

## Results-Based Financing

### Contribution to Improving The Quality Of Care: The Case Of Burkina Faso

By: Dr. Rita ZIZIEN, Dr. Watton Rodrigue DIAO, Dr. Oumar OUATTARA

#### Introduction/Context

Burkina Faso is committed to reaching the Sustainable Development Goals (SDGs), which follow the Millennium Development Goals (MDGs). To this end, since 2000, the country has developed and implemented many initiatives. Although these initiatives generated significant results, outcomes remained below expectations. As a result, the Ministry of Health – with the support of its Technical and Financial Partners – chose to implement innovative strategies, including Results-Based Financing.

This strategy was first tested in three health districts (i.e. Boulsa, Leo, and Titao) starting in the second quarter of 2011. Following an 18 months testing period, three evaluations – one internal and two external – were conducted. These evaluations showed encouraging trends, including improvements in the quality of care. Subsequently, the project was piloted by the Ministry of Health of Burkina Faso in fifteen health districts (including the three districts in which the strategy was tested) located in six regions (i.e. Boucle du Mouhoun, Centre-east, Centre-west, Centre-north, North and South-west). This piloting benefited from World Bank financing.

The pilot RBF project was launched on 26 December 2013. RBF purchases health worker results. It pays subsidies for the quantity of services provided and provides a bonus for the quality of care, which is assessed at facility and community levels. In this context, RBF differs from traditional financing strategies whereby the Government typically provides inputs without any requirement for results and without consulting with beneficiaries. With increased resource shortages and increased discussions on the quality of care, we can ask the following question: has RBF contributed in improving the quality of care as well as the quality of health services?

**Goal:** Demonstrate how RBF contributes to improving the quality of care in health facilities implementing RBF in Burkina Faso.

#### **Objectives:**

- Describe the evolution over the past 18 months of the technical quality scores of health facilities implementing RBF;
- Identify the factors that could explain variations in technical quality scores;
- Describe the effect as well as the impact of RBF on the quality of care;
- Identify lessons learned during the implementation of RBF – over the last 18 months;
- Make recommendations to improve the quality of care in health facilities implementing RBF.

#### Hypothesis:

##### ❖ Main hypothesis:

Variations observed in improving the quality of care are linked to factors that are internal and external to health facilities implementing RBF.

##### ❖ Secondary Hypothesis:

- ✚ H1: Improvements in the quality of care are linked to the existence of health infrastructures, human resources and equipment, which comply with health facilities' norms and standards.
- ✚ H2: There are factors linked to healthcare professionals which determine improvements in the quality of care in RBF health facilities.
- ✚ H3: Improvements in the technical quality of care are manifest in health facilities benefiting from management support.

