

# SP4PHC

## Strategic Purchasing for Primary Health Care

### UGANDA REPRODUCTIVE, MATERNAL, AND CHILD HEALTH SERVICES IMPROVEMENT PROJECT: AN OVERVIEW OF THE RESULTS-BASED FINANCING COMPONENT

THINKWELL

The Strategic Purchasing for Primary Health Care (SP4PHC) project aims to improve how governments purchase primary health care services, with a focus on family planning and maternal, newborn, and child health (MNCH). The project is supported by the Bill & Melinda Gates Foundation and implemented by ThinkWell in collaboration with country governments and local research partners. SP4PHC is focused on purchasing reforms in five countries: Burkina Faso, Indonesia, Kenya, the Philippines, and Uganda.

In Uganda, SP4PHC supports the Ministry of Health and the Kampala Capital City Authority to develop and implement more coherent approaches to health purchasing, drawing from the country's experience with results-based financing and leveraging both the public and private service delivery sectors.

**With support from the World Bank, the Global Financing Facility, and the Swedish International Development Cooperation Agency, Uganda is implementing the Uganda Reproductive, Maternal, and Child Health Services Improvement Project to support efforts to scale-up essential reproductive, maternal, newborn, adolescent, and child health services. This brief provides an overview of the operational structure of the project's results-based financing component.**

#### BACKGROUND

**Uganda's Health Financing Strategy calls for the government to make the necessary resources available to deliver an essential package of health services in an efficient and equitable manner toward achieving the Sustainable Development Goals and universal health coverage.** The strategy outlines intervention areas to strengthen the three health financing functions: revenue raising, pooling, and purchasing. Results-based financing (RBF) is a key pillar of the strategy's approach to making the government's purchasing of health services more strategic, including through performance-based remuneration of health facilities and health workers "on the basis of the quality and volume of services offered" (MOH 2016a).

**Over the past two decades, Uganda has implemented several RBF programs with support from development partners.** These include supply-side mechanisms wherein health facilities earn additional revenue for achieving performance targets, which they can use to augment health

worker salaries through bonuses, spend more on operations, and invest in facility improvements. RBF programs also include demand-side mechanisms such as voucher programs that largely focus on maternal, newborn, and child health (MNCH) and family planning (FP) (MOH 2016d).

**Uganda has implemented a range of RBF programs that have yielded encouraging results.** The first program was implemented by the World Bank between 2003 and 2005. Several other programs followed, including the Jinja Catholic Diocese program from 2009 to 2015, supported by the Dutch Catholic Organization for Relief and Development Aid, a United Kingdom Department for International Development-funded program in Northern Uganda from 2011 to 2015, and the Enabling Health in Acholi project—implemented by Enabel and financed by the United States Agency for International Development (USAID)—which started in 2019. The largest RBF program to date is part of Uganda Reproductive, Maternal, and Child Health

Services Improvement Project (URMCHIP) (World Bank 2016; MOH 2016d).

**Although RBF programs have contributed to improvements in maternal and child health outcomes, there has been no uniformity in the design and implementation of the various programs.** Therefore, the government developed a National RBF Framework to guide RBF implementation in the health sector (MOH 2016b). The government also developed the National Reproductive, Maternal, New-born, Child, and Adolescent Health (RMNCAH) Sharpened Plan and Investment Case to accelerate the attainment of the Millennium Development Goals and long-term objectives to achieve equitable improvements in maternal, newborn, and child health. These lay out strategies to accelerate improvements in maternal and child health, with RBF seen as one way to promote the delivery of high-quality RMNCAH services (MOH 2013; 2016c).

### URMCHIP OVERVIEW

**URMCHIP was initiated as a five-year project in August 2016 and was initially set to run until June 2021.** Due to delays at inception, implementation of project activities did not begin until October 2018. In 2020, the project was granted an 18-month extension and is now scheduled to run until December 2022 (World Bank 2016; 2020).

**URMCHIP’s goal is to support efforts to scale-up essential reproductive, maternal, new-born, child, and adolescent health (RMNCAH) services as described in Uganda’s Sharpened Plan and Investment Case (MOH 2013; 2016c).** Specifically, URMCHIP aims to:

1. Improve the utilization of essential health services, with a focus on RMNCAH services in target districts.
2. Scale up birth and registration services.
3. Provide an immediate and effective response to an eligible crisis or emergency (World Bank 2016; 2020).

