Alliance for Health Policy and Systems Research (AHPSR) and the WHO Department of Health Systems Governance and Financing

Implementation Research: Taking Results Based Financing from scheme to system

CALL FOR RESEARCH PROJECT

BACKGROUND

The Alliance for Health Policy and Systems Research (AHPSR) in collaboration with the WHO Department of Health Systems Governance and Financing (HGF) is launching a new Implementation Research programme focused on results based financing (RBF). There is significant interest in the use of strategic purchasing mechanisms such as RBF that link payments to providers or consumers to quantity or quality indicators as a means to improve the performance of health systems and help systems move towards Universal Health Coverage (UHC). A number of initiatives such as the World Bank’s Health Results Innovation Trust Fund (HRITF) are supporting the use of RBF as a means to strengthen health systems in low and middle income countries (LMICs). The use of similar measures in OECD countries is also widespread, where they have historically been framed as pay for performance (P4P) initiatives. In LMICs, these mechanisms have largely been implemented and analysed as pilot or standalone programmes with research focused on impact evaluation. Insufficient attention has been given to the details of implementation that need to be addressed if these initiatives are to be integrated and sustained within the national health system. Among these key issues are the connection between the “performance” element and underlying provider payment mechanisms, information systems streamlining, sustainable verification processes, public financial management, and many others.

This call aims to fill this gap in the shared knowledge on RBF by supporting the development of analytical case studies on RBF and similar initiatives in selected LMICs that can help answer questions on enablers and hindrances in the transition of these types of initiatives from a scheme/project to being fully integrated into the health system. The move from scheme to system is an interactive and iterative process that is influenced by policy processes, a range of actors and political economy factors. Additionally, we seek to understand not only how, but also if and when scale up is appropriate, recognizing that implementation is itself a graded phenomenon. In that regard, pilot experiences that were never scaled-up are also relevant illustrations of implementation challenges. It is hoped that these case studies will inform and facilitate decision-making with regard to the scale up and integration of existing RBF initiatives into national health systems.

Researchers experienced in the study of RBF as well as the analysis of public policy in LMICs, implementers of RBF programs and policy makers in LMICs are the main target audience for this call. The country selection will aim to maximize diversity of RBF projects in terms of geographical scale up, scale up in terms of integration into national health systems and project sustainability.
DEFINITIONS

We define **Results Based Financing (RBF)** as a purchasing mechanism that links payments (to producers or consumers) to process or output measures (which may be quantitative or quality measures or a mix of both) that can serve as indicators of, or proxies for, improved health outcomes. It typically also includes some other health system changes such as greater provider autonomy. Our definition thus includes both supply side mechanisms that have been alternatively labelled as Performance Based Financing (PBF) or Pay for Performance (P4P), as well as mechanisms such as Conditional Cash Transfers (CCTs) or other mechanisms that seek to alter the demand for health services, by providing consumers with tangible benefits (cash, food) in return for performing specific actions (immunization, making ANC visits). We seek to learn from a variety of projects, including those supported by the World Bank’s HRITF initiative, but also from projects supported by other funders as well as national projects that use strategic purchasing mechanisms as a means to strengthen health systems in LMICs and that fit the generic description provided here.

We understand **Implementation Research** as the scientific study of the effective delivery of health interventions in diverse settings and within the existing range of health systems. Implementation research goes beyond understanding what is and is not working, to explain also how and why implementation is going right or wrong in that particular setting. There are a number of reasons why an intervention that is successful in one setting, may fail to achieve the desired objective in another, influenced as it is by questions of acceptability, feasibility, perceived appropriateness as well as fidelity to the original design. Implementation research can be used to explain for example, why RBF was adopted or not in a particular setting, why a particular mixture of payment methods came into being, how political bargaining influenced what was covered, why scale up failed or did occur and why provider autonomy did not yield optimal benefits.

Finally, for the purposes of this call, we adopt a definition of programme scale up along three dimensions, namely:

a) **coverage** including geographical coverage, population coverage (absolute numbers or percentages), services covered and whether the private sector is included or not,

b) **system integration**, for example whether the purchasing function has been transferred to a national institution, the RBF project’s relationship with other health system reforms, financial management or budgetary reforms,

c) **sustainability** for example, in terms of ownership, the development of verification mechanisms that balance accuracy with sustainability, and whether RBF has been made a part of national policy.
RESEARCH QUESTIONS

The case study questions proposed must contribute towards the overarching question that this call seeks to answer, namely:

What are the dynamics (actors and factors) that enable or hinder RBF scale-up decisions and/or implementation?

