POLICY BRIEF

EVOLUTION OF RESULTS-BASED FINANCING IN ZIMBABWE

BACKGROUND

Emerging from the economic meltdown of 2008, the health system was severely constrained in all its pillars. This was well reflected in the 2010-11 Demographic Health survey (DHS) which showed a sudden reversal of downward trends in key maternal and child health indicators. The maternal mortality ratio was up from 612 per 100,000 live births in the 2005 survey to 960 per 100,000 live births[1]. Key childhood indicators are summarized in table 1.

Table 1: 2010-11 ZDHS Key Childhood Mortality Indicators

Survey	Approximate Time of estimated rates	Neonatal Mortality	Infant Mortality	Child Mortality	Under 5 Mortality
1999 DHS	1994-1999	29	65	40	102
2005-06 DHS	2001-2005	24	60	24	82
2010-11 DHS	2006-2010	31	57	29	84

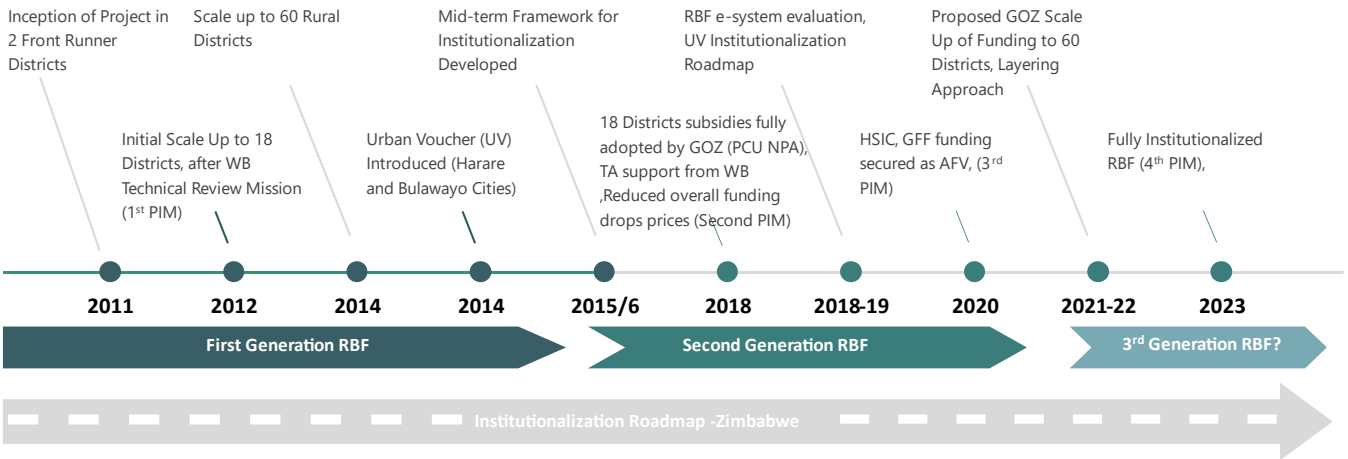
Using the results of the DHS, the ministry of health developed an investment case in 2010 to promote investment into the system. In response to this investment case, the Ministry of Health and Child Care (MOHCC) received support from the World Bank (WB) to introduce a Results Based Financing program (RBF) in Zimbabwe in 2011. Results Based Financing (RBF) is an approach focused on improving populations' access to health services, including reducing financial barriers, strengthening health services quality through

[1] ZHDS 2010-11 https://dhsprogram.com/pubs/pdf/Fr254/Fr254.pdf

improving health facility performance and management and promoting results orientation, with the potential to contribute toward improved health system performance. The initial pilot was done in 2 front runner districts and after a WB led technical review, the MOHCC and the Government of Zimbabwe (GOZ) approved the scaling up of RBF to 16 more districts with funding from the World Bank and counterpart financing from the Ministry of Finance and Economic Development (MOFED) in 2012. In 2014, with funding from the Health Development Fund (HDF), Crown Agents became the NPA (National Purchasing Agency) for the remaining 42 rural districts, while Catholic Organization for Relief and Development (CORDAID) continued to be the management and purchasing agency for the 18 districts. The GOZ continued to provide counterpart financing at an increasing rate as the WB began to scale down its funding for subsidies for the 18 rural districts. In 2015, the Medium-Term Strategic Framework was done which explored the potential sustainability of RBF in Zimbabwe and the impact it was making to the key RMNCH-N indicators and the whole health system. It included a strong recommendation for the institutionalization of RBF in Zimbabwe, specifically further adapting the governance, funding, institutional arrangements, and verification methodology to the Zimbabwe context with increased local ownership. The GOZ adopted that framework and developed a policy position of RBF institutionalization which was to inform any future design and implementation of RBF.

