Taking Results Based Financing from Scheme to System: Conceptual and methodological innovations and key findings of a multi-country research

Policy Brief

Results Based Financing (RBF) is increasingly implemented and scaled up in many low and middle-income countries. It is now the time to reflect on and learn from the experiences of scale up across different settings, so that we can better address the challenges and avoid pitfalls and failures of such complex processes.

Our research program aimed precisely at this. To do so, we articulated our research in two phases: (i) we developed a **conceptual and methodological approach** for the analysis of RBF scale-up processes, (ii) we built a series of empirical **case studies across 11 countries** (**Box 1**), which apply the approach and framework and (iii) we draw **policy lessons** by systematically comparing and contrasting the experience of each country. In this brief, we focus on the (i) and (iii) stages of our research program.

Box 1. Countries included in the research

- Armenia
- Burundi
- Cambodia
- Cameroon
- Chad
- Kenya
- Macedonia
- Mozambique
- Rwanda
- Tanzania
- Uganda

Conceptual and Methodological Innovations for the Multi-Country Research

A common research question

Our central research question, which was explored in each setting and across countries, focused on: What are the **enablers** and **barriers** to the scale up and integration of RBF schemes?

A shared conceptual approach

So far, most research has been based on (quantitative) impact evaluations of RBF and focused on health outcomes. In contrast, we want to move towards a more careful analysis of (qualitative) processes and a consideration of the impact of RBF, and its scale up, on the broader health system. Therefore, we adopted a conceptual approach that considers RBF interventions as ***policies in development***. This perspective allows to embrace and capture the dynamics of scale up processes, and their differences at each development stage.

A multidimensional definition of scale up

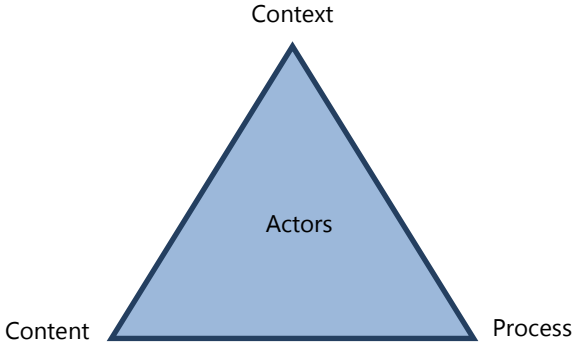
Scale up does not mean a simple increase in the geographical coverage of an intervention. In our view, it is a **multidimensional process** encompassing five dimensions:

- Population coverage: geographical coverage, age and income groups, overall population
- Service coverage: number and type of services, number, type (public, private, etc.) and level (primary, secondary, etc.) of facilities
- Health system integration: connections with other building blocks of the system, integration within the broader health system and its routine mechanisms, involvement of multiple stakeholders (e.g. multiple aid agencies)
- Cross-sectoral diffusion: changes beyond the health sector (finance system, education)
- Knowledge: evolving status in the attributes of RBF knowledge, i.e., from intuition to hypotheses and evidence; from external to internal/national knowledge; from theoretical learning to empirical experience and analytical capacity.

A tailored analytical framework

To guide our analysis, we adapted the '**policy triangle**' framework developed by Walt and Gilson (1), which looks at four key elements: process, context, content and actors, described overleaf (**Figure 1**).

Figure 1: The 'policy triangle'



A tailored analytical framework (cont.)

- **Focus on process**. Given the focus of our research, the analysis of processes was central to describing the evolution of RBF in each setting. A timeline was used by each team to map the detail of the process and provide a thick, yet clear chronological narration.
- **Centrality of actors**. Actors lie at the center of the policy triangle and are essential to drive many of the policy dynamics. Actors, as individuals, groups of individuals and organizations (state or non-state, national or international, at local or central level) were given particular attention in our analysis. In some cases, stakeholder analysis was carried out to map the actors, their position in support or against RBF and their degree of power and influence.
- **Double status of policy content**. We considered the 'content' element under two perspectives: on the one hand, it consists of the design of the RBF intervention at a particular stage in the scale up process. On the other, it is also one of the factors which can enable or impede further scale up in the future stages of the RBF development. In other words, as a systemic intervention, the content of RBF must change overtime to adapt to the evolving needs of the scale up. Our analysis aims to capture this dimension of flexibility and change as well.
- **Awareness of the context**. The analysis of the context is essential to understand why and how RBF is introduced, designed, implemented and scaled up. We look at the political, economic, social contexts at local, national and global level, both within and beyond the health sector.

Box 2. The research process in practice

- Our multi-country research started in October 2014 with a workshop focused on the development of a common research protocol, and the definition of our **conceptual and methodological approach**, and central research question.
- The country teams then developed each country-specific **research protocol and data collection tools**, and obtained ethics approval for their research
- Data collection was based on **documentary review** and **key informant interviews**. Data were collected following an iterative and cumulative process, done in parallel with data analysis and the development of the timeline, until saturation was reached and the timeline completed (**Figure 2**).

