

USING
RESULTS-BASED FUNDING
TO DRIVE

HEALTH EQUITY

POLICY PAPER

Rita Perakis, Social Finance



ACTION

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USING RESULTS-BASED FUNDING TO DRIVE HEALTH EQUITY

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SUMMARY

Important strides have been made in global health, but progress has not been evenly distributed and the poor and disadvantaged are increasingly left behind. Major gaps exist in health access and quality for disadvantaged populations, who may be disadvantaged because of their income level, gender, geographic location, or ethnicity, to name just a few factors.

While some inequalities are unavoidable, *inequity* is attributable to social determinants that are within the capacity of societies to moderate. Development funding can be allocated in ways that increase or reduce inequities, independent of overall population or country health results. As development challenges become increasingly complex and funding increasingly scarce, funders must make critical choices about global health funding allocation that affect many lives.

Results-based funding (RBF) is a relatively new approach to development funding, which involves a transfer of funds in exchange for the delivery of specified results. Development funders are exploring a range of forms of RBF as a way to improve funding efficiency and effectiveness and drive better health outcomes. When implemented well, RBF can increase the results focus, rigour, and recipient autonomy and flexibility of development programmes. Conversely, poorly conceived contracts could create incentives to work with populations or individuals who are relatively less marginalised and represent ‘quick wins’. RBF has been widely tested in global health, with overall positive results. But a question that has not been fully explored is: to what extent can RBF be a driver for equity?

While greater equity is not a given in RBF programmes, experience to date has shown that, when there has been a focus on reaching disadvantaged populations, RBF has helped to improve equity—and it has considerable potential to do so further. The first step is defining disadvantaged target populations for whom results must improve before funds are disbursed. The way that success metrics are designed (i.e.,

what outcomes funders are paying for) and the way that programmes are implemented (i.e., with enough flexibility to meet the needs of disadvantaged populations) is also critical in determining how much this new funding modality can lead to better outcomes and greater equity.

Experience has shown that offering greater incentives for reaching the hardest to reach can ensure that these populations remain the focus of a programme and that RBF creates the incentives to measure needs and results for these populations rigorously. Emerging evidence also highlights the importance of contractual flexibility—allowing programme implementers scope to adapt their interventions to variable and changing local needs—to realising the full potential of an RBF approach.

For policymakers who want to use RBF to promote equity, the following recommendations highlight features critical to programme design:

- 1. Target poor/disadvantaged populations**
- 2. Focus on outcomes**
- 3. Reward progress, not just absolute success**
- 4. Engage governments to identify priorities that fit within health plans**
- 5. Independently verify outcomes to ensure credibility**
- 6. Allow implementers flexibility to deliver interventions**

It is critical for the poor and marginalised populations of the world that equity remains a priority in global health. Greater use of well-designed and well-implemented results-based funding contracts can contribute to this goal.

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Prioritising Equity in Global Health

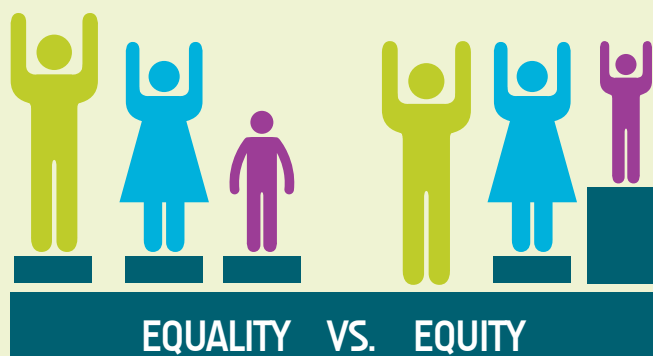
Since the start of the millennium, significant progress has been made toward health and development goals, but this progress has not been evenly distributed and the poorest and most vulnerable people are being left behind.¹ Major gaps in health access and outcomes exist both between and within countries, between the poorest and richest households, and between rural and urban areas. For instance, in developing countries, under-five mortality rates are almost twice as high for children in the poorest households as for children in the richest. Progress towards eliminating measles has stalled, with many of the infants who lack access to the effective and inexpensive vaccine coming from poor and marginalised communities. And, only 56 percent of births are attended by skilled health personnel in rural areas, compared with 87 percent in urban areas, a gap that is even wider in sub-Saharan Africa and Southern Asia.²

In response to findings like these, there is a growing focus on equity and the need to ensure that services reach the poor and vulnerable. Whereas the Millennium Development Goals for health were focused on improving overall rates of progress on a small number of narrowly defined issues,³ target 3.8 of the Sustainable Development Goals makes a broader call for 'access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all'. In addition to being a right on its own, health is a prerequisite for building human capital and inclusive economic growth.⁴ Achieving access to quality services *for all* requires a shift in focus from overall coverage to equity and a concerted effort to reach vulnerable populations.

In this context, equity is taken to mean fairness in the distribution of health services and health outcomes between more and less advantaged social groups.⁵ Inequity may exist across a range of factors including income level, geographic location, gender, age,

ethnicity, sexual orientation, and disability. Although differences in health status are inevitable across populations, the health equity agenda aims to reduce health inequalities that stem from social determinants that are within the capacity of societies to moderate. Figure 1 illustrates the difference between equality and equity, in that achieving equity requires policy actions and social interventions specifically focused on disadvantaged populations to level the playing field.

Figure 1. What is equity?



Source: Groundswellcenter.org

An equitable health system will ensure that all members of society have access to healthcare, according to their needs, regardless of background or circumstance. This could require increasing coverage in areas with insufficient health services and improving quality where services are inadequate. Services need to be affordable to all and non-discriminatory, with different populations having the same capacity to benefit from them (for example, having similar knowledge of health services and how to use them). An equitable health system also works to prioritise and treat individuals according to their level of need. Differences in health need could include differences in the number of health problems, type and severity of disease or

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risk of contracting certain diseases. As domestic budgets assume a growing share of healthcare costs, it may be tempting to be satisfied with results that indicate overall country progress is maintained or improved, but reports on a country's progress can conceal underlying inequities. It is critical for poor and marginalised populations that equity stays firmly on the agenda, and that, wherever possible, programme funding and contracting mechanisms are designed to promote this.

What is results-based funding?

A growing acknowledgement that traditional grant and public resources will not be sufficient to address the scale of today's development challenges has led to growing interest in innovative financing mechanisms that can attract new sources of funding and/or increase spending effectiveness.

