT: MAIN FINDINGS AND REFLECTIONS

The special issue begins with a commentary by Agnès Soucat and colleagues. Their article makes the case for shifting debate from a focus on whether offering financial incentives to providers works to improve the quality and efficiency of health care to one that focuses principally on how an output-based payment system such as RBF can contribute to health systems strengthening.13 The latter focus necessitates analyzing how incentive payments interact with underlying provider payment mechanisms and financial management systems; developing verification procedures and systems that are both adequate and financially sustainable; and putting in place measures to enhance provider autonomy. The authors conclude that these changes require RBF approaches to be integrated into the broader health system and financing reforms, rather than being implemented as standalone programs.

The issue then proceeds to present four empirical countries studies. Two country examples focus on specific aspects of the scale-up process. The first case study comes from Chad. Joël Arthur Kiendrébéogo and colleagues use Kingdon’s agenda-setting theory to explain why, in the face of seemingly favorable circumstances, PBF did not emerge on Chad’s national policy agenda.14 The authors consider why the PBF pilot project in Chad was never scaled up, despite funds being made available by the Chadian government. High turnover of officials within the Ministry of Health led to weak “ownership” of the PBF program at the national level. Further, the PBF reform was administratively and financially managed by the Ministry of Economics and International Cooperation, without sufficient coordination with the Ministry of Health. The reform, which was introduced by the World Bank, remained top-down and exogenous. The authors argue that PBF was unable to move from the “governmental agenda” to the “decision agenda” due to a lack of policy entrepreneurship.

The second case study, by Isidore Sieleunou and colleagues, describes the Cameroonian experience with PBF and addresses an important issue around program sustainability. The article analyzes the process through which implementation of the PBF purchasing function was successfully transferred from international nongovernmental organizations and consultancy firms to a national entity. Given the high costs of having the purchasing function carried out by international nongovernmental organizations, this transfer was vital for the long-term financial sustainability of PBF in Cameroon. Using Dolowitz and Marsh’s policy transfer framework,15 the authors found that systematic planning and necessary legal changes enabled the transfer. However, the lack of a clear division of roles and responsibilities and a short time period for implementing the transfer hindered the process.

In contrast to the first two country examples that focus on specific aspects of the scale-up process (moving from a pilot to a program and transferring the purchasing function respectively), the other two country case studies examine the scale-up process from pilot to national policy. Keovathanak Khim and colleagues examine the evolution of contracting for health in rural Cambodia between 1997 and 2015. The authors explain that the three-phase process moved slowly, characterized by much back-and-forth between the Cambodian government and development partners. The government was eager to gradually increase national technical and managerial capacity for contracting as well as to reduce financial dependence on foreign funding. The study concludes that home-grown solutions, initially regarded as technically sub-optimal and often opposed by development partners, were ultimately adopted due to the political buy-in they generated. These proved key to the long-term sustainability of the program, highlighting the centrality of local adaptation in enabling scale-up.

The final country case study, by Varduhi Petrosyan and colleagues, examines the scaling up and integration of RBF into the primary health care system in Armenia using the
Walt and Gilson health policy analysis framework. Implemented nationwide since 2011, RBF in Armenia has been associated with increased utilization of primary health care services in the country; this was the initial rationale for its introduction as a pilot project. The authors cite the confluence of a number of factors that contributed to programmatic success: a well-sequenced health reform process engaging national and international stakeholders; appropriate and timely changes in legal and regulatory frameworks; and the provision of national level funding early on, which helped to build national ownership for RBF. The article also considers potential challenges faced by the program. It concludes by discussing implications of this research for other middle-income countries, particularly the importance of combining pay-for-performance measures with underlying capitation payment systems to prevent potential cost inflation that can be brought about by performance measures paid on a fee for service basis.

The second cross-cutting article, by Zubin Cyrus Shroff and colleagues, presents the findings of this research program on the enablers and barriers to scaling up RBF, based on a comparison of the country studies. The authors apply concepts derived from the Walt and Gilson framework to each of the four phases of scale-up, identifying factors that facilitated or hindered transitions from one phase to the next. A key factor in early phases was the convergence of global, regional (in some cases), and national contexts that enabled global health financing experts to work with donor agencies establishing pilot projects (the first transition of generation: from idea to project). The development of national-level technical capacity and a national political context in favor of transparency enable the second transition (adoption: from project to program). The availability of domestic financial resources and legislative and financial arrangements to enhance facility autonomy was found to be important to move from program to national policy (the third transition from program to policy). The article concludes with comments about the importance of utilizing tailored advocacy arguments, depending on the national context and phase of scale-up, to promote the institutionalization of RBF. It also discusses the need to balance optimal technical solutions with what is politically feasible. Finally, the authors discuss the need for donors to ensure that RBF contributes to strengthening health systems by engaging effectively with national stakeholders.

CONCLUSION

The articles in this special issue offer new knowledge on implementation and scale-up of RBF in countries; further, a range of broad and widely applicable lessons are derived from the case studies and the research methods developed for the research program. For example, Kingdon’s well-established policy analysis framework on agenda-setting is used to explain policy non-emergence, as in the case study from Chad. Other articles explore less-studied policy processes, such as the transfer of purchasing function, as in the study from Cameroon. At the cross-country level, the special issue presents new conceptual frameworks, including a four-phase scale-up model, additionally testing its applicability using empirical data collected in country studies.

The research findings presented in this issue serve to reinforce the need for RBF schemes to be developed, progressively, in ways that consolidate progress toward broader health sector reform agendas aligned with the main goal of universal health coverage.

As shown in the articles in this issue and the research program on which they are based, many questions remain to be studied around RBF. Findings from the research program were presented at several international meetings, including two workshops in Africa gathering experts directly involved in implementing RBF and two international scientific conferences. A series of four country-specific and cross-national policy briefs has also been produced previously, and two webinars have been held. A key source of additional information for RBF implementers and experts is the PBF Community of Practice blog.
This research program on RBF has underscored the catalytic role of the Alliance for Health Policy and Systems Research. Ultimately, this program of work represents the Alliance at its best: it has brought to the forefront understudied research questions at the intersection of two different research areas, systems thinking and implementation research; by mobilizing and supporting research teams from 11 LMICs, the program has enlarged the community of researchers involved in the study of RBF schemes and contributed to increased participation in the global learning agenda on RBF.

Finally, the ongoing collaboration of the WHO Department of Health Governance and Financing, the country-based research teams, and the PBF Community of Practice demonstrates the Alliance’s unique role of adding value to and facilitating partnerships among a diverse group of actors and organizations. Together, this group has generated new and critical knowledge on RBF policies, and this knowledge sheds light more generally on how to strengthen health systems and improve health in moving toward universal health coverage.

DISCLAIMER

The authors are staff members of the World Health Organization and 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 or Taylor & Francis Group.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

Zubin Cyrus Shroff, Nhan Tran, and Abdul Ghaffar are 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 this 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.

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