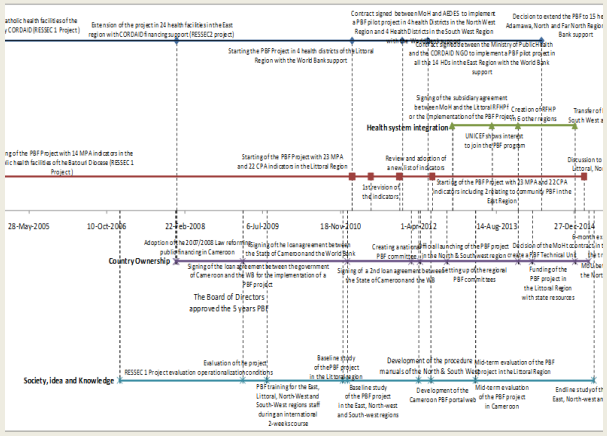
Figure 2: The iterative process of data collection and timeline development

Source: (2)

- Each country adopted specific techniques for **data analysis**, including, for example, stakeholder analysis or other tools. All country teams developed a timeline and an assessment of RBF scale up in their setting against the five dimensions identified (**Figure 3**).

Figure 3: Some of the analytical techniques adopted by country teams

Timeline of RBF evolution in Cameroon



Source: (3)

Stakeholder analysis for Armenia

Player name	Nature of the interest in MAP Expansion	Category	Position	Power
Academic/Technical experts	**Public/Professional** – addresses the public issue of professional concern	Interest group – civil society	Non-Mobilized	Low
Citizens/patients	**Beneficial** – access to basic health insurance, financial protection	Individual	Non-Mobilized	Low
Health Providers	**Financial – both harmful and beneficial** – P4P may provide additional income but may requires additional paperwork and knowledge/skills they did not possess	Interest group - Commercial	Medium Support	Low
International Development Partner – USAID	**Global/Public** – supporting the MDGs, new PHC Model, RBF schemes globally and in Armenia	Interest group - international	High Support	Medium
International Development Partner – World Bank	**Global/Public** – supporting the health reform and RBF schemes as the way improve the effectiveness of preventive/PHC services Globally and in Armenia	Interest group - international	High Support	Medium
Local Governments – marz health departments	**Political/financial** – will help to increase the revenues for the health facilities owned by them and may increase the satisfaction of their constituents	Elected/ appointed	Medium Support	High
Ministry of Finance	**Financial/both beneficial and harmful** – may increase the effectiveness of the public spending on health but will require additional public outlays	Appointed officials	Medium Support	High
Ministry of Health/State Health Agency/Primary Health Department/Maternal and Child Health Department	**Policy** – addressing the issues of low motivation and effectiveness of PHC providers and high OOPs, improving the utilization of PHC and MCH services	Appointed officials	High Support	High

Source: (4)

- A second workshop was organized in June 2015 to present the **early findings** and share lessons learned from a methodological perspective. Draft **reports** were then prepared by each team, as well as academic **articles** and comparative cross-country analyses.

What are the Enablers and Barriers of RBF Scale Up at the different stages?

In order to organize our analysis, we developed a four stage model which serves as a framing device to help categorize the country experiences by their extent of scale up (**Figure 4**). For each of the stages, we identified a series of **defining features** in terms of actors, context, content and process, which can act as **enablers** or **barriers** for the progress of RBF towards more advanced scale up stages.

Generation

Generation. From an idea to the design and implementation of a pilot project.

Context – increasing **dissatisfaction** with existing situation and current solutions (e.g. input-based approach), high-level (Presidential) involvement and political willingness to reform.

Actors – key role of **knowledge brokers** and implementing agencies to convert idea into contextualized experience (e.g., development partners, international NGOs, international and local policy entrepreneurs).

Content – influenced by implementers and funders, and their agendas (e.g., HIV focus in Mozambique vs. **Great Lakes model** applied in Chad and Cameroon).

Process – varying degrees of **involvement of Ministry of Health (MoH) and national/local institutions** depending on funders/implementers (e.g., involvement of central-level in Armenia, Cameroon, Tanzania vs. engagement at provincial level in Mozambique and district level in Uganda).

Adoption

Adoption. From a pilot to a program, with coherent institutional arrangements and increased coverage.

Context – existence of **policy frameworks and semi-autonomous institutions** (such as the Regional Funds for Health Promotion in Cameroon – policy brief "*Advanced stages of PBF scale up: lessons learned from Cameroon on the transfer of the strategic purchasing function to national agencies*") + framing of RBF as instrumental to a **broader national agenda** as for example the anti-corruption drive in Cameroon or the culture of accountability for results in Rwanda.