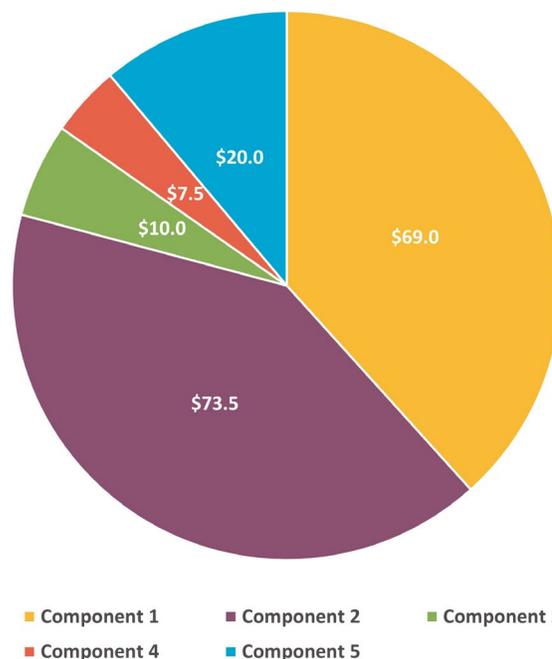
The last objective was added in 2020, when Uganda implemented activities to simultaneously prevent an Ebola outbreak and contain the spread of COVID-19 (World Bank 2020).

**Worth USD 180 million, URMCHIP is co-financed by the Government of Uganda, the World Bank, the Global Finance Facility (GFF), and SIDA.** The World Bank provides 69% of funds through a credit from the International Development Association, while 17% of the funding comes from the GFF Trust Fund grant, and the rest comes through a SIDA grant (World Bank 2020). The project was initially valued at USD 140 million, to which an additional USD 25 million and USD 15 million were added in September 2018 and November 2020, respectively

**The funding is distributed across five project components (World Bank 2016; 2020) (Figure 1):**

- Component 1.** RBF for PHC services
- Component 2.** Health systems strengthening to deliver RMNCAH services
- Component 3.** Capacity strengthening to scale up delivery of births and deaths registration services
- Component 4.** Institutional capacity enhanced to manage project-supported activities
- Component 5.** Contingent emergency response

Figure 1. URMCHIP funding by component (USD millions)



Source: World Bank (2020).

**The MOH is responsible for overall project coordination and financial management.** It also leads implementation of all activities except under

component 3, which is overseen by the National Identification and Registration Authority (NIRA) (World Bank 2016).

## RESULTS-BASED FINANCING FOR PRIMARY HEALTH CARE

**The remainder of this section documents the RBF design and operational processes under URMCHIP, which unfold within Uganda’s decentralized health financing and delivery system.**<sup>1</sup> A dedicated RBF Unit within the MOH Department of Planning, Financing, and Policy oversees implementation. The RBF Unit provides technical support and coordinates the implementation of all RBF activities in the country, not just those supported by URMCHIP. LG HMTs oversee local implementation (World Bank 2016), led by the LG health officer and supported by a designated RBF focal person within the LG HMT. Health facility in-charges oversee site-level implementation, also supported by a designated RBF focal person within the facility management team.