In this second-generation institutionalized RBF, the MOHCC Programme Coordinating Unit (PCU) became the National Purchasing Agency (NPA) acting on behalf of the GOZ. While the initial timelines changed due to slow progress, the overall milestones did not change. These are shown in the actual timeline in fig 1 below.

Figure 1: Institutionalization Timelines



First generation RBF was more focused on improved utilization of health services, while the second generation significantly focused on quality of services and institutionalization, and the third generation shall be focused on health system strengthening and domestic financing.

THE VISION: INSTITUTIONALIZATION

In 2014 an exploratory study was carried out to inform RBF institutionalization and this led to the development of the Mid-Term Framework of RBF institutionalization which was finalized and disseminated for adoption in 2016. A lot of progress was registered from 2017 and in a strategic session under the strategic purchasing part of the Mid-Term Review of the National Health Strategy (NHS) 2016-20, the MOHCC reflected that beyond 2020 the GOZ wishes to see a fully-fledged national RBF program, owned, and run by the MOHCC, and funded by GOZ with support from partners through the HDF and any other mechanisms that may come up. In this institutionalized RBF, it was envisaged that the positive features of RBF such as provider autonomy, accountability, robust monitoring, and verification shall be mainstreamed into the health system and expanded to other ministries as part of all government Results Based Management (RBM). In the interim, institutionalization would continue to be done in phases. Fig 1 above shows these phases.

EVOLUTION OF RBF GOVERNANCE: INSTITUTIONAL ARRANGEMENTS FOR SEPARATION OF FUNCTIONS

RBF in Zimbabwe has had clear separation of function spelled out in each Program Implementation Manual from the first PIM in 2013. In the present case, the stewardship and oversight role for RBF continues to be conducted by the National Steering Committee (NSC) and the Districts Steering Committees (DSC). The RBF NSC reports to the Permanent Secretary MOHCC and MOFED. Though the health system is three tiered with national, provincial, and district level governance structures, RBF has adopted a three-tiered system with a National Steering Committee, District Steering Committee, and a Health Centre Committee (HCC) from 2013 to 2020. With the dissolution of governance and establishment of provincial councils, the previously inactive Provincial Steering Committee will need to be activated. The RBF governance system is aligned to the Public Health Act and its structures such as the HCCs derive their powers form the act while the DSC is a social services subcommittee of the Rural District Coordination Committee. This alignment with the local government act and public health act has made these structures sustainable.

In the first and second generations of RBF, DSC's role has been oversight of implementation, but consensus is emerging that DSC -- being at the core of RBF -- has the potential to be a strategic purchasing hub. This committee is going to play a much stronger stewardship role in the future, when – as envisaged –the DSC in collaboration with the DHE and PHE will manage the selection and pricing of RBF indicators for health facilities at the district level. As of end 2017, the DSC was not optimally functional in some of the districts and the link with the NSC is beginning to be strengthened.

In the same vein, HCCs have been experiencing some challenges varying from attrition to conflict of interest among members. The current RBF implementation has allowed facilities to have bank subaccounts under the district cost center temporary deposit accounts (TDAs), develop their operational plans and budgets, procure commodities, and use the indices tools for paying personal incentives. They, however, operate on a semi-autonomous basis in the sense that these plans, budgets, and procurement processes are subject to approval by the DHEs and PHEs and they cannot hire and fire staff as they see fit. The capacity and