Specific questions that could be addressed include:

1. What was the motivation behind the decision to scale up? Who were the drivers, actors and what were the processes followed?

A successful pilot is often only one of the considerations that decision-makers take into account when deciding to scale up a program, political economy considerations may be equally if not more important. Case studies could examine factors such as: a) the role of donors; global, regional and national stakeholders and the national government in driving scale-up and why they took the positions that they did, what was their understanding and why were they ready to embrace RBF, b) identification of policy-entrepreneurs and how they exploited the window of opportunity to bring the scale-up of RBF on to the national agenda, c) the process behind the scale up decision, whether it was closed and confined to a few key actors or open and broad based, and how this affected policy adoption and design, d) the type and strength of evidence and information exchange that informed and supported the scaling-up (e.g. publications, major events, communities of practice) and e) elements that were changed / adjusted in the design of RBF program as it transitioned from a separate scheme to system integration and why were these adaptations made.

2. To what extent is the scale up of the RBF program being achieved? What are the factors explaining this? What are the key health system and wider government reforms that should be considered?

As explained above, for the purpose of this call, scale up is broadly defined and includes scale up in terms of coverage, integration of the RBF program into the health system as well as sustainability of the RBF program. We seek to learn from countries with RBF programs at various stages of scale up along each of the three dimensions, about enablers and hindrances to the scale up process in their case. These include factors such as: a) political economy considerations, including program ownership, stakeholder engagement and the role of individuals and agencies in facilitating or hampering scale up, b) institutional considerations such as the design of public financial management systems, institutional mechanisms, broader institutional environment, enabling facility and provider autonomy, as well as integration of RBF into underlying payment mechanisms and into national health care financing strategies, c) capacity to implement RBF
including the role of health information systems, local capacity for strategic purchasing, effective supply and delivery chains, and the ability to detect and punish fraudulent reporting and d) the role of local and international evidence, as well as knowledge management strategies that supported documentation and learning from pilots.

3. **Which strategies and processes have been effective in sustaining the scale up and integration of RBF?**

There is much that can be learnt from national experience about specific strategies and processes that were implemented to enable scale-up. Examples of these strategies would include: a) political strategies such as the types of negotiation and bargaining that were used to overcome opposition (if any) to the scale up process, b) strategies to implement public financial management reform and the provision of autonomy to health facilities as well as the management of the reform process, these include both technical aspects such as reform design that made them amenable to Ministries of Finance for example, as well as political strategies such as how the reform was framed and sold to win over stakeholders and engage with or overcome entrenched interest groups, c) strategies that were used to develop local capacity for strategic purchasing, strengthen health information systems and improve data monitoring and fraud detection, including the provision of training in these skills as well as the establishment of partnerships to develop capacity in these areas, d) extent by which original pilots schemes were redesigned to fit a larger scale format. It would also be important to learn from strategies that failed to meet their objectives and understand why this was the case in that setting.

4. **What were the expected, unexpected, positive, and negative consequences of RBF on and beyond the health system, including for example fiscal and governance implications that had to be taken into account during scaling-up?**

The consequences of RBF on and beyond the health system have been widely debated. Proponents argue that RBF schemes increase accountability to stakeholders, enhance provider productivity, improve coverage rates of health services, and spur larger public financial system reform. On the other hand, critics allege, that these schemes are expensive both in terms of providing incentives, as well as verification and information systems, that they undermine provider motivation and that they lead to prioritization of services based on reimbursement rates. In addition to an empirically grounded description of the consequences of RBF on the health system in a particular setting, case studies should seek to explain the mechanisms through which RBF has led to the observed consequences in that setting. For example, an assertion that RBF programs have undermined provider motivation could be supported by data from in-depth interviews of providers explaining how it has undermined their motivation. It is important therefore to understand whether and how the expected and unexpected
consequences of RBF initial schemes on and beyond the health system have been taken into account during the scaling up process.