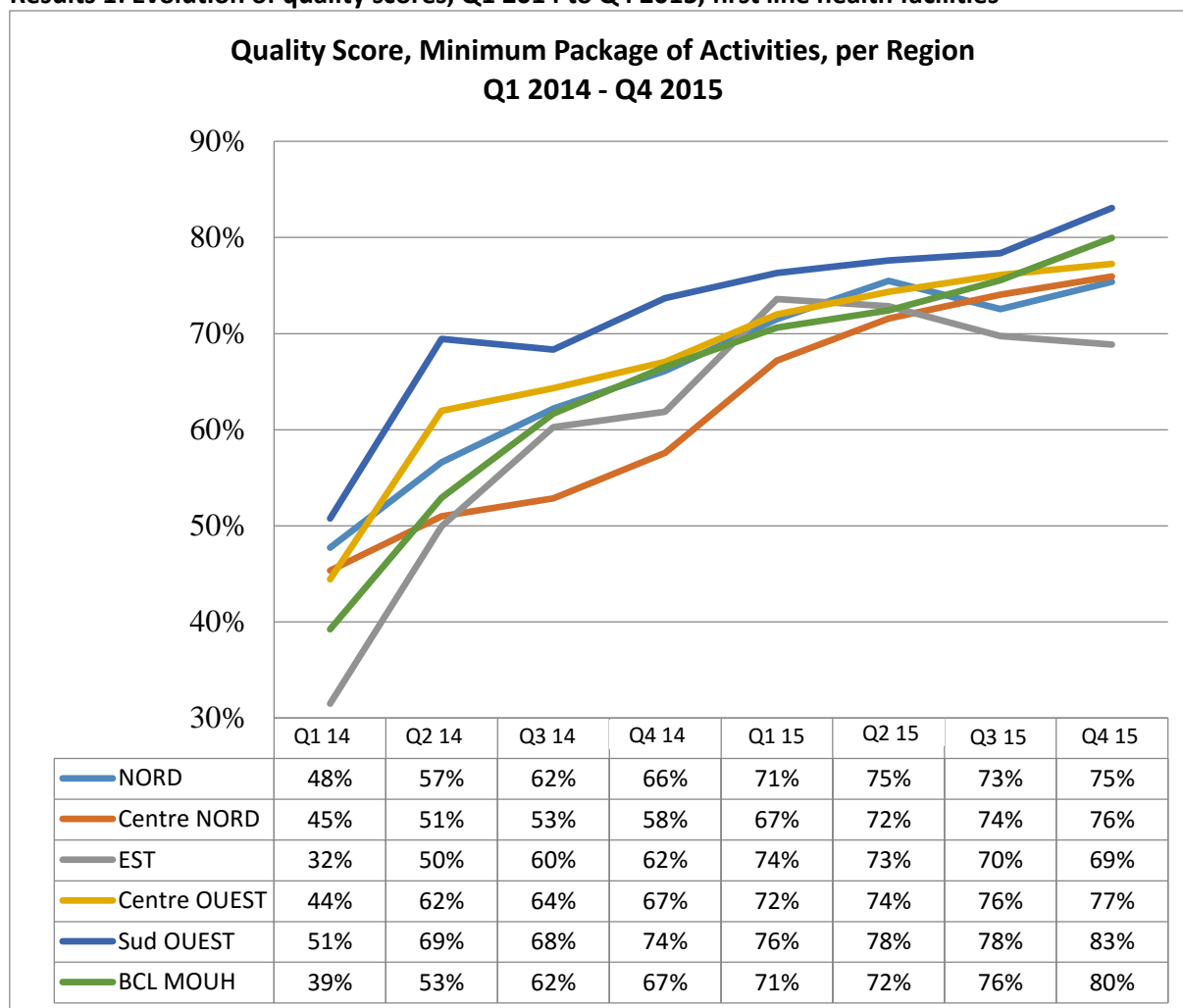
## Methodology:

A compilation and analysis of data were carried out based on the outcomes of quarterly qualitative verifications conducted in first line, second line and second level health facilities. The minimum acceptable technical quality score for a health facility is 50%. Specific verification aspects and areas selected for the verification of quality in first line, second line and second level health facilities are presented in Tables 1, 2 and 3 below.

## Results

The chart below shows how quality scores evolved between 2014 and 2015 in first line health facilities.