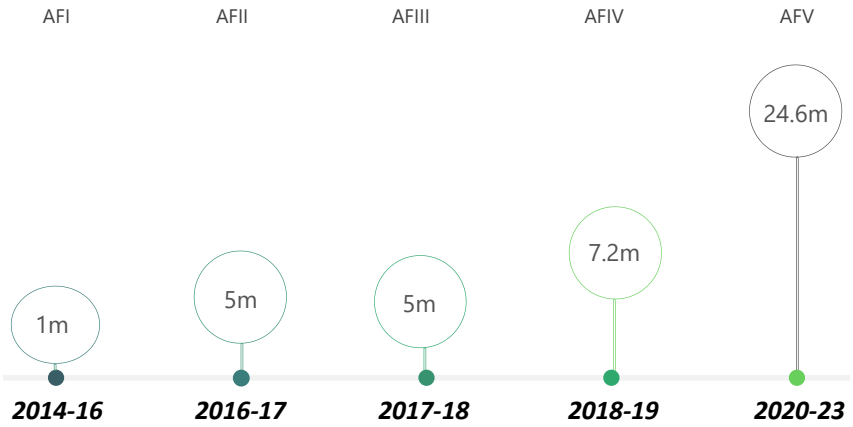
composition of HCC will require an evaluation and review to enhance their contribution to community and health facility.[2]

FUNDING AND PURCHASING ARRANGEMENTS

Funding Streams: At its inception, RBF was fully funded by the World Bank-Health Result Innovation Trust Fund (HRITF) in two (2) front runner districts. Though it was initially envisaged to be scaled up after a year, an assessment by the WB and demonstration of results with strong advocacy especially from Provincial Medical Directors led to its early adoption and scale up. At the same time, the government buy-in (due to its alignment with Results-Based Management (RBM) led to a co-financing arrangement in which the government's contribution to the subsidies increased since 2013. In 2014, the Health Transition Fund (HTF) (a multi-donor funding mechanism mostly focused on input health support) was reviewed and evolved into the Health Development Fund (HDF) whose scope shifted in focus based on the demonstrated results of RBF. RBF's successes in the 18 districts led to its adoption as the strategic purchasing pillar of the HDF, which adopted the remaining 42 rural districts. This effectively meant that all rural districts in Zimbabwe were under RBF. Cordaid which had been the National Purchasing Agency (NPA) in the 18 districts continued with Crown Agents assuming NPA role in the 42. Despite the several economic and fiscal shocks that affected the country, the government continued to provide its co-financing which progressively increased from USD 1 million in 2013 to USD 7.2 million Annual Allocation in 2019.

[2] Assessment of Functioning of Health Centre Committees District Steering Committees DHE and PHEs, 2019

Figure 2: Government Co-financing (USD) to WB Additional Financing Timelines



Inflation-Mitigation Measures to retain value: In 2018, when the local currency was re-introduced and inflation began to affect subsidies, the government began to allocate RBF funds in USD. The allocated funds would them be changed at the interbank rates at the time of disbursement to retain value. From 2018, the World Bank began to focus on providing funding only for technical support to the MOHCC in the Institutionalization of RBF to the tune of 2 million with an additional 1 million going toward the Urban Voucher project while the government assumed full financing of subsidies in the 18 districts.

Fundholding and fund flow – intergovernmental connection: RBF has now been included in the Public Finance Management system (PFM). The PCU has got a separate status within MOHCC. Its separation will be safeguarded by means of an unequivocal agreement between MOHCC and MOFED whereby the PCU will have an account into which MOFED deposits RBF funds. PFMS has been configured to allow payments into the various service delivery facilities' Temporary Deposit Accounts from Provincial Accounts. RBF funds are included in the MOHCC budget based on subsidy and program management estimates for the 18 districts under the PCU. It is now included in the blue book as a stand-alone budget line. To support and facilitate this process, both CORDAID and Crown Agents have been providing strategic capacity building of the PCU and MOHCC at national, provincial, and district level in RBF related financial processes for efficiency. This culminated in a new version of RBF Finance Management Guidelines, that were adopted as a policy document in 2019. The possibility for fund holding capacity within MOFED is going to continue to be explored given that MOFED is keen on lessons learned in RBF for application in other sectors.

Sustainable Program management: PCU-The solution within. The PCU assumed full purchasing function in 2018, initially with Cordaid assisting in implementation directly for Q1 and Q2 before it fully shifted due to technical assistance. For this to work, the PCU with the support of the WB has filled in the positions outlined in the Institutionalization Roadmap. All the five Full Time Employees (FTE) who are needed at the central PCU office and 8 staff at the regional PCU embedded within PHEs have been employed. They are seconded from CORDAID. From 2019, the MOFED adopted an austerity approach which froze creation of any additional posts. As a result, the PCU RBF staff have not yet been absorbed into the MOHCC structure,

though in the grant negotiations with the World Bank, the MOHCC indicated its preparedness to absorb them once MOFED concurs.