There exist a number of analytical case studies that examine the interactions between RBF programs and national health systems, and that can serve as examples for the kind of outputs expected under this call. These include work by Soeters et al (2006) that looks at factors enabling the success of the RBF program in Rwanda, by Bertone and Meessen (2012) examining the links between institutional arrangements and health systems performance based on an analysis of two RBF schemes in Burundi, and by Jacobs et al (2009) analyzing the role of performance based financing in the successful transition of a high service delivery level program from NGO to public management in Cambodia. Ir et al (2010) is a good example of the analysis of the policy process and the use of locally generated evidence to support decision making for the establishment of an RBF program based on the experience of Cambodia’s Health Equity Fund. Finally, work by Sengooba et al (2012) and Fox et al (2014) both analyze reasons for the failure or sub-optimal performance of RBF programs in Uganda and the DRC respectively. This list of case studies is illustrative, but by no means exhaustive or indicative of the kinds of questions that applicants are expected to address under this call.

References


THIS CALL

The Alliance for Health Policy and Systems Research (AHPSR), in collaboration with the WHO Department of Health Systems Governance and Financing (HGF), is soliciting expressions of interest for analytical case studies on RBF initiatives in selected LMICs to be part of a multi-site implementation research study on the scale up of RBF and similar initiatives. Specifically, these case studies will seek to understand the enablers, barriers, as well as contextual factors that influenced the scale up of these initiatives from schemes to systems.

Grants for carrying out case studies of 12 months will be of up to US$ 75,000 depending on the context in which the study is taking place.

1. ELIGIBILITY CRITERIA

- The Principal Investigator must be a researcher, policymaker or implementer from a Low or Middle Income Country¹, directly or indirectly associated with an RBF program/project or experienced in carrying out policy analysis or research about RBF. Individuals associated with RBF projects that failed to scale up are also welcome to apply as there is substantial learning to be obtained from such projects.
- Implementers, particularly if they are not trained in research methods, are encouraged to submit their application in collaboration with researchers from an academic institution or research institute. The roles in the team and the distribution of the work should be clearly explained.
- Additionally the team should display the required technical expertise relevant for the proposed case study (e.g. policy analysis, health system analysis, qualitative research methods.).
- A balanced gender composition, ensuring participation of women in the research team is encouraged.
- Individuals from high-income countries are not eligible to apply as principle investigators. Collaborations between organizations based in LMICs and individuals and organizations in high-income countries are acceptable on the condition that not more than 15% of the total grant value can go to individuals or organizations based in high-income countries. Applications from UN agencies including WHO will not be considered and though UN country or regional offices can be listed as collaborators they will not be entitled to receive any funding from the research grant.

¹ [http://data.worldbank.org/about/country-classifications/country-and-lending-groups](http://data.worldbank.org/about/country-classifications/country-and-lending-groups)
2. INSTRUCTIONS FOR APPLICANTS

2.1. Format and content of the expression of interest

- All submissions must be made online through the Implementation Research Platform proposal submission site at http://www.implementationresearchplatform.org/call-for-proposals/.
- Hard copies and emails of submissions will NOT be accepted.
- All submissions must be written in English.

- This expression of interest should be maximum 3,000 words and should:
  1. Describe the specific case proposed for study and explain how it fits into one or several of the overarching research questions of this call.
  2. Provide a brief description of the RBF project in the setting proposed including stage of implementation/ scale up, population and geographical area covered, services covered, nature of purchasing agent, RBF’s integration with other payment mechanisms and RBF’s incorporation into national policy. Applicants are also encouraged to consider RBF projects that failed to scale-up, in view of sharing lessons from these experiences. The research process should describe how policy makers and stewards of RBF schemes are invited to self-reflect on the achievements, strengths and weaknesses of the RBF scheme and its scaling-up.
  3. Clearly spell out the approach proposed to gather and / or access information / data on the RBF project. Describe quality assurance mechanisms for ensuring validity of information collected.
  4. Provide details of the research team including the position and qualifications of the Principal Investigator and other team members as well as their role in the RBF project under study and/or research experience in RBF. The description of the team should also give an indication of the team’s capacity for applying policy analysis, health system and implementation research methods and mixed methods approaches. Finally, the research team should demonstrate that they are able to successfully connect and dialogue with policy makers and other stakeholders involved in RBF in their study context.
  5. Provide an estimate and itemized budget summary.

2.2. Closing date

Applicants must submit their expression of interest by 2 May 2014. This is a firm deadline. Expression of interest received after the deadline will not be accepted or considered.

WHO may, at its own discretion, extend this closing date for the submission of expressions of interest by notifying all applicants thereof in writing.