### Objective

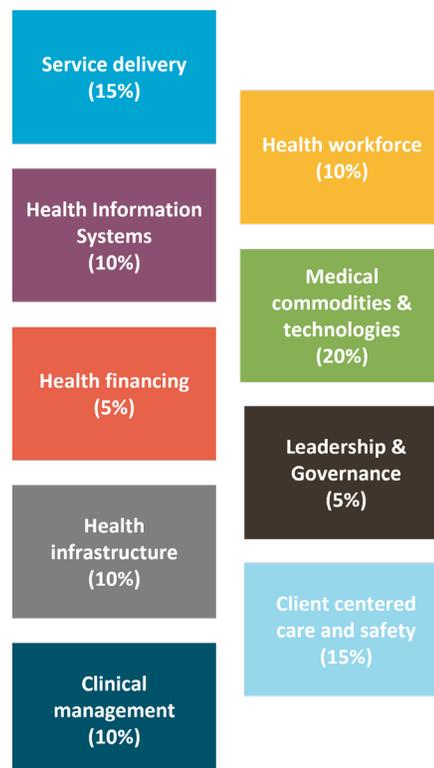
**The objective of component one of URMCHIP is to scale up and institutionalize RBF, with a focus on RMNCAH services.** Specifically, the RBF mechanism is used to incentivize public and qualifying PNFP health center (HC) IIIs, HC IVs, and hospitals<sup>2</sup> to expand the provision of high-quality and cost-effective RMNCAH services. In addition, it rewards LG HMTs for monitoring data and service quality (World Bank 2016). The design of the RBF component is based on the National RBF Framework, which is used across RBF programs in Uganda to reinforce compliance with service delivery standards and promote accountability for results in a decentralized service delivery context (MOH 2016d).

### Facility eligibility and contracting RBF payments to health facilities

**All public HC IIIs, HC IVs, and hospitals were eligible for the scheme, as were PNFPs that received PHC**

**grant funding**<sup>3</sup>(MOH 2019; World Bank 2019). To initiate the contracting of facilities, LGs were required to participate in an orientation on the implementation and financial management of the scheme held by the MOH RBF Unit. Following orientation, the MOH RBF Unit used a prequalification assessment (PQA) tool to select facilities to be contracted. The PQA tool was adapted from the MOH’s Health Facility Quality of Care Assessment Program (HFQAP) and related tools (MOH 2016b). The PQA tool measured performance across nine weighted modules to generate an overall score (Figure 2). Facilities were required to achieve a PQA score of at least 65% to be contracted under the RBF scheme. Non-qualifying facilities could request a re-assessment after six months (World Bank 2016).

Figure 2. Prequalification Assessment Models & Weighting



Source: MOH (2020)

<sup>1</sup> For a detailed analysis of decentralization, public financial management, and health financing in Uganda, see Jordanwood et al. (2022).

<sup>2</sup> Uganda has a pyramidal public health delivery network, with national and regional referral hospitals reporting to the central government and general hospitals, health centres (types II, III, and IV), and village health teams under LG jurisdiction (MOH 2016a). The government owns 45%

of all health facilities in the country, with the remainder being either private-for-profit (40%) or largely faith-based PNFP (15%) (MOH 2018).

<sup>3</sup> Most enrolled PNFPs were affiliated with one of the faith-based medical bureaus, which include the Uganda Catholic Medical Bureau, Uganda Protestant Medical Bureau, and Uganda Muslim Medical Bureau.

**Following the PQA, facilities developed individualized performance improvement plans (PIPs) to address identified performance gaps and priorities in the RBF implementation manual (MOH 2016d; World Bank 2016; MOH 2020).** Each facility's PIP was reviewed by its LG HMT and approved by the MOH RBF Unit to establish a contractual agreement between the facility and the MOH.<sup>4</sup> Implementation of the PIP was then overseen and supported by the LG HMT. Upon signing its agreement with the MOH, each facility received a start-up grant based on its PIP. On average, start-up grants were UGX 4.5 million for LG HMTs, UGX 6.0 million for HC IIIs, UGX 16.6 million for HC IVs, and UGX 75.1 million for hospitals.

**URMCHIP was key to realizing national coverage of RBF.** Orientation of LGs and contracting of facilities took place in four cohorts, referred to as phases. HC IIIs and HC IVs were contracted during phases 1 to 3, which began in October 2018, March 2019, and January 2020, respectively. Hospitals were contracted during phase 4 (hospital phase), beginning in January 2020. As of the beginning of 2022, 1,423 facilities in 131 districts and the Kampala Capital City Authority (KCCA) were participating in RBF under URMCHIP, including 1,315 HC IIIs and IVs and 108 hospitals. In the remaining four districts, 38 additional facilities were participating in a similar RBF initiative under the Enabling Health in Acholi sub-region project (EHA), funded by USAID and implemented by Enabel.<sup>5</sup>

#### **RBF Payments to LGs and Health Facilities**

**Under URMCHIP, RBF payments are additional to funds from the government's largely input-based budget allocations to LGs and facilities, including those channeled through the wage, development, and non-wage recurrent PHC grants.** LG HMTs earn RBF payments by completing workplan activities related to RBF oversight, including quarterly support supervision, facility results verification, and performance reviews. For each facility type—HC III, HC IV, and hospital—there are incentivized output indicators with corresponding tariffs (Table 1).