Results-based funding (RBF) refers to a range of contractual arrangements that involve a transfer of funds in exchange for the delivery of specified results.⁶ Official donors are exploring different forms of RBF to improve aid effectiveness and demonstrate that funds have delivered results.⁷ Proponents have argued that RBF can be more effective than traditional input-based funding by increasing the following:⁸

- **Results focus:** Funding is tied directly to results, which creates incentives to focus on how to achieve these results and better understand whether programmes achieve progress, through which interventions and at what cost. Particularly when results are defined as development outcomes, results-based funding mechanisms align partners' focus on a programme's overall development objectives, rather than rigid adherence to and reporting against how programme inputs are used.

- **Rigour:** Results-based approaches define the results that will trigger payments from the outset and define how these results will be measured. Linking funding to results creates incentives for rigorous, independently verified measures of success. This can spur better collection and use of data to inform spending and policy decisions, and it shifts accountability for public funds away from cost and towards the value of spending in terms of impact.
- **Recipient autonomy:** Because funders do not specify delivery models or project inputs, funding recipients have the discretion to implement the strategies they think are most important for achieving the agreed results. This creates greater flexibility to try innovative approaches, adapt interventions to changing circumstances on the ground, and learn from mistakes and successes, making significant and sustainable impact more likely.

Results-based funding comes in many forms and terms are not consistently used. The key features of an RBF programme are *who* is being paid and for *what* they are being paid. A range of common approaches are outlined in table 1.

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Table 1: Types of results-based funding mechanisms

TYPE	APPROACH	SOURCE OF RESULTS-BASED FUNDING	RECIPIENT OF FUNDS	SOURCE OF UPFRONT FINANCE	RESULTS TARGETED
CASH ON DELIVERY / RESULTS-BASED AID	Payment for measurable progress against country goals	Bilateral or multilateral donor agencies	Partner government	Various – sourced by partner government	Outcomes through enhanced governance
RESULTS-BASED FINANCING / OUTPUT-BASED AID / PAY FOR PERFORMANCE	Payments linked to specific results metrics	Governments, bilateral and/or multilateral donor agencies	Service providers	Various – sourced by service provider; often come in part from outcome funder	Outcomes or outputs through improved service provider performance
SOCIAL / DEVELOPMENT IMPACT BOND ⁹	Risk capital provides up-front financing for service delivery with payments from donors and/or governments for impact achieved	Governments, bilateral and/or multilateral donor agencies	Investors and sometimes service providers	Outcomes-based investment	Improved outcomes through adaptive service delivery and rigorous programme management

Results-based funding for health

There are a number of possible reasons why development funders choose to use results-based funding. These may include providing incentives to a delivery agent who is motivated by financial gains; drawing increased attention on results through availability of data on results; increasing accountability for results; and encouraging flexibility in implementation, which creates space for innovation and local autonomy.¹⁰ The health sector holds some of the longest-standing examples of results-based

funding. RBF has been used in health to motivate staff, focus attention on and provide evidence of measurable results, strengthen information systems, build local capacity to manage and deliver health systems and, most importantly, to improve health outcomes.

Programmes have taken different forms, including donors providing incentives directly to government entities ('results-based aid') or to private service providers ('results-based financing' or 'output-based aid'). Donors have also offered grant support to countries to develop their own results-based financing

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systems that reward providers for good performance, offered incentives to individuals or households for changing health behaviours ('demand-side' incentives such as vouchers or conditional cash transfers), and incentivised private firms to improve research and development for issues that affect developing countries.¹¹

Overall, RBF in health has produced positive results, particularly when programmes are designed with a focus on outcomes, rigorous measurement, and recipient autonomy and flexibility.¹² Although implementation experiences have been varied, RBF approaches are credited with improving healthcare coverage and quality, particularly for vulnerable populations, and RBF has expanded rapidly in low-income countries.¹³

The remainder of this paper focuses on RBF supply-side incentive programmes—namely results-based financing, results-based aid and Impact Bonds—which provide incentives for health provider organisations to improve service delivery. Providers may be private NGOs or extensions of public health systems (such as government-funded rural clinics). A small number of cases involve national level schemes for which results payments are made to health ministries. In all cases, the principle is the same: donor funds are tied to measurable progress against pre-defined results. Given that there are a range of possible motivations for using RBF, this paper will focus on the extent to which a need to ensure equity has been a factor in programme design and implementation.

Can results-based funding be a driver for health equity?

As the development community places greater emphasis on equity, a question that has not yet been fully explored is the extent to which different funding mechanisms might or might not advance equity objectives. Approaches that link funding to results have raised questions as to whether they serve

the poorest populations and those most in need of services. One concern is that these approaches may create incentives to reach the populations that are easiest to work with and achieve only short-term measurable gains. Emerging evidence shows that, in fact, results-based funding can produce positive results and be a powerful tool to drive equity in health access and quality in developing countries. However, this is not a given. The way that RBF programmes are designed and implemented can mitigate unintended consequences and will determine whether or not they improve health equity.

For some programmes, health equity itself is the main objective; these programmes seek to expand basic services to marginalised and hard-to-reach populations.¹⁴ Other programmes have a health outcome goal—such as reducing prevalence of disease, reducing maternal or child mortality, or improving health systems—for a broader population. To reach everyone in need, they must include efforts to reach marginalised populations and ensure that people are served according to their health needs rather than ease of service provision. Often, programmes combine both objectives.

In any case, there are multiple means through which programmes can improve equity. These are the two main factors that determine the effect that RBF will have on equity:

1. How the target population is defined; and
2. How contractual payment triggers (success) are structured.

RBF can improve equity by targeting marginalised populations or establishing payment mechanisms that provide incentives for reaching the hardest to reach, whether equitable access to services is a key programme objective or programmes have a broader objective. Moreover, an RBF programme that takes equity into consideration when defining target populations and success metrics may still

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be ineffective if certain contractual features are not properly considered. In particular, genuine flexibility to innovate and adapt interventions when it comes to programme implementation should be a key benefit of RBF that differentiates it from other funding approaches, but must be contractually defined.¹⁵

To ensure that an RBF programme provides a sustainable solution, which contributes to improving a country's healthcare system over the longer-term, governments should be engaged from the beginning of the programme. Under some programmes reviewed (e.g., the Salud Mesoamerica Initiative and GAVI's immunisation services support programme), incentives are provided to governments. Part of the theory behind this is that, by requiring governments to develop and own the strategies that will lead to improved results, RBF will have a long-term impact on the development of public institutions.