***Local Purchasing Function-PHEs as Regional LPAs*:** The Local Purchasing Function of the PCU has been embedded within the PHE through secondment of key personnel. This function has significantly improved PHEs ability to manage funds and the Global Fund has approved the assumption by PHEs of the role of Sub-Recipients. These further cements the strategic position of the PCU as the NPA as it harnesses resources availed through both GF and WB to further enhance RBF institutionalization.

EVOLUTION OF INDICATOR PACKAGE: ALIGNMENT TO NATIONAL STRATEGY AND PRIORITIES

In 2011, when RBF was started in Zimbabwe, its focus was informed by the 2010 Zimbabwe Demographic Health Survey (ZDHS) and the 2010-2013 National Health Strategy. It came in as a Fee for Service Conditional to Quality, with the supply side quality and client satisfaction being part of the approach. However, the supply side quality was largely infrastructural, but this evolved to increase share of process quality indicators to 65% in the quality checklist**.** Utilization of health services and uptake of long-term family planning services was at an all-time low. The package of indicators was therefore focused on utilization of health facilities and improved coverage of family planning and maternal health services. All the indicators rapidly improved, and by 2014, they had reached a plateauing phase. At the same time the MOHCC was working on the NHS 2016 to 2020, which began to prioritize quality of services as outcomes remained poor even with the improved coverage. The RBF therefore began to include clinical quality indicators. Earnings for facilities gradually began to increase, through the effect of quality was not significant in facilities that provided a high volume of services. The health facilities rapidly met quality standards, and quality indicators improved over time. At the same time, the expansion of RBF into all 60 districts presented a new challenge of limited funds due to a fixed funding envelope. The next PIM revision therefore implemented a de-linking of quality and quality (explained in section 6 below), flat-lining earnings while redistributing them across more facilities. The Global Fund began to show interest in RBF and the NSC approved an updated package of indicators in 2017 that included HIV/TB and Malaria. This also led to even more alignment with the 2015 NHS.

As the institutionalization of RBF proceeded in 2018, and more disease control programmes got involved, it became necessary to relook at the indicators and the quality and quantity split. This led to the 2019 PIM revision where the Mid Term Review of the NHS prioritization and the Health Sector Investment Case were utilized. The selection of indicators was then aligned to a life course approach as opposed to a disease focused approach. This new approach reduced the number of quantity indicators from 26 to 20. The MTR and the HSIC also informed the introduction of a quality focused RBF at tertiary and quaternal levels of care while introducing a Community RBF aligned to the recently concluded Community Health Strategy. The versatility of RBF enabled health facilities especially at primary level to continue offering services when the Covid-19

pandemic hit as they were able to procure their own PPEs. At the same time the ownership of the RBF systems made it easier to adjust the tools for quality assessments to add Covid-19 specific IPC.

THE EVOLUTION OF PROCING: EQUITY

Pricing of RBF at Inception: The pricing of RBF indicators has evolved from the inception of the project in 2011. The RBF program was designed to strengthen primary care service provision and therefore, pricing would reflect the level of care and the level of effort required to deliver a service. The available budget, number of indicators, and the relative weight of the indicators determined pricing of the indicators. Initially, pricing was based on the available budget and the forecasted outputs of the incentivized indicators. Health facility earnings were based on outputs produced without recognizing the quality of the outputs produced as they related to the long-term public health implications of increased outputs. A qualitative weighting of incentivized indicators was done based on national priorities within Maternal, Neonatal and Child Health (MNCH)- Sexual and Reproductive Health (SRH) including family planning. Outputs were projected based on historical data and prices were set to optimize the available budget. Health facilities would earn subsidies based on the number of outputs produced.

RBF Scale-Up 2014: In the next iteration of 2014, when RBF was scaled up to 60 districts, the quantity of outputs produced per indicator still determined the total amount of subsidy earned by a health facility with an adjustment made to the total amount earned by the health facility that considered the health facility's quality score from the quality checklist that was developed. An assessment of the service provided by the health facility was conducted every quarter; and a quality score attained. As this was implemented for the next two years, it was observed that there was no equity as smaller facilities with small catchment populations were earning very low amounts and yet, they need more resources.