Actors – **national ownership**: initial policy entrepreneur(s) (often external) must be complemented by local actors. The **lack of national ownership** is often a barrier to scale up (policy brief "*Why PBF failed to emerge on the national policy agenda in Chad? The case of non-scale up of a pilot project*").

Content – RBF is **feasible** and not too cumbersome and costly + RBF is an **integral part of the health sector policy**. **Vertical approaches** to RBF (e.g. focus on HIV in Mozambique, **little involvement of MoH** in Chad) may prove a barrier to move on to the institutionalization stage.

Process – improved **coordination and alignment**, at central and local level. Earlier focus on provincial/district level actors (such as in Mozambique) can hinder further scale up. Similarly, **lack of coordination** can lead to '**pilotitis**' (i.e., multiplication of pilot projects), as for example in Cambodia.

Institutionalisation

Institutionalization. From program to national policy - RBF becomes integral part of the country's health financing policy.

Context – further development of RBF's institutional arrangements and legal frameworks, integrated within the national policies and procedures (e.g. public financing management and budgeting) + **decrease in external funding** and need to find national resources.

Actors – increasing technical and political leadership from national institutions, increased **skills and expertise** at national level.

Content – national policy covering the entire country and generation of **'spill-over' effects** concerning, for example, the health information system (HMIS) or the strategic purchasing function. At this stage, **implementation challenges**, **high costs** and **low financial sustainability** of RBF may prove important barriers to its continuation and scale up.

Process – complete ownership and management of RBF at national level + emerging **scientific agenda** and early (**positive** or **negative**) **results** on RBF impact, which can increase its support or opposition.

Expansion

Expansion. From a policy concerning provider payment to a principle informing health system reform and public policy.

Context – clear national agenda for **societal reform** or local needs to improve service delivery in other sectors, which RBF's principles are aligned to and supportive of.

Actors – high-level (ministerial and/or presidential) **political ownership** and leadership on RBF. Possible **brain-drain** of key national experts to other countries, which may diminish RBF's management capacity.

Content – iterative **adaptations and improvements** (e.g., introduction of community RBF in Rwanda) based on growing experience and evidence base. In contrast, **routine implementation** of RBF may lead to its diminishing relevance and impact, and therefore to less support.

Process – involvement of national stakeholders and, increasingly, of **political actors** rather than only technical experts.

Lessons Learned and Recommendations

Although we presented the RBF scale up in clear-cut stages, the process of expansion and integration of RBF is a **complex process** subject to many variables which are context-specific. In order to be successful, the scale up process must be **actively and attentively managed** by national and international stakeholders. The cross-country analysis and comparisons allow us to draw some lessons on how to manage these processes.

A chain of actors. The multiple actors active at each of the stages of the scale up play a key role in driving change and enabling or hindering the expansion of RBF. At the initial stages, **external actors**, such as agencies or NGOs have been essential in many contexts as funders and/or implementers to ensure that the RBF ideas evolve into pilot projects which serve as proof of concept. However, at later stages, the presence of **national policy entrepreneur(s)** who can support the introduction of RBF as a national program, well integrated within the broad health system architecture, becomes essential. The lack of national ownership and leadership, both political and technical, can prove an important barrier to the further scale up of RBF. In the final stages of scale up, higher-level political interest and involvement can ensure that RBF becomes a cornerstone in the countries' reforms.

Path dependency and thinking ahead. Each of the stages of scale up builds on the previous ones and is defined by them. Choices made at the initial stages can therefore enable or hinder the expansion of RBF years later, when those initial choices and arrangements cannot be modified anymore. For example, solely engaging at the provincial level for the introduction of RBF in Mozambique was associated with inadequate involvement of central-level agencies, which were important later on for potentially scaling this up to the national level. In Chad, the rapidity in the introduction of RBF and the lack of ownership and capacity of the MoH are some of the causes that led to RBF's discontinuation, despite the positive results and the availability of funding.

Ensuring sustainability. Long-term **financial sustainability** is essential for the scale up of RBF. It is important that governments and the MoH consider it early on in order to make national resources available to RBF, as external funding is often unpredictable and relatively short-term. However, financial sustainability is not the only aspect that needs attention. Careful reflection should be given, from the early stages, to the **institutional sustainability** of RBF, in terms of its integration within the existing arrangements and procedures of the health system and the public sector, as well as in terms of the skills and capacity of the agencies in charge of its management.

Keeping it flexible. The content of an RBF intervention must not be static as RBF is scaled up. In fact, to ensure the successful expansion, it needs to evolve and change overtime to adapt to the new situation and reflect the needs and challenges of each specific stage of scale up. **Flexibility in implementation** and the capacity to iteratively change and improve the RBF intervention can guarantee evolution and survival of RBF, as well as its effectiveness.

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