The majority of RBF programmes in the health sector, however, provide incentives directly to providers, using either government or donor funding or a combination of the two. These programmes can still have wider health systems improvements as part of their objectives (see box 1). Where governments are paying for results, they have a clear role in defining target populations and outcomes that align with country sector plans. Under programmes where contracts are between a donor and third party provider (e.g., the Global Partnership on Output-Based Aid), national or local governments should play a role in defining priority outcomes and populations, as well as in regulating the quality of care provided. Over time, it may be appropriate for governments to take up funding of the programme on a results-basis or otherwise. Government involvement and careful consideration of how a programme fits into a country's overall health sector plan are needed for any type of RBF programme to ensure that impacts are sustainable.

Box 1. The Health Results Innovation Trust Fund

The Health Results Innovation Trust Fund (HRITF) is a multi-donor trust fund, administered by the World Bank, which was established to improve access to and quality of maternal and child health care through results-based funding. HRITF was created in 2007 and has nearly \$500 million in contributions to date from the governments of Norway and the United Kingdom. As such, it has been one of the largest funders of RBF health programmes.

As of July 2015, HRITF has funded 36 RBF programmes in 30 countries, mostly in sub-Saharan Africa. In addition, it provides funding for programme evaluations and knowledge and learning grants to stimulate dialogue and knowledge-sharing about RBF design and implementation in low-income countries.

A core objective of HRITF is to build country institutional capacity to scale up and sustain RBF mechanisms as part of the national health strategy and system. Projects are typically linked to wider World Bank projects and therefore benefit from links with governments and emphasize alignment with broader reforms and development policies. This ensures that RBF projects are contributing to the long-term development of health systems.

Sources: <http://www.rbfhealth.org/>; Martinez, J., Pearson, M., Sorensen, B.H., James, B., & Sambo, C. (2012). *Evaluation of the Health Results Innovation Trust Fund*. Retrieved from Norad Website: <https://www.norad.no/om-bistand/publikasjon/2012/evaluation-of-the-health-results-innovation-trust-fund-hritf/>.

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Targeting

Health programmes, under traditional funding mechanisms, are often not designed to primarily benefit marginalised segments of the population. Indeed, they often struggle to benefit the poor because it is harder for services to reach poor neighbourhoods, especially in rural areas, and because marginalised groups do not exercise enough political influence to direct spending to meet their needs.¹⁶ In contrast, a review of experiences with the Global Partnership on Output-Based Aid notes that results-based funding has specifically targeted the services that the poor are most likely to use, in addition to helping to mitigate the costs to poor households of accessing basic health services.¹⁷ Rigorous data requirements

for RBF mean that the poor and disadvantaged can be better targeted and tracked throughout programme implementation compared to traditional input-based programmes.¹⁸

Targeting is the first step to ensuring that RBF programmes successfully promote equity. While RBF programmes that seek to improve healthcare provision are likely to benefit the poor, without taking specific measures to target the poor and disadvantaged, the programme may have an unclear or minimal effect on equity (see box 2).

There are two main targeting mechanisms that RBF programmes can use to ensure that services reach poor and marginalised populations: targeting by geography and targeting by household or individual.

Box 2. A Countrywide RBF Scheme in Rwanda

In 2005, the government of Rwanda adopted a results-based funding strategy to increase healthcare service output and improve quality of care. The programme built on lessons from donor-financed pilots and was rolled out uniformly across the country. It aimed to address deficiencies within the health system, with no explicit targeting of the poorest or most marginalised populations. Payments were linked to indicators that captured usage and quality of maternal and child primary health services.

Results improved between 2005 and 2007 across all wealth groups. During that time period, equity gaps narrowed across outcomes such as contraceptive use and facility deliveries. However, an evaluation that looked specifically at the effects of the RBF programme on equity found no statistically significant differences within populations based on income status or geography (rural vs. urban).^{*} The evaluation concluded that, on its own, without specific provisions to target the poorest in the population, RBF is neither a 'pro-poor' or 'pro-rich' strategy.

^{*} Skiles, M.P., Curtis, S.L., Basinga, P., & Angeles, G. (2013, December). An equity analysis of performance-based financing in Rwanda: are services reaching the poorest women? *Health Policy and Planning*, 1-13. Retrieved from <http://heapol.oxfordjournals.org/content/early/2012/12/06/heapol.czs122.full>.

Sources: Skiles et al., 2013; Eichler and Levine, 2009.

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Geographic Targeting

Geographic targeting, or selecting poorer regions as the focus of RBF programmes, is the most common form of targeting and is particularly effective when intended beneficiaries are concentrated in certain areas.¹⁹ The main consideration is typically the poverty level of a particular area. For example, an RBF programme to improve access to maternal and child health services in Zimbabwe specifically targeted rural and low-income urban and peri-urban districts for programme implementation. In this case, the use of RBF led to an increased likelihood of women from households with below median wealth delivering babies in health facilities and an initial pilot was expanded to additional rural districts.²⁰

Household or Individual Targeting

Targeting by household or individual, also known as **means-tested targeting**, involves measuring a beneficiaries' need, for example according to income or wealth. This can be done when individuals go to a clinic to access services (post-identification) or by programme staff actively seeking out individuals to target before they access services (pre-identification).

Information to identify beneficiaries can be collected through surveys or questionnaires. While, historically, surveys have often been time consuming and costly to disseminate, new tools are making it easier to reach beneficiaries and identify their needs.²¹ An alternative is to use **proxy means testing**. This involves using easily observable characteristics, such as a certain type or size of house, as a proxy for a household's income.

Means testing or proxy means testing are considered to be more effective than geographic targeting for RBF programmes, which aim to improve coverage of basic services for the poor, because the poor and non-poor may be interspersed in any defined geographic area. These methods were employed to implement health equity funds in Cambodia (box 3).

Box 3. Health Equity Funds in Cambodia

User fees are a common way to generate resources for health systems in many developing countries, but they can make access to services unaffordable for the poor. Meanwhile, health facilities often cannot afford to accept non-paying patients. Health Equity Funds (HEFs) were established by the government in Cambodia in 2000 to fund health services for the poor. HEFs in Cambodia pooled funds in four different districts to purchase health services for those who could not afford the required user fees. Health facilities waived user fees for poorer patients and HEFs reimbursed them based on the number of patients they treated for free. In some regions, they also used demand-side RBF to cover some of the patients' costs associated with accessing health facilities such as travel and food.