Second PIM: De-linking of Quantity and Quality: The 2017 PIM sought to revise the pricing approach. Quantity and quality indicators were delinked to allow for quantity indicators to earn subsidies and quality to determine the other proportion of earnings. For primary care facilities, the split became 50:50 between the qualitative and quantitative indicators and 60:40 for secondary care facilities. The quality score is checked against the four quality ranges for each level of care to determine which percentage of the capped quarterly amount each of the sub-components that the facility would earn. The quality earnings caps were determined by the weighting of the quality component and the overall RBF budget. For equity purposes, facilities in remote areas with low catchment populations would also receive an equity bonus calculated according to pre-determined criteria.

Third PIM: Sustainable Pricing and Revisiting Equity: After implementing the second PIM from 2017 to 2019, another PIM revision was done. The 2016-17 pricing structure was designed around ensuring that the limited funding envelop covered every facility. One of the major observations was that, while complete delinking of quality and quantity spread earnings evenly across facilities, it had led to inequitably low earnings for high volume facilities. Therefore, another pricing approach was done which sought to ensure adequate coverage of low catchment population facilities while ensuring that the high catchment population facilities with greater need were catered for. First, indicator selection followed a life course approach which

ensures person-centered financing as opposed to disease centered. The principles of ranking indicators based on their importance in the package, identification of the anchor indicator, estimating annual coverage, as well as the consideration of the budget envelope were maintained, albeit applied using different methodologies. Four health groupings were applied, i.e., Maternal Health, Child Health, Communicable, and Non-Communicable Diseases. Secondly, a population factor was computed and added to the pricing formula Sustainable Systems and Robust Verification: Quantity and Quality.

SUSTAINABLE SYSTEMS AND ROBUST VERIFICATION: QUANTITY AND QUALITY

The RBF Management Information System: Integration for Institutionalization: The RBF processes require a robust information system to allow timely and easy verification of results for payment. From the inception of RBF until 2017, the RBF verification and quality assessments were all manual and cumbersome. In 2016 the first RBF system based on DHIS2 was developed. This was then upgraded in 2018 as part of institutionalization as the sever was moved to the MOHCC data centre. Part of the technical support staff hired included a DHIS2 programmer to improve the system for better integration with MOHCC DHIS2. The various paper passed tools were migrated to ODK and linked to DHIS2 through a form server. All these systems were developed with specifications developed by the MOHCC Health informatics and ICT departments for seamless integration. Currently the RBF management Information Systems is housed in the MOHCC data centre and there are plans to improve bandwidth for better stability and utilization.

***Results Verification – opting for a cost-effective lighter version*:** The cost of verification has been established as the cost driver that threatened the viability of RBF in Zimbabwe as a cost-effective strategic purchasing mechanism during the evaluations. These findings were similar in other countries[3]. To refine RBF, Zimbabwe undertook an approach to verification called risk-based verification, which was evaluated by the WB and found to remain effective while cutting cost by more than 50%. This was a major contributor to the government's positive attitude towards RBF as the conversations around sustainability began to take center stage. The current risk-based model will still need further evaluation in view of eliminating second level verification. Zimbabwe is aggressively rolling out Electronic Health Records, which may eventually remove the need for verification as it has been traditionally done.

Results Counter verification: Counter verification is critical for the integrity of any RBF mechanism. From inception till 2017, this function was done by the University of Zimbabwe, a private entity. As part of institutionalization, the NSC sought to have a more cost-effective entity with sufficient institutional capacity

[3] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2148-9

and independence to carry out this function. The Health Professions Authority (HPA) was identified based on its legal mandate and institutional capacity. The UZ assessed it and laid out a capacity building plan. The HPA is already mandated with the regulation of all health institutions and draws from its councils, a multi-disciplined team to do counter-verification. This was envisaged to drive lower the cost of counter-verification while maintaining its independence and robustness.

Health System wide quality assurance and improvement: Quality assurance and improvement actions are being conducted within and outside the RBF realm. The RBF quality checklist has proven to be an instrument of much value to the system and will continue to undergo revisions as different methods of assessing quality need to be explored. By end 2017, most DHEs and PHEs had fully mastered the use of the ODK quality app in supervision. However, challenges have been identified in the feedback mechanisms, seamless follow up of identified gaps, practical assessment of quality during the visits, and quality dashboards. The 2019 PIM has proposed a revision of the assessment tools for quality to further make them sensitive to change in quality of care over time.