*Table 1. Incentivized Output Indicators and tariffs, by facility type*

Indicator	Tariff (UGX)
<b>HC III and IV</b>	
New outpatient visit for a child aged 0-59 months	1,200
First ANC visit during the first trimester (16 weeks)	1,200
Case of complete antenatal care visits (ANC 4)	4,200
Pregnant woman receiving the second dose of IPTp	1,200
Normal deliveries	30,000
Referral mother in labor	12,000
PNC visit within 6 days or 6 weeks	1,200
Uptake or continuation of modern short-term contraceptive method	2,400
Uptake or continuation of modern long-term contraceptive method	20,000
Fully immunized child under 1 year	4,200
Caesarean sections	90,000
Birth notification	1,000
Death notification	10,000
<b>Hospitals</b>	
Maternal and perinatal death reviews	500,000 <sup>6</sup>
Provision of ambulance services	2,600 <sup>7</sup>
Birth notification	1,000
Death notification	10,000

Source: MOH (2020).

<sup>4</sup> In many cases this represented the first contractual relationship between the government and facilities. For example, despite the longstanding practice of LGs subsidizing PNFPs with PHC grant funds, the relationships have not always been formalized in contracts.

<sup>5</sup> The Acholi sub-region includes Amuru, Gulu, Nwoya, and Omoro districts.

<sup>6</sup> This is a flat fee for all maternal and perinatal deaths reviewed quarterly.

<sup>7</sup> Per kilometer to and from HC referring patient to the hospital.

Additionally, payments to facilities for outputs are adjusted by a percentage increment based on quality assessment scores (Table 2). Payments are also augmented for selected facilities located in hard-to-reach areas or on islands, suffering from critical capacity gaps, or with other equity considerations.<sup>8</sup> To ensure funds would last until the project closes, MOH adopted cost-containment measures in the final year of implementation. These included reducing the tariff for long-term family methods from UGX 20,000 to UGX 10,000, raising the threshold for quality bonuses from a score of 65% to 85% on the quarterly assessment, and lowering the maximum quality bonus.

Table 2. Quality Score Ranges & Payment Adjustments

Increment to Output Based-Payment		
Quality Assessment Score	Prior to FY 2021/22	During FY 2021/22
<55	-20%	-25%
55-64.9	No increment	-20%
65-74.9	+15%	-15%
75-84.9	+20%	No increment
85-94.9	+25%	+15%
≥ 95	+30%	+20%

Source: Authors and MOH (2020).

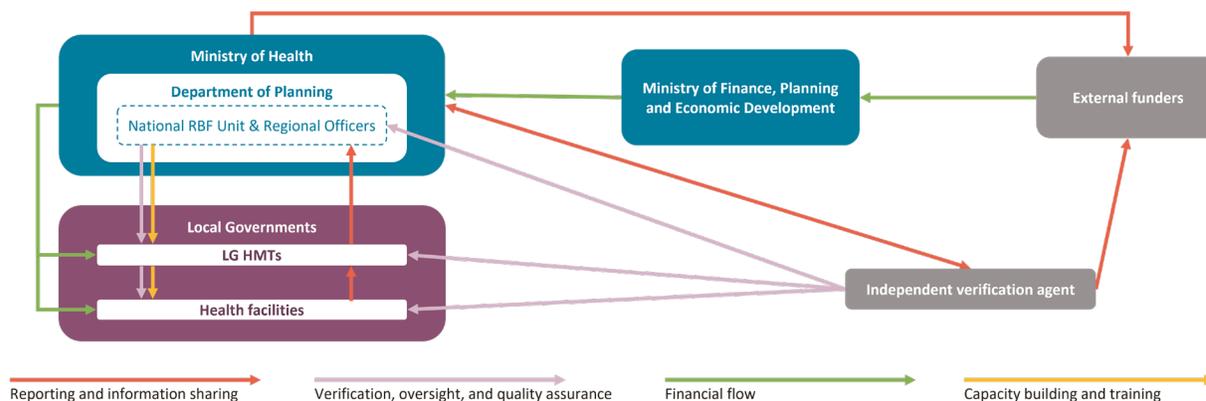
### Invoices and disbursement of funds

RBF implementation involves a cyclical process of service delivery, self-assessment and invoicing, verification, validation, and payment (Figure 3).