The Funds operate independently of health facilities and are funded through donor and government contributions. The HEFs use household questionnaires and interviews to identify the poor, and in some cases, identified poor individuals through episodes of illness at hospitals. They use proxy-means testing to identify poor households, including assessment of factors like productive assets and belongings (e.g., type of housing, means of transport or size of farmland) as well as overall income. Two of the districts considered presence of a severe illness in a household as part of the criteria.

An HEF in Kirivong Health District used community-based targeting by engaging with local pagodas (temples). Clinics asked religious and community leaders to provide a list of households considered to be most in need. Funds for the HEFs were raised from the local community at pagodas and mosques. This, in addition to a supporting committee comprised of pagoda representatives, resulted in a locally-driven RBF initiative.

Source: Noirhomme, M. et al. (2007). *Improving access to hospital care for the poor: Comparative analysis of four Health Equity Funds in Cambodia*. Retrieved from Instituut voor Tropische Geneeskunde Website: <http://www.itg.be/itg/Uploads/Netwerken/HS/doc/1/ref%201.23%20access%20compare%204%20HEF%20Camb%20-%20preprint%20versie%20MN.pdf>

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Programmes may also use **community-based targeting** methods such as participatory wealth ranking (PWR) as a way to identify disadvantaged households or individuals; PWR and similar techniques involve collaborating with community members to identify those most in need of services. This has the benefit of local participation and ownership in projects. However, it typically requires a significant time commitment from programme managers and may run the risk of being skewed by special interests within a community.²²

Finally, programmes with an explicit goal to increase health equity can use **self-selection targeting** by only funding basic health care services. While wealthier patients may favour more sophisticated facilities, poor individuals would self-select into the RBF-funded facilities.²³ Programmes can and often have used a combination of targeting mechanisms as in, for example the Salud Mesoamerica Initiative, which uses a mix of geographic and household targeting (box 4).

Box 4. Salud Mesoamerica Initiative

The Salud Mesoamerica Initiative is a large-scale example of a programme with a direct health equity objective, which used targeting to achieve its goals. The initiative was set up specifically to address maternal and child health inequities in eight countries. The \$114 million, 5-year initiative was aimed to draw attention to problems of health equity and create incentives for countries to re-programme domestic resources towards key services for vulnerable populations. It used national and regional poverty maps to determine the localities that would be eligible for interventions. It then used census data, household interviews and surveys of health facilities to identify the poorest households and allow it to advance goals of reaching the poorest 20 percent of the population.

Sources: www.saludmesoamerica2015.org; Mokdad et al. (2015, February). Salud Mesoamerica 2015 Initiative: design, implementation, and baseline findings. *Population Health Metrics* 13(3). Retrieved from Population Health Metrics Website: <https://pophealthmetrics.biomedcentral.com/articles/10.1186/s12963-015-0034-4>.

Recommendations

- » Make equity a programme objective and use appropriate targeting techniques to identify marginalised populations.
- » When a target population is not concentrated in a specific geographic area, funders should invest in more sophisticated methods of identifying and targeting the most marginalised individuals and households.
- » Engage governments from the outset of the programme. If governments are not direct programme funders, they should be involved in identifying priority outcomes and populations, and possibly regulating the quality of services, so that the programme aligns with the national health plan.

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Defining Success

In any RBF programme, it is important to ensure that payment triggers create the right incentives. The wide variety of ways in which payments can be structured presents risks: poor structuring could jeopardise the success of the programme and incentivise the wrong behaviours. However, results indicators and payment mechanisms also present an opportunity to ensure that vulnerable groups are prioritised. How success is defined (which indicators are used) and how success is valued (the payment amounts and timeframes that correspond to results indicators) will determine the focus of service providers.

Defining Results Metrics (Indicator Selection)

How contractual success is defined has important implications for equity. Indicators may or may not be selected according to outcomes that matter the most for poor and disadvantaged populations, such as ensuring consistent access and quality of basic health services. There will often be an overlap between a broad health goal—such as reduction of malaria in a country—and the need to ensure access to services for poor or marginalised populations—for example, provision of bed nets or access to treatment. But, if equity is a programme objective, outcome metrics must be explicitly defined to reflect priorities for marginalised and disadvantaged populations.

Often, coverage of priority health interventions for the poor is the key result that programmes with an equity objective seek to achieve. A common approach is to offer additional incentives to health care providers that work in marginalised areas, such as clinics in rural or inaccessible areas or areas with high poverty levels. These clinics are often less attractive for health workers than urban hubs and require more intensive work schedules, so workers need additional incentives to serve these areas.

RBF could also be designed to pay only for the services that small, remote clinics deliver as some health clinics may not be able to deliver certain services (such as surgery or laboratory testing) due to size and capacity. Programmes should also take into consideration that operational costs for smaller health centres in remote areas may also be higher because they have higher costs to transport drugs and equipment and are less able to benefit from economies of scale. Incentive payment structures should be designed accordingly.

Indicators can also be designed with a view to overcoming barriers to accessing healthcare. Disadvantaged populations often face such barriers due to limited resources, distance from health clinics, and lack of quality health services. Indicators that could be used to reduce these barriers might include increased numbers of home visits conducted by clinical staff, which gives incentives to bring services to the door-step of harder-to-reach populations that may not otherwise visit clinics (see as, an example, the incentive scheme used in an RBF programme in Cameroon in box 5).

Indicators that capture quality of care and not only access are essential to improving equity. Access to health services will not lead to better health outcomes if services are of poor quality. Indicators could, for instance, capture length of waiting times or the presence of qualified health workers at clinics. An even better way to measure quality is to, wherever possible, define measures that capture health outcomes. Paying for outcomes provides a better indication of the improvement of a health system and reductions in health disparities, than paying for an output. It would be better, for example, to pay for reductions in child stunting or reduced prevalence of a disease (outcome) rather than for availability of clinics and staff (output). As much as possible, payment triggers related to health access or coverage indicators should be linked to improvements in a health outcome. Some

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Box 5. Results-based Funding in Cameroon

A World Bank-supported RBF program in Cameroon funds health centres and hospitals with the aim of improving the use and quality of health services. A pilot program implemented in 2012 in four districts in the northwest region of the country aimed to deliver a defined health package, with a focus on child and maternal health and communicable diseases, on a results basis. Output indicators were set centrally by the Ministry of Health and spanned a range of services, from family planning and antenatal care, to tuberculosis and sexually transmitted disease detection and treatment.