THE EVOLUTION OF INCENTIVES STRUCTURE: SUSTAINABLE MOTIVATION

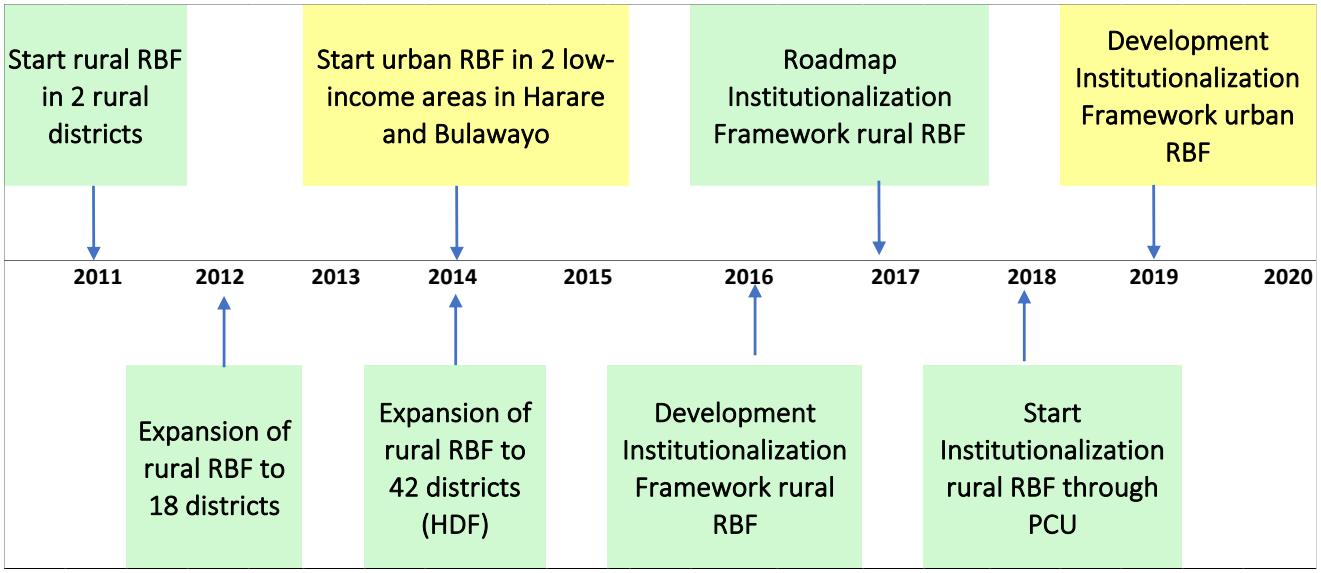
RBF in its generic design is supposed to incentivise providers to go the extra mile in achieving pre-agreed outputs. When RBF was adopted by the government of Zimbabwe, health worker salaries significantly flatlined after the economic meltdown. The government did not want to create biases in health worker earnings, so in terms of incentives, the generic RBF design autonomy was not applying to health facilities. From the initial 2 years of no incentive payments from 2013, the government started paying health workers incentives based on an incentive calculator only for 25% of the total earnings while the 75% went to the facility. The Impact evaluation[4] done in 2016, showed that health workers had multiple pathways to improved satisfaction beyond the personal earning. In 2017, these incentives were linked to quality scores. As the total funding basket reduced in 2016, the earnings continued to drop, and this became worse in 2019, when the local currency (ZWL) was re-introduced and in the 18 districts the funds were in ZWL. To mitigate the worsening inflationary pressures on the incentives, the government began to disburse the subsidies using the prevailing interbank rate while calculating them using USD.