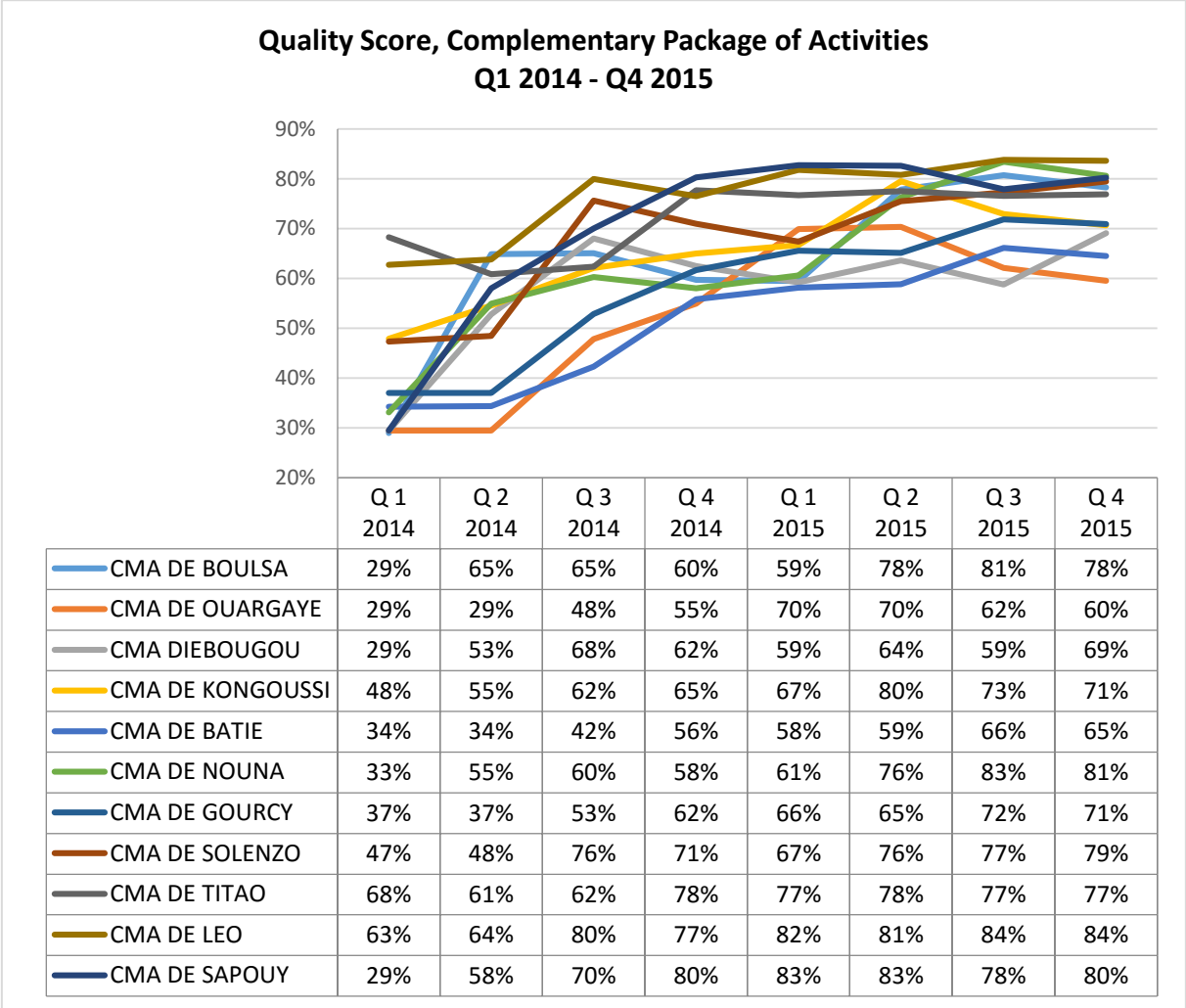
### Results 1: Evolution of quality scores, Q1 2014 to Q4 2015, first line health facilities



Quality scores have increasingly evolved during these two years of implementation. The first quarterly evaluation highlighted quality scores ranging from 32% in the Central-eastern region to 51% in the South-western region. As of the second quarter of 2014, all regions had an average quality score of 50%, and the quality scores in the Central-eastern and South-western regions had evolved to respectively reach 69% and 83%.

The chart below shows how quality scores evolved between 2014 and 2015 in second line health facilities.