To give incentive for equitable provision of services, higher payments were triggered for services delivered for free to 'poor and vulnerable' persons. The program also took into account the geographic accessibility of health centres—and the population density and poverty levels of the area—when calculating results payments. Health centres could receive up to 30 percent higher payments as an 'equity bonus' for operating in poorer areas. The bonuses were flexible over time, accounting for changes in the population and wealth of the area. Health centres under the program had autonomy on how to spend the RBF funding, although no more than 50 percent could be used for staff incentives. Since 2012, the World Bank has supported performance-based funding in Cameroon to reach a national scale.

Source: Consortium AEDES/IRESO. (2012). *Performance Based Financing Implementation Procedures Manual*. Retrieved from: http://www.fbrcameroun.org/cside/contents/docs/Procedure_Manual.pdf; The World Bank. (2014). *World Bank Supports Expanded Health Care Services for Rural, Poor Families in Cameroon* [Press release]. Retrieved from <http://www.worldbank.org/en/news/press-release/2014/06/24/world-bank-expanded-health-care-services-rural-poor-families-cameroon>

health outputs such as coverage of a vaccine or family planning services to meet unmet needs could be considered good proxies for outcomes.

For example, in the Salud Mesoamerica Initiative highlighted in box 4, indicators vary across countries according to the needs of the poor in each geography. The programme seeks to reduce the barriers between demand and access to services, in addition to improving the quality of services for the poorest quintile of the population.²⁴ The programme pays governments against indicators that capture progress towards decreasing these discrepancies. This includes output indicators such as whether or not health facilities have the equipment necessary for pre- and post-natal care in poorer geographies, and outcome indicators such as reductions in anaemia.

Paying for Improvements, Not Just Absolute Success

If a set target for receiving payments in an RBF programme is too high and viewed as unachievable, clinics in poorer, more remote areas may not have the proper incentive to improve performance. Likewise, if a target is met, there may be no incentives to make progress beyond that minimum target. To avoid the challenges of setting appropriate targets, some RBF programmes define success in terms of increases in the number or percentage of people accessing services, rather than setting absolute targets to be attained before payments are triggered. For example, in Cameroon, service providers are paid for each person treated in the clinic. This means that

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although there are targets set for each indicator, if a smaller clinic lacks the capacity to reach these targets, it is still rewarded for any improvements it can make. This approach to structuring payments ensures that providers have incentives to work with a maximum number of individuals, as opposed to the minimum number of easiest-to-reach individuals that will allow them to meet their targets.

Regardless of the way that the payment mechanism is set up, to ensure the credibility of the programme, results should be independently verified. A third party agent that specialises in evaluation should confirm that the interventions led to the intended results before funds are disbursed. This will increase the confidence of all parties in the programme and provide clear evidence of the outcomes achieved.

Recommendations

- » Pay more for services delivered to people with greater needs (adjusting incentives for factors like remote locations or poverty).
- » Pay for improvements, not just absolute levels of success.
- » Focus on impact and outcomes, not just outputs.
- » Insist on independent verification of results for all RBF programmes.

ENSURING EQUITY WITHIN PROGRAMMES FOCUSSED ON ACHIEVING A BROADER HEALTH OUTCOME

Results-based funding can be an effective way to target disadvantaged populations and help to ensure equity in access to health services, as seen in the Cambodia Health Equity Funds, Salud Mesoamerica Initiative, and a range of other RBF programmes funded by the World Bank Health Results Innovation Trust Fund or Global Partnership on Output-Based Aid.²⁵ But, equity also matters in terms of measurable improvements in health outcomes. Ample evidence shows that health outcomes vary among social groups according to, for example, employment status, income level, sex, or ethnicity in ways that can be affected by the right interventions.²⁶

Many health programmes aim to encourage improvements for a specific health issue—for example, reducing disease prevalence or child stunting—rather than improving coverage of priority health interventions for a general population or disadvantaged segments of the population. RBF experiences with programmes that have health outcome objectives are limited compared to the use of RBF to improve access to and usage of health services, but there is significant potential to build on current experiences and use RBF to drive equity in health outcomes.

For programmes that are focussed on achieving a broader health outcome, ensuring equity means ensuring that people are served according to their health needs. This requires understanding what the needs of sub-populations are and focusing efforts where need is greatest. For example, a programme that aims to reduce tuberculosis (TB) in a country with high prevalence might focus on populations, such as mine workers, that have a higher degree of need. Targeting and payment mechanisms in an RBF programme can be designed to ensure that programmes serve those with the greatest needs, and bring overall populations closer to equitable health status.

Targeting

Targeting requires understanding the health needs of sub-populations and directing resources to those with the greatest need. A focus on those with the greatest needs can help to drive greater effectiveness of health spending because this is where the biggest improvements stand to be made. Where greater costs and risks are associated with targeting those with the greatest needs—who often will be the hardest to reach—RBF can help to mitigate these risks for donors because donors only have to pay for success.

Targeting according to need requires understanding how a disease or health problem is distributed in the population across a range of dimensions—for example, by geography, income level, race, gender, age, or vocation. Programmes must use disaggregated data to understand who target populations are and how populations or sub-populations are impacted by programme interventions. At a minimum, population data should be disaggregated by economic status (measured by household income, expenditure, or wealth), place of residence (rural or urban), and gender.²⁷ However, disadvantaged target groups may also be defined by other dimensions; for example, people employed as mine workers or sex workers may be more vulnerable to TB or HIV. Disaggregated data can be used to direct resources to those with the most acute needs and, thereby, drive progress towards a defined health outcome.

For example, the Salud Mesoamerica Initiative identified low-income and indigenous communities with worse health outcomes than national and regional averages through the use of both census and household survey data. The programme directs resources for maternal and child health services to the poorest 20 percent of the population in selected countries based on health outcomes for this group, such as child mortality rates that are twice as high

ENSURING EQUITY WITHIN PROGRAMMES FOCUSSED ON ACHIEVING A BROADER HEALTH OUTCOME

as national averages. Specific performance targets are negotiated taking into account health trends in each country.²⁸

Results-based funding can drive a stronger focus on the needs of disadvantaged populations because it requires rigorous baseline measurements of the health status of these populations and rigorous measures of the impact of programme interventions. Linking funding to health outcomes creates incentives to ensure that outcomes are properly measured. Therefore, as with programmes focused on access to health services, the definition of outcomes or success metrics is key to ensuring the success of RBF.

for children and, at a later stage, outcomes such as prevalence of anaemia. GAVI's immunisation services support (ISS) programme paid for increased coverage of the DTP3 vaccine, which could be considered an output but is a close proxy for the outcome of improved child health, as well as a measure of the quality of a country's healthcare system. When populations or sub-populations with the greatest need are identified, RBF programmes should create incentives to focus on individuals from these groups. This will ensure that efforts are put in place to improve the health outcomes of disadvantaged sub-populations and bring different sub-populations closer to equal levels of health outcomes.