[4] Rewarding Provider Performance to Improve Quality and Coverage of Maternal and Child Health Outcomes. Zimbabwe Results-Based Financing Pilot Program Evidence to Inform Policy and Management Decisions. June 17, 2016

A review of the retention systems done by UNDP in 2019[5], demonstrated that it was not just the incentive to individuals that was valued by the health workers but also the subsidies that went to the facilities as it made their work easier through better tooling and locally driven decisions in purchasing. Processes are underway to provide justification to The Global Fund to utilize the incentive calculation system to pay retention allowances as part of linking all health worker support to performance for sustainability in line with the government`s RBM system. At the same time, the MOHCC is exploring the possibility of a hybrid mechanism for health worker retention that incorporates the best features of both RBF and the fixed amount retention scheme

TIMELINE AND KEY MILESTONES: URBAN VOUCHER TO URBAN RBF PROGRAM

Urban RBF Timelines relative to Rural RBF



The RBF urban sub-component started in 2014 and introduced a financing mechanism that aims to protect the poor from financial catastrophe due to Maternal, Neonatal, and Child Health (MNCH) emergencies, while enhancing the revenue of health facilities and quality of services by providing incentives based on

[5] Review of the Health Worker Retention Scheme in Light of Results Based Financing in the Zimbabwe Health Sector 17 December 2019

attainment of targets for quality indicators**.** In consultation with City Health Departments, two low-income districts were selected, one in Harare and one in Bulawayo to pilot three interventions:

- An urban voucher (UV) targeted at poor households focused on MNCH services.
- A performance-based payment mechanism to strengthen the quality of services offered by the municipal health providers in the pilot districts.
- A performance-based contracting mechanism which strengthens community and 'grassroots' organization involvement in building health awareness and changing health seeking behavior, as well as in monitoring and supervision.

The Process Monitoring Evaluation of the Maternal, Neonatal, and Child Health Urban Voucher Scheme of the Zimbabwe Results Based Financing Project[6] whose results were released in February 2020, showed that Urban RBF was successful: the voucher component successfully targeted poor women reducing inequalities to health access in low-income urban settings. The pay-for-quality component succeeded in improving the quality of the services at the participating health facilities. The community component encouraged poor women to deliver their baby in a health facility, implemented client satisfaction surveys, and provided feedback to health staff.

As part of the institutionalization conversation, both the City Health Departments and the MOHCC demonstrated interest in ensuring financial sustainability of the interventions targeted to the urban poor and quality of services. In 2019**,** the GOZ requested for World Bank (WB) support to develop options for scaling-up and institutionalizing the urban RBF program. From 2019**, t**he GOZ as part of supporting Urban RBF Institutionalization Framework[7], began to contribute counterpart financing with the expectation of Cities to co-finance the urban RBF scheme.

The MOHCC has interest to develop a mandatory prepayment mechanism as aspired in the National Health Financing Policy and Strategy, such as a National Health Insurance (NHI) for which a roadmap has been developed that will soon be discussed by the Cabinet. All three urban RBF components: quality, community work, and voucher as a mechanism to channel subsidies to the poor who cannot pay the premium, would be very helpful in facilitating implementation of any financing scheme.

[6] Process Monitoring Evaluation of the Maternal, Neonatal and Child Health Urban Voucher Scheme of the Zimbabwe Results Based Financing Project, Feb 20, 2020

[7] Scale-up and institutionalization of the Urban Results Based Financing pilot in health in Harare and Bulawayo, Zimbabwe, August 2019.

OVERALL ADAPTIVE LEARNING APPROACHES TO RBF INSTITUTIONALIZATION

The RBF programme in Zimbabwe benefitted from early adoption and adaptation through engagement processes that saw senior management in MOHCC being at the forefront of its evolution. At the same time, platforms such as the National Steering Committee provided effective mechanism for the tabling of challenges and proposed adjustments with quick adoption of agreed changes. Innovations were approved for adoption by the same mechanism, and that is how Risk-Based verification was adopted and drove the cost of RBF down. Iterative change management that allowed course correction on-the-go has characterized the development of RBF in Zimbabwe. The investment of significant domestic financing made the government a key stakeholder and brought in the need for accountability to the highest level of government, including the legislature. Communities became drivers of the RBF agenda through their involvement at HCC level, hence driving change at a local level. Structural and institutional changes required to address some of the feedback however, lagged due to lack of a clear feedback loop to DHE. The latest PIM version has addressed this by putting in a requirement for each CSS result to be shared with DHE, for monitoring the changes and for addressing higher level issues. Managing processes of change and improvement across all the key elements of RBF at the same time through the leadership of the MOHCC ensured that the integrity of RBF has been maintained. It can be safely concluded that these are the key adaptive learning approaches that have taken Zimbabwe to a stage of having significant changes introduced through and into RBF being embedded and sustained in the MOHCC way of doing business.