**Results 2: Evolution of quality scores, Q1 2014 to Q4 2015, second line health facilities**



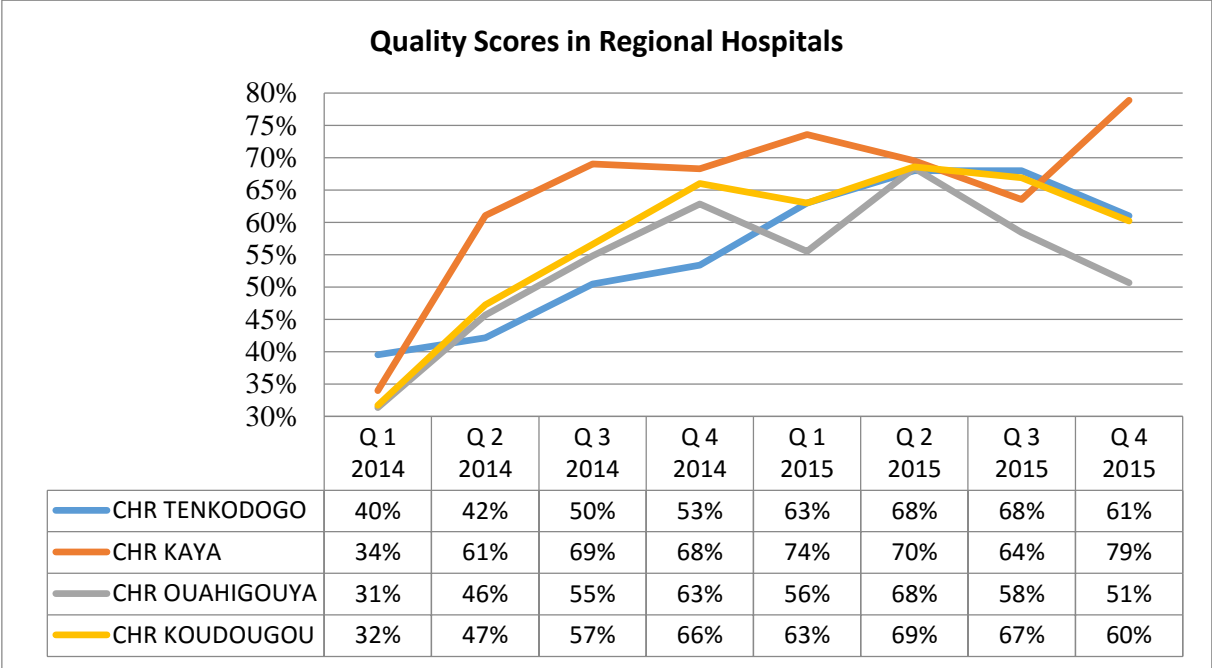
The curves follow an upward trend for all second line facilities. Between Q1 2014 and Q4 2015, second line health facilities progressed from 29% (i.e. CMAs<sup>1</sup> in Sapouy, Dédougou, Ouargaye, respectively located in the Centre-western, South-western and Centre-eastern regions) and 68% (i.e. CMAs in Titao located in the Northern region) to 60% (i.e. CMAs in Ouargaye in the Centre-eastern region) and 84% (i.e. CMAs in Leo in the Centre-western region). By the end of the first year of implementation, the quality scores of all CMAs exceeded the threshold of 50%, and they have since kept increasing.

Between Q2 2014 and Q2 2015, no improvements linked to the implementation of RBF could be observed. Nevertheless, improved quality scores could be observed in Q3 and Q4 2014 as quality checklists were changed to further stimulate health worker efforts.

<sup>1</sup> Medical Centre with Surgical Services

The chart below shows how quality scores evolved between 2014 and 2015 in second level health facilities.

**Results 3: Evolution of quality scores, Q1 2014 to Q4 2015, second level health facilities**



Quality scores have also been increasing in second level health facilities during these two years of implementation. The first qualitative evaluation generated baseline quality scores for regional hospitals, ranging from 32% in both Ouahigouya and Koudougou to 40% in Tenkodogo. As of the third quarter of 2014, all regional hospitals exceeded the threshold of 50%.

However, although regional hospitals maintained a quality score superior to 50%, the subsequent evaluation showed large variations. In general, average technical quality scores either only evolving slightly or not at all during the second and fourth quarters of 2015. On the one hand, this can be explained by the fact that health workers move to other regions – either to attend trainings or because of social problems. On the other hand, this trend also coincides with the period when performance subsidies are disbursed, which can have a demotivating effect on some health workers. In this context, some health facilities have been able to maintain their level of performance while others have experienced decreased performance.

Hypothesis potentially explaining these results:

**The question is: what explains quality of care improvements?**

Observed improvements in quality scores – potentially explained by health worker motivation, professional training and management – result from developing and implementing performance improvement plans (PAP); forecasting financial reserves using the index tool; upgrading equipment; obtaining beneficiary feedback through community surveys; from the availability of qualified health workers and medical drugs; and from a stable socio-political environment.

**1. Health Worker Motivation:**

It is extrinsic. Extrinsic motivation stems from the financial incentives provided as subsidies. Individual bonuses – which are independent of salaries – are derived from these subsidies based on criteria defined in the index tool. Individual bonuses vary: they are a function of (a) the health facility’s productivity with regard to the quantity and the quantity of services provided; and (b) the

individual health worker's performance. Extrinsic motivation also derives from the presence of verification teams, which could explain increasing trends in technical quality scores.

Motivation is also intrinsic. Improved quality of care is typically challenged by human concerns. Quality is not decided in an office: norms and protocols are not enough to impel change. RBF appears to have created a general business dynamic within which healthcare providers want to see their company grow. This dynamic could explain increased ownership, heightened respect for norms and protocols, increased health facility upgrading, and improved patient reception – all aspects contributing to improvements in the quality of care.