2.3. Amendments of the call

WHO may, at any time before the closing date, for any reason, whether on its own initiative or in response to a clarification requested by a (prospective) applicant, modify the call by written amendment.
Amendments could, inter alia, include modification of the project scope or requirements, the project timeline expectations and/or extension of the closing date for submission.

All prospective applicants that have submitted an expression of interest with regard to the call will be notified in writing of all amendments to the call and will, where applicable, be invited to amend their submission accordingly.

3. SELECTION OF SUCCESSFUL APPLICATIONS

3.1. Selection criteria

- Expressions of interest will be judged on:
  - The case proposed and how it fits into overarching research questions of this call
  - The RBF project and its context. The selection will aim at maximizing diversity of selected projects in terms of: a) coverage (for example population, geography, scope of services covered), b) system integration (for example, transfer of purchasing function to national institutions, RBFs relationship with underlying payment mechanisms), c) sustainability (in terms of ownership and whether RBF has been made a part of national policy).
  - Proposed approach for gathering information and collecting data on the RBF project, capacity of the team to access information and data on RBF, and to successfully connect and dialogue with policy makers and other stakeholders
  - Qualifications, experience of the team, and quality assurance mechanisms for the research
  - Value for money.

- If needed and based on the expressions of interest, applicants may be shortlisted for a telephonic interview conducted by staff from the Alliance for Health Policy and Systems Research and WHO Department of Health Financing and Governance during the week of 26th-30th May 2014. Applicants should expect to be asked to expand on issues addressed in the expressions of interest as well as their motivations to apply, and justify reasons for their being selected.
- The country selection will aim to maximize diversity of RBF projects in terms of geographical scale up, scale up in terms of integration into national health systems and project sustainability.

- Successful applicants will be notified by 15th June 2014

However, WHO reserves the right to:
- Award the contract to an applicant of its choice, even if its proposal is not the lowest;
b) Accept or reject any proposal, and to annul the solicitation process and reject all proposals at any time prior to award of contract, without thereby incurring any liability to the affected applicants and without any obligation to inform the affected applicants of the grounds for WHO’s action;
c) Award the contract on the basis of the Organization’s particular objectives to an applicant whose proposal is considered to be the most responsive to the needs of the Organization and the activity concerned;
d) Not award any contract at all

WHO has the right to eliminate proposals for technical or other reasons throughout the evaluation/selection process. WHO shall not in any way be obligated to reveal, or discuss with any applicant, how a proposal was assessed, or to provide any other information relative to the evaluation/selection process or to state the reasons for elimination to any applicant.

NOTE: WHO is acting in good faith by issuing this call. However, this document does not obligate WHO to contract for the performance of any work, nor for the supply of any products or services.

3.2. WHO’s right to enter into negotiations
WHO reserves the right to enter into negotiations with one or more applicants of its choice, including but not limited to negotiation of the terms of the proposal(s), the price quoted in such proposal(s) and/or the deletion of certain parts of the work, components or items called for under this call.

3.3. Signing of the contract
Within 30 days of receipt of the contract, the successful applicant shall sign and date the contract and return it to WHO according to the instructions provided at that time. If the applicant does not accept the contract terms without changes, then WHO has the right not to proceed with the selected applicant and instead contract with another applicant of its choice.

4. IMPLEMENTATION OF THE RESEARCH PROJECTS

4.1. Protocol development
Selected research teams will be invited to a protocol development workshop in July 2014 facilitated by health financing experts from the WHO and leading experts in the field of RBF. During the protocol development workshop, the outline of a generic protocol will be proposed to the selected team. The aim of the protocol development workshop is to:
  o Refine research questions
  o Discuss analytical frameworks and methods to guide each case study and enable analytical generalizability across the studies
  o Develop a draft protocol and research plan for each case study
Research teams should thus expect that their proposed case study may undergo significant revision at this stage.
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Based on inputs from the protocol development workshop, teams will be expected to develop the protocols by **15th September 2014**, when they will be submitted to the Ethical Review Committee of the WHO. Teams will also be expected to obtain local ethical board clearance in the study setting.

**4.2. Field research**

It is expected that projects would become operational by **October 2014**, subject to clearances and approvals. All research projects are expected to end in **October 2015**.

A coordinating center, with proven expertise in implementation research, health systems research and track record of publications on RBF or technical assistance with RBF projects will support the implementation of all research projects.

**FOCAL POINTS:**

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**TIMELINE FOR CALL**

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<td>Review of EoI</td>
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