IMPROVING HEALTH SERVICE DELIVERY THROUGH PBF

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Photo Cordaid, photographer Wilco van Dijen, 2015, Uganda

A SHOWCASE PROJECT IN KAMULI DISTRICT, UGANDA

Cordaid initiated and financed a Performance Based Financing (PBF) pilot in Kamuli District. This pilot involved a unique collaboration between the Kamuli District Health Office and the Health Office of the Catholic Diocese of Jinja. For four years (mid 2013 – mid 2017) the project contributed significantly to Universal Health Coverage (UHC) by availing essential primary and secondary care services of adequate quality to the district's population (almost 500.000 people). The project led to a significant increase in service utilization which was made possible with an investment of just over $ 1 per capita per year only.

SUSTAINABLE DEVELOPMENT GOALS

3 GOOD HEALTH AND WELL-BEING

Cordaid had supported the Health Office of Diocese of Jinja since 2009. The diocesan health units had in place a basic performance management and funding model from the Uganda Catholic Medical Bureau (UCMB) which worked fairly well. Based on the successful introduction of PBF by Cordaid in various countries the idea emerged to develop a more sophisticated PBF approach that would cover all the health units in a district, i.e. both Government facilities and so-called Private-Not-For-Profit (PNFP) facilities, i.e. church-related facilities.

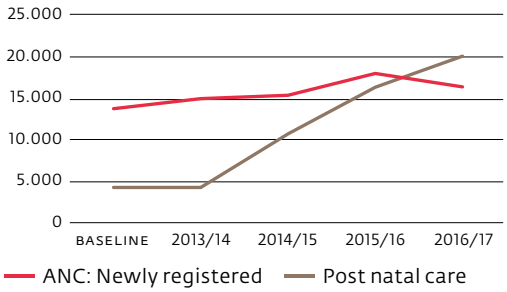
A unique collaboration between local government health authorities and a diocese then developed, in which the diocese took the lead in introducing PBF in Kamuli District.
A comparative study of all health facilities in four districts in Busoga region was undertaken which exposed poor mother and child health, a weak referral system, frequent drugs stock-out, poor planning, limited financial resources for operational expenses, low health worker capacity and motivation and low service quality. Kamuli District was selected for a PBF pilot and most public (12) and all private (2) health facilities of level 3 or higher were contracted .

It was Cordaid's ambition to prove the feasibility of PBF in Uganda and if successful to promote the approach for replication elsewhere in the country. Hence at the end of the project an independent counter-verification was done which confirmed the validity of the data presented. Most data from the counter-verification differed less than 1% from the verified/validated data by the district health team verifiers. In addition, an independent evaluation contributed to a deeper understanding of how the results were realized and what are lessons to be learnt.

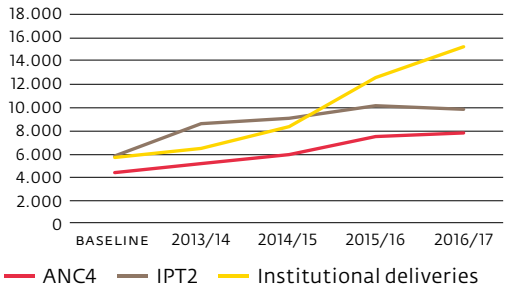
The pilot aligned with the Reproductive Maternal, Newborn Child Adolescent Health ambitions of the Ministry of Health. Moreover it befitted the decentralization policy of the Government and the Public Private Partnership in Health Policy. Cordaid was the sole funder to the project and delegated fundholding and purchasing tasks to the Diocesan Health Office. A PBF steering committee had oversight responsibilities. The district health team and the diocesan health department provided quality and quantity verification. Community Based Organizations (CBOs) were contracted for community satisfaction verification and end-user engagement. All health facilities were contracted on a three monthly basis and incentivized for verified and validated results on a monthly basis; an approved business plan guided use of earned funds. Experts from Cordaid provided regular back-stopping which led to adjustments in the project design when required.