## **2. Qualitative evaluations**

Qualitative evaluations measure the difference between desired (i.e. as per RBF quality criteria) and obtained quality. They also assess the difference between expected quality (particularly in the context of how users are received) and perceived quality (i.e. user satisfaction). As such, qualitative evaluations highlight gaps, which health facilities endeavor to resolve by implementing a virtuous cycle of quality-related actions<sup>2</sup> - namely planning, implementation, verification, and action for improved quality of care. In Burkina Faso, the implementation of RBF could partly explain progress experienced in quality scores and the positive impact observed on the quality of care.

## **3. Some aspects which could improve the quality of care:**

During the implementation of RBF, the following effects on the quality of care were observed:

- Improvements in the way health service users are received, with the creation of a front desk, the purchase of chairs and benches, the manufacturing of curtains and the purchase of screens to ensure patient privacy.
- Improvements in the supply of health services, with the purchase of medical and technical equipment (such as oxygen bags, beds, mattresses, delivery tables, consultation tables, etc.), the availability of mosquito nets for all patients either under observation or hospitalized, and the contracting of qualified health workers to provide quality care.
- Strengthened infrastructure with the construction of warehouses for the sale of essential generic medication (MEG), the construction of houses for health workers and, in some cases, the standardization of health centers (e.g. construction of dispensaries or maternity wards).
- Strengthened logistics, with the purchase of motorcycles to carry out preventive activities.

## **Limits**

The evaluation of quality scores has been carried out on the basis of both process and outcome indicators, limiting our capacity to link high quality scores with improved quality of care.

## **Lessons learned**

The implementation of RBF in Burkina Faso highlighted the following lesson: high technical quality scores – resulting from health worker motivation, regular evaluations and the provision of subsidies – necessarily generate effects on the quality of care.

## **Conclusion**

In Burkina Faso, RBF is an innovative financing strategy. Its piloting has contributed to improving the quality of care, as shown by the constant increase in quality scores in RBF health facilities. Nevertheless, RBF implementation can face challenges, and actions must be taken to respond to these challenges and optimize the achievement of health objectives.

## ANNEXES

**Table 1: Aspects linked to the verification of quality, first line health facilities**

| <b>N°</b>    | <b>Areas</b>   | <b>Verification Aspects</b>  |
|--------------|--|--|
| 1            | General indicators                                     | General indicators   |
|              |  | Maintaining data collection tools  |
| 2            | Infrastructures – Equipment – Prevention of infections | Reception conditions for users   |
|              |  | Availability of medical and technical material   |
|              |  | Prevention of infections   |
| 3            | Drugs and perishables                                  | Management: drugs, perishables and inputs  |
|              |  | Abidance with preservation standards for perishables and implementation of activities  |
| 4            | Financial planning and management                      | Financial management   |
|              |  | Performance Improvement Plan (PAP)   |
| 5            | Home visits  |  |
| 6            | Curative visits and observation                        | Care for new patients aged 5 and more and received in CCI                              |
|              |  | Care for sick children aged 2 months to 5 years  |
|              |  | Patients placed under observation  |
| 7            | Child health   | Immunization children 0-11 months  |
|              |  | Visit with a healthy infant aged 0-11 months   |
|              |  | Visit with a healthy infant aged 12-23 months  |
| 8            | Maternal health  | Prenatal visit   |
|              |  | Postnatal visit  |
|              |  | Delivery   |
|              |  | Family planning (all methods)  |
| 9            | Malnutrition   | Care for malnourished children aged 6-59 months (MAM)                                  |
|              |  | Care for severely malnourished children aged 6-59 months (MAM) (MAS sans complication) |
| 10           | HIV/AIDS   | HIV testing  |
|              |  | Care for pregnant women who are HIV positive   |
|              |  | Monitoring of people living with HIV receiving ARVs                                    |
|              |  | PMTCT at birth for babies born from HIV positive mothers                               |
| 11           | Tuberculosis   | Tuberculosis testing   |
|              |  | Care for TB cases (treated and cured) (TPM+)   |
| <b>TOTAL</b> |  |  |