Each quarter, a facility submits a paper-based invoice to its LG HMT summarizing the quantities of services delivered (MOH 2016d; 2020). The LG HMT verifies facility invoices and assesses quality by applying the PQA tool (MOH 2016d; World Bank 2017). As part of verification, LG HMTs are supposed to ensure that outputs reported in facility invoices are consistent with their registers. Next, the LG HMT submits paper-based invoices with a report on facility outputs and PQA scores to the MOH RBF Unit (MOH 2019; World Bank 2019). The MOH RBF Unit digitizes the submissions and validates reported outputs against data in the Health Management Information System (HMIS) to determine the final invoice amounts. HMIS data are generated by facilities on paper forms, based on information captured in their registers, and then inputted into the District Health Information System (DHIS-2) software by either a member of the facility staff, if the facility has the needed IT infrastructure, or the LG HMT.

To promote accurate reporting, penalties are imposed when invoiced outputs differ significantly from the HMIS. Payments are denied for any indicator with a variance greater than 5%. If there are any variances greater than 30%, payment for the entire invoice is denied. LG HMTs are also

Figure 3. RBF Process Flow



Source: Authors based on World Bank (2016) and MOH (2020).

<sup>8</sup> This approach differs from how MOH accounts for equity in the allocation of other PHC funding. For example, PHC NWR grant funds are allocated to LGs and facilities in part based on formulae that include

weighted parameters for population including refugees, poverty headcount, infant mortality, and population in hard-to-reach and hard-to-stay areas (MOH 2021).

subject to penalties if they fail to detect and appropriate sanction variances during their verification of facilities' performance.

**Finally, the RBF Unit consolidates validated invoices and prepares an internal memo for approval by the Commissioner, Health Services Planning, Financing and Policy.** The memo is then submitted to the URMCHIP Project Coordinator for review and approval, supported by the URMCHIP internal auditor. Next, the URMCHIP Project Coordinator submits to the MOH Permanent Secretary (PS) for payment recommendation. Following PS approval, the URMCHIP Project Accountant uploads the payment into the Integrated Financial Management System (IFMS), where it is approved by the URMCHIP Project Coordinator, then the MOH PS, and finally the MOH Assistant Commissioner of Accounts. Payments are then disbursed to LG and health facility accounts (MOH 2019). LGs receive RBF payments in their respective sub-accounts of the treasury single account (TSA). In contrast, facility payments are transferred directly from MOH's TSA sub-account to each facility's commercial bank account, which also receives the facility's quarterly PHC NWR grant disbursement from its LG.

**Regional supervisory structures based at regional referral hospitals were envisioned to counter-verify through validation of LG HMTs invoices to trigger payments.** However, these regional structures are not yet functionalized, so the National RBF Unit, comprising headquarters-based and regional officers, undertakes verification of facility and LG HMT performance. This has created a heavy workload for the understaffed MOH RBF Unit, contributing to payment delays.

**As part of URMCHIP's mechanisms for transparency and accountability, the independent verification agent (IVA) conducts semi-annual verification of RBF activities.** The external verification exercise includes further checks of reported outputs against the HMIS and facility audits in the event of irregularities.

#### **Guidelines on the Use of Funds**

**Health facilities are supposed to use at least 60% of their income to invest in operational capacity and up to 40% on cash bonuses to motivate their staff.** Investments in operational capacity are supposed to

be guided by approved PIPs. Bonuses are supposed to be shared across all facility staff members, based on individual performance evaluations (MOH 2020).

SP4PHC is a project that ThinkWell is implementing in partnership with government agencies and local research institutions in five countries, with support from a grant from the Bill & Melinda Gates Foundation.

For more information, please visit our website at <https://thinkwell.global/projects/sp4phc/>.

For questions, please write to us at [sp4phc@thinkwell.global](mailto:sp4phc@thinkwell.global).

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