A programme that seeks to improve a health outcome for a broader population could offer higher payments if services are delivered to individuals from key target groups. As with programmes that seek to improve access to basic services, it is more effective to pay for improvements rather than absolute success, but there may be a need for extra efforts to reach the most disadvantaged populations. For example, GAVI's ISS worked across 62 countries at the national level to increase routine immunisations and, thereby, improve health system capacity and child health outcomes. Multi-donor funds were awarded to national governments for increased coverage of the DTP3 vaccine for children at the rate of \$20 for each additional child reached with three doses of the vaccine. This payment mechanism created incentives for reaching more children, but the programme was not found to have a direct impact on equity.²⁹ An alternative would be to make higher payments for children from marginalised areas with the poorest access to immunisation services and where the largest improvements would stand to be made.

Similarly, a programme that seeks to reduce HIV might specifically target high risk populations; for example, in sub-Saharan Africa, HIV prevalence is disproportionately high among female sex workers,

Recommendations

- » Identify populations with the most acute health needs, and target programme resources accordingly.
- » Use RBF to create incentives and systems for better measurement, including clear indicators of programme impact.

Defining Success

For programmes that are focused on achieving health outcomes, payments should be triggered by clear measures that these outcomes have been achieved. Defining payment metrics as health outcomes ensures that outcomes remain the focus of the programme. Although it may be possible to pay for interim outputs, programmes are more likely to be effective if outcomes are defined as simply as possible and incentives remain aligned towards the ultimate outcome. For example, in some countries in Central America, the Salud Mesoamerica Initiative links funding to outputs such as the introduction of nutritional supplements

ENSURING EQUITY WITHIN PROGRAMMES FOCUSSED ON ACHIEVING A BROADER HEALTH OUTCOME

men who have sex with men, transgender people, and injecting drug users.³⁰ RBF programmes working with the general population in countries with high prevalence could offer higher incentive payments for progress made among key hard-to-reach populations to ensure that they are not left behind even as overall prevalence rates improve. In countries that have lower overall prevalence at the onset but a high proportion of cases from key populations, an additional incentive may not be needed. Targeting these populations may be sufficient to drive greater equity, and an RBF mechanism can help to ensure that interventions that meet the needs of these populations are implemented as effectively as possible.

Measuring success will require investments in collecting data at a disaggregated level. For example, if the goal of a programme is reduction of a particular disease, there is a need to ensure that any measured reductions are proportional to the health needs of sub-groups (i.e., any effect of a programme or intervention on the quintile with the worst health outcomes should be at least equal proportionate to the overall population effect and ideally significantly greater). As noted previously, an advantage of the RBF mechanism is that it requires rigorous measurement of project outcomes. To fully realise the benefits of the model, providers should be able to adapt delivery according to measured progress in real-time, a programme feature discussed further in the next section.

Recommendations

- » Design success metrics such that funding is linked directly to improved outcomes for vulnerable populations.
- » For programmes that serve general populations, consider offering higher incentive payments if individuals are from vulnerable or hard-to-reach sub-populations.
- » Monitor performance and results at a disaggregated level to understand how disadvantaged and hard-to-reach groups are affected.

AUTONOMY AND CONTRACTUAL FLEXIBILITY IN RBF HEALTH PROGRAMMES

Clear definitions of target populations and success metrics are the core features of any RBF programme. As discussed previously, these should be agreed with governments to ensure that programmes are appropriately integrated into national health plans. However, regardless of how these features are designed, programmes are unlikely to be successful if service providers are not granted the flexibility to implement interventions they expect will lead to better health outcomes and adapt programmes to varied

beneficiary needs and changing circumstances, while taking into consideration country priorities. Contracts must move away from requirements to monitor inputs and activities if results-based funding is to offer a truly impactful and cost-effective way of achieving results, including greater health equity. RBF programmes for which flexibility has been a key feature have indicated that it has contributed to successful results (see two different examples in boxes 6 and 7).

Box 6. Increasing Flexibility and Improving Results in Haiti

In 1995, USAID began funding a project that contracted NGOs to deliver basic health services in Haiti, where 40 percent of the population had no access to basic healthcare and outcomes such as life expectancy and infant and maternal mortality were much worse than in the neighbouring Dominican Republic. The project's aims were to increase access to essential services and strengthen health service organisations while improving the government's capacity to oversee the health sector. The project introduced a performance incentive in 1999, which offered a bonus equal to as much as 10 percent of the project budget. While 95 percent of the budget was allocated as expenditure-based reimbursements, NGOs risked losing 5 percent of the budget if they did not reach pre-determined targets, but could gain an additional 5 percent if they did.

Several lessons emerged during implementation. First, the project showed that it is not necessary to get the details right from the outset; for example, two of the original seven results indicators were deemed to be irrelevant and were dropped. Second, RBF allowed for more effective technical assistance (TA) because TA was demand-driven, rather than top-down and prescriptive. This made external assistance more effective in helping NGOs to grow their capacity. Third and perhaps most important, NGOs reported that the stronger results focus motivated them to question and experiment with their models of service delivery. They were strongly supportive of the expanded managerial and budgetary flexibility and an incentive scheme, which increased staff motivation to develop new ways of improving results—for example, by increasing community participation. As observed in other RBF programmes, the flexibility of funds allowed service providers to concentrate their efforts on activities that worked.

Following positive results from the initial pilot, which involved three NGOs, USAID integrated results payments into future phases of the project. By the end of 2005, the project supported delivery of basic health services to 2.7 million people by contracted NGOs, with results reaching twice the national average for some indicators.

Source: Eichler and Levine, 2009.

AUTONOMY AND CONTRACTUAL FLEXIBILITY IN RBF HEALTH PROGRAMMES

Contractual flexibility could be particularly relevant for an equity objective because it gives service providers the space to develop solutions that address the needs of disadvantaged populations. Programmes that aim to reach the vulnerable and hard-to-reach will need to take a sharper focus on the specific obstacles facing smaller, disaggregated populations and will need to be even more adaptable to emerging learning during

programme implementation than programmes that aim to roll out a service for a general population. As a general rule, defining results as health outcomes, without imposing requirements for how these outcomes are to be achieved, should create the flexibility that providers need to innovate and adapt services to stay focused on achieving these outcomes for target populations.