**Table 2: Aspects linked to the verification of quality, second line health facilities**

| N°                                      | Areas  | Aspects of Verification  |
|---|--|--|
| 1                                       | General Indicators                                     | General Indicators   |
|   |  | Maintaining data collection tools  |
| 2                                       | Infrastructures – Equipment – Prevention of infections | Reception conditions for users   |
|   |  | Availability of medical and technical material   |
|   |  | Prevention of infections   |
| 3                                       | Drugs and perishables                                  | Management: drugs, perishables and inputs  |
|   |  | Abidance with preservation standards for perishables and implementation of activities  |
| 4                                       | Financial planning and management                      | Financial management   |
|   |  | Performance Improvement Plan (PAP)   |
| 5                                       | Outpatient visits and counter-referrals                | Outpatient visits  |
|   |  | Counter-referrals carried out and transmitted to the center for health information and epidemiological surveillance/service for medical information (i.e. CISSE/SIM) |
| 6                                       | Child health   | Care for children aged 29 days – 59 months (according to the ETAT approach)  |
|   |  | Emergency neonatal care  |
|   |  | Qualitative evaluation of the management of cases of severe acute malnutrition with complications  |
| 7                                       | Hospitalization and surgeries                          | Hospitalization  |
|   |  | Major surgical interventions   |
| 8                                       | Maternal health  | Normal deliveries, assisted  |
|   |  | C-section  |
|   |  | Management of ectopic pregnancies  |
|   |  | Dystocic deliveries  |
|   |  | Prenatal visits  |
|   |  | Postnatal visits   |
|   |  | Post-abortion care   |
|   |  | Management of FP users (oral contraceptives, injectables, IUD, implants)   |
| Management of FP users (tubal ligation) |  |  |
| 9                                       | HIV/AIDS   | Voluntary HIV testing  |
|   |  | ARV treatment for HIV positive pregnant women  |
|   |  | Care for babies born from HIV positive mothers   |
|   |  | ARV initiation for PLWHIV  |
|   |  | Monitoring PLWHIV under ARV treatment  |
| 10                                      | Tuberculosis   | Voluntary testing TB+ cases  |
|   |  | Management of TB cases, treated and cured (TPM+)   |
| <b>TOTAL</b>                            |  |  |

**Table 3:** Aspects linked to the verification of quality, second level health facilities

| <b>N°</b>                               | <b>Areas</b>   | <b>Aspects of Verification</b>   |
|---|--|--|
| 1                                       | General Indicators                                     | General Indicators   |
|   |  | Maintaining data collection tools  |
| 2                                       | Infrastructures – Equipment – Prevention of infections | Reception conditions for users   |
|   |  | Availability of medical and technical material   |
|   |  | Prevention of infections   |
| 3                                       | Drugs and perishables                                  | Management: drugs, perishables and inputs  |
|   |  | Abidance with preservation standards for perishables and implementation of activities  |
| 4                                       | Financial planning and management                      | Financial management   |
|   |  | Performance Improvement Plan (PAP)   |
| 5                                       | Outpatient visits and counter-referrals                | Outpatient visits  |
|   |  | Counter-referrals carried out and transmitted to the center for health information and epidemiological surveillance/service for medical information (i.e. CISSE/SIM) |
| 6                                       | Child health   | Care for children aged 29 days – 59 months (according to the ETAT approach)  |
|   |  | Emergency neonatal care  |
|   |  | Qualitative evaluation of the management of cases of severe acute malnutrition with complications  |
| 7                                       | Hospitalization and surgeries                          | Hospitalization  |
|   |  | Major surgical interventions   |
| 8                                       | Maternal health  | Normal deliveries, assisted  |
|   |  | C-section  |
|   |  | Management of ectopic pregnancies  |
|   |  | Dystocic deliveries  |
|   |  | Prenatal visits  |
|   |  | Postnatal visits   |
|   |  | Post-abortion care   |
|   |  | Management of FP users (oral contraceptives, injectable, IUD, implants)  |
| Management of FP users (tubal ligation) |  |  |
| 9                                       | HIV/AIDS   | Voluntary HIV testing  |
|   |  | ARV treatment for HIV positive pregnant women  |
|   |  | Care for babies born from HIV positive mothers   |
|   |  | ARV initiation for PLWHIV  |
|   |  | Monitoring PLWHIV under ARV treatment  |
| 10                                      | Tuberculosis   | Voluntary testing TB+ cases  |
|   |  | Management of TB cases, treated and cured (TPM+)   |
| <b>TOTAL</b>                            |  |  |