Right from the start the increase in utilization was impressive as is highlighted by the following graphs.

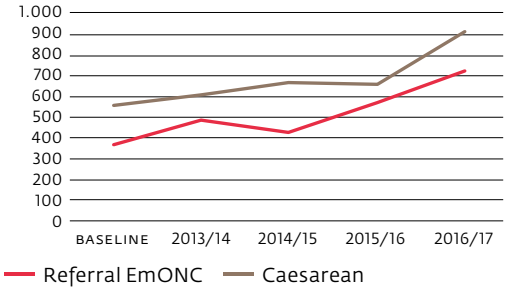
G.1 ANC first visit and PNC



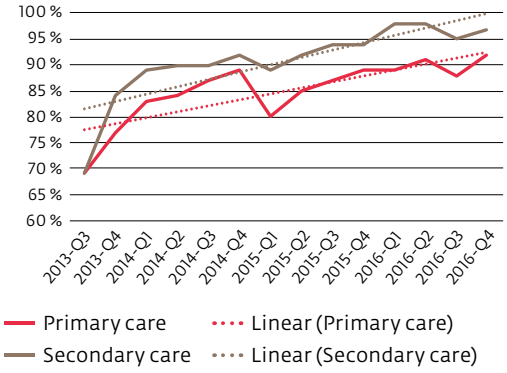
G.2 ANC4, IPT2 and Institutional deliveries



G.3 Referral EmONC and Caesarean



G.4 Quality Score Primary & secondary care, contracted PBF facilities



- Utilization of most services significantly increased over the duration of the project : +73% outpatient consultations, +135% institutional deliveries, +53% caesarean sections and +372% post-natal care so that utilization of these surpassed national norms. The use of other services nearly reached these norms.
- Quality of care, based on a three monthly assessment, increased in primary (+21%) and secondary care (+8%) as is indicated in the graph 4.
- Cordaid contributed US$ 2.120 million for PBF earnings by contracted facilities and project management, verification, etc. costs. This amounts to an average of around $ 1,10 per capita per year.

Abbreviations:

- ANC: Ante-Natal Care
- PNC: Post-Natal Care
- ANC4: fourth Ante-Natal Care visit
- IPT2: Intermittent Preventive Treatment in pregnancy second dose.
- EmONC: Emergency Obstetrical and Neonatal Care

Lessons learned

- Effective collaboration between public and private entities is an asset for increasing universal health; project management by a diocesan health department proved very functional;
- The function distribution has worked well and contributed to a high level of commitment and ownership among stakeholders involved;
- The rather stringent monitoring and verification arrangement worked well, but costs could be reduced by applying a risk-based set-up;
- Due to monthly performance-based payments, facilities regularly received cash to overcome urgent problems such as shortage of drugs;
- Quarterly quality assessment prioritized capacity development over fault finding and had a motivating effect;
- Use of CBOs elicited patient feedback, enhanced patient empowerment and health unit responsiveness;
- Health worker motivation increased rapidly, due to better working environment and provision of a performance bonus which worked as a catalyzer for leverage of effects.

The **overriding conclusion** is that the PBF pilot in Kamuli District has generated enormous momentum in a short period only, advancing universal health coverage at very low cost in both public and private health facilities.

ABOUT CORDAID

Cordaid works to end poverty and exclusion. We do this in the world's most fragile and conflict-affected areas as well as in the Netherlands. We engage local communities to rebuild trust and resilience and increase people's self-reliance. Our professionals provide humanitarian assistance and create opportunities to improve security, healthcare and education and stimulate inclusive economic growth. We are supported by 273.000 private donors in the Netherlands and by a worldwide partner network.

HEALTH UNIT GOAL

Access to quality health care services is far from being a universal reality. Especially in fragile and conflict-affected countries, where needs are urgent and health care services are lacking. Cordaid contributes to Universal Health Coverage by improving access to health for all (SDG 3.8 and 5.6): ensuring all people have access to essential quality (reproductive) health services.

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