Box 7. Results-based Funding for Private Not-for-Profit Health Facilities in Uganda

The evaluation of one performance-based contracting programme launched by the government of Uganda in 2003 attempted to assess the impact of granting flexibility to health facilities to decide how to allocate resources. The programme compared the results of private not-for-profit health facilities that were offered a performance bonus with and without the freedom to make decisions about how spending would be allocated. Results were measured in terms of mainly 'access' indicators for the poor and most vulnerable, including increases in outpatient visits, malaria treatment, children immunised, attended births, and uptake of modern family planning.

The performance incentive without flexibility did not lead to an increased positive impact on results, due to design and implementation issues that were overlooked. For example, incentives may have been too small and bonus structures were too complex for facilities to understand and implement. Facilities had poor information management systems, and the timeframe for the project (2 years) may have been too short given the time required for facility workers to understand and show interest in the new approach. These findings demonstrate that RBF requires upfront investment in design and data collection methods and careful implementation.

However, despite challenges with the performance incentive, where the government also granted autonomy to facilities in financial decision making, there was a more positive impact on health service provision. Facility directors were cited as saying that they did not need more money, rather they 'simply needed to be able to spend [funds] in the way they saw fit, rather than according to health ministry mandates'. This provides evidence that RBF schemes are likely to have a greater impact if flexibility for implementers is part of the contractual arrangement.

Source: Morgan, L. (2010b). *Some Days are Better than Others: Lessons Learned from Uganda's First Results-Based Financing Pilot*. Retrieved from The World Bank Website: https://www.rbhealth.org/sites/rbf/files/RBF_FEATURE_Uganda.pdf; Lundberg, M. (2007). Output-based Contracting for Health Service Delivery in Uganda. Presentation http://cgdev.org.488elwb02.blackmesh.com/sites/default/files/archive/doc/events/6.06.07/uganda_cgdev_2007_handouts.pdf.

AUTONOMY AND CONTRACTUAL FLEXIBILITY IN RBF HEALTH PROGRAMMES

Under typical input-based programmes, it can be a challenge for development funders to allow for flexibility, as a result of the understandable need to be accountable for public funds. Project implementers are often required to follow and report against rigidly prescribed plans for how funds should be used. Depending on how RBF programmes are designed and implemented, this can be a challenge for RBF too. Burdensome rules and procedures of governments and donor agencies imposed on service providers have in some cases affected service quality and limited service providers' ability to innovate, particularly smaller service providers.³¹ Without a concerted move away from input and activity-based accountability, RBF programmes risk being very similar to traditional input-based programmes, with the added burden of financial risk to service providers.

To get around these challenges and increase the impact of RBF, donors are increasingly looking to new mechanisms such as Development Impact Bonds (DIBs). DIBs raise philanthropic and commercial investment to pre-finance programmes and assume

the risk that outcomes are delivered. (See box 9 for an explanation of DIBs.) Because of this, DIBs can use a greater proportion of donor funding to pay for results than other RBF approaches, which often provide a portion of funds on a traditional input, or activity, basis in recognition that service providers need funding upfront to deliver effectively. This offers service providers greater scope to adapt programme delivery to respond to beneficiaries' needs. Moreover, the need to track outcomes data for investors creates incentives to implement rigorous and adaptive management systems which ensure that delivery remains focused on outcomes. These mechanisms which are built into the DIB model should make it easier to realise the benefits of results-based approaches.

Box 8 illustrates how flexible funding under an Impact Bond in the UK context has allowed service providers to develop an intervention model that meets the specific needs of a vulnerable group. DIBs are a new approach that have not yet been tested in the health sector in developing countries, although a number of projects are currently under development.

Recommendations

- » Where possible, move away from contractual requirements for service providers to deliver and report against pre-determined inputs and activities. Focus instead on clearly defining success metrics and payments, and allow delivery flexibility for implementers, to ensure that results-based funding genuinely provides proper incentive for better results, including greater health equity where appropriate.
- » Consider an Impact Bond model when financial risks to service providers are too high and/or their access to other sources of upfront financing for services are too limited to enable the kind of contractual flexibility required to enable RBF programmes to be most effective.

AUTONOMY AND CONTRACTUAL FLEXIBILITY IN RBF HEALTH PROGRAMMES

Box 8. Using Social Impact Bonds to Implement a Flexible Intervention Model

In Essex County in the UK, a Social Impact Bond is being used to provide multi-systemic therapy (MST) to adolescents who are at the risk of being taken into care. The service delivery organisation, Action for Children, provides the intensive, evidence-based MST therapy to children, aged 11–17, who show risky behaviours and their families. The method involves helping families grow the skills and confidence to manage the young people more effectively and addressing the child's entire support network, including schools, peers, and community. Therapeutic support is available at all hours, including weekends or overnight when necessary. Pre-financing comes from social investors whose entire investment is at risk if the programme fails to reduce care placements relative to a historical comparison group. Under this agreement, Essex County Council will only pay for success and hence does not take on financial risk.

At the end of the programme's second year, 101 cases closed with more than 80 percent of young people remaining safely in their homes. One of the most valued features of the programme is a flexible fund, which is incorporated into the budget provided by social investors—a novelty compared to other MST programmes. Therapists can use this discretionary fund to provide additional support to children and families, which address individuals' needs. Because funding is tied to outcomes and not a prescribed project plan, the provider has the flexibility to deliver a comprehensive, adaptable package of services that are tailored to young people's changing circumstances and needs.

Sources: B Green and N Matthews. 2014. *The Essex Social Impact Bond: A Year in Review*. Retrieved from Social Finance Website: http://www.socialfinance.org.uk/wp-content/uploads/2014/11/Essex_A_year_in_review.pdf; Social Finance. (26 November 2014). The Essex Social Impact Bond – a year in review [blog post]. Retrieved from <http://www.socialfinance.org.uk/the-essex-social-impact-bond-a-year-in-review/> ; Sin, Dr. C.H. and Robers, L. (2015). OPM Evaluation of the Essex MST SIB – Interim Findings – Year 2 [PowerPoint slides]. Retrieved from <http://www.opm.co.uk/wp-content/uploads/2016/02/OPM-Essex-MST-SIB-Evaluation-Interim-Findings-Year-2-1.pps>

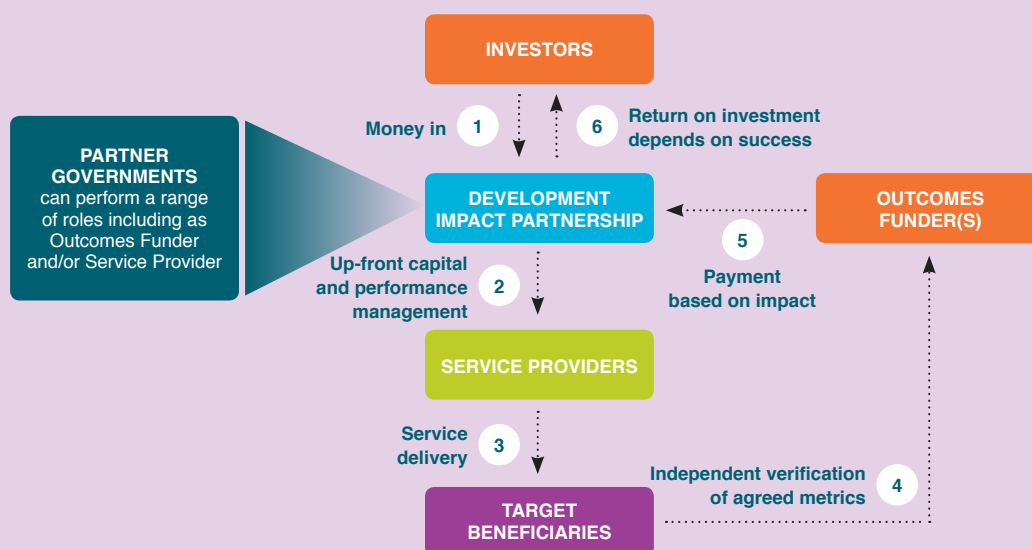
Box 9. What is a Development Impact Bond?

A Development Impact Bond (DIB) is an instrument whereby investors pay in advance for interventions needed to achieve agreed development results, and they work with delivery organisations to ensure that the results are achieved efficiently and effectively. Outcome funders (typically official donors) make payments to investors if the interventions succeed, with returns linked to results achieved. Donor or government outcome funders pay for results as with other forms of results-based financing, but DIBs involve a source of pre-financing for service providers, and a private sector perspective that can change the way that services are delivered. DIBs follow the same model as Social Impact Bonds, with the distinguishing feature of a DIB being the role of third party donors in providing all or some of the outcomes payments.

DIBs focus accountability on desired outcomes, with the inputs and processes necessary to achieve those outcomes left more flexible than in traditional funding models. The focus is not on whether particular inputs are being delivered, but rather on what is and isn't working to achieve the agreed outcomes. Typically, DIBs are managed by an intermediary who oversees performance management to ensure interventions are leading to the intended outcomes and delivery organisations can change course if necessary.

Investment in DIBs from the private sector brings not only financing, but also expertise in areas such as user feedback and data analysis. This results focus is supported by the use of real-time data and analysis on programme impact, and by performance management that responds quickly to such new information. DIBs offer the advantages of providing a platform for collaboration between public, private and civil society sectors; stimulating innovation through greater flexibility for programme implementers; and creating incentives for rigorous measurement. This can help to build up an evidence base around independently verified intervention costs and impact, enabling knowledge sharing and greater transparency around public spending and development outcomes.

Typical Development Impact Bond Structure



CONCLUSIONS & RECOMMENDATIONS

Results-based funding can be a powerful driver to improve global health equity. Programmes in a range of geographies from Cambodia to Cameroon and Central America have shown how results-based payment triggers have been designed to create incentives to successfully reach poor and vulnerable populations. These programmes have led to improvements for these groups, particularly with regard to increased access to health services.

However, certain features must be in place in order for an RBF programme to drive health equity. Three main ways to ensure that equity is a part of the programme are targeting poor and disadvantaged populations, designing payment mechanisms to reward a focus on meeting the needs of disadvantaged populations, and ensuring that service providers have the flexibility to adapt programmes to meet beneficiaries' needs. Engagement of governments and quality data measures, including independently verified results, are also critical for programme success and sustainability, and can help to drive an equity focus.

To increase the likelihood of successful programmes and ensure that equity remains at the centre of programme goals, RBF programmes should include the following features:

1 Target poor/disadvantaged populations

Programmes should invest the resources to identify where marginalised populations with unmet health needs are located. This would involve geographic or community-based targeting where target populations are concentrated in a specific area and more sophisticated methods of targeting where they are not.

Programmes which do not have a sole equity goal, but seek to ensure equity while focusing on improving health outcomes for a broader population, should

at the onset identify sub-populations with the most acute health needs and target programme resources accordingly. New survey tools are making it easier to target disadvantaged populations and understand their needs.

2 Focus on outcomes

As much as possible, programmes should focus on health outcomes which reflect improved health and better quality services for poor and disadvantaged populations. Programmes should measure results at a disaggregated level to understand whether outcomes improved.

3 Reward progress, not just absolute success

Success metrics should be designed to provide proper incentives for reaching disadvantaged populations. This could include paying more for services delivered to these populations and paying for improvements, not just absolute success. Paying for each level of progress creates incentives to continue making efforts to reach the hardest to reach.

4 Allow implementers flexibility to deliver interventions

RBF programmes should allow flexibility for providers to adapt services according to the varied and changing needs of target populations throughout programme implementation. Flexibility in the intervention model can help to ensure that services are tailored to the needs of specific populations which could be particularly important for disadvantaged and hard-to-reach populations.

The Impact Bond model is one way to enable an appropriate level of flexibility and adaptability by removing the need for outcomes funders to also provide pre-financing for services.

CONCLUSIONS & RECOMMENDATIONS

5

Engage governments to identify priorities that fit within health plans

To ensure that programme impacts are sustainable, governments should be involved from the beginning of the programme's design, even if the government is not a direct programme funder. At a minimum, governments should be engaged in identifying priority populations and outcomes. Learnings generated from RBF programmes should also be used to inform future policy decisions and future programmes. RBF programmes could be a way to discover what works to achieve outcomes for disadvantaged populations at little risk to governments and external donors. Learnings from the design and implementation of RBF programmes can inform the development of health systems and policies to retain a focus on the needs of disadvantaged populations.

6

Independently verify outcomes to ensure credibility

In order for programmes to be credible and ensure quality data collection and clear evidence of the outcomes achieved, programme results must be verified by an independent third party before payment results are triggered. RBF can help to create the incentives for good data collection on needs and programme outcomes for disadvantaged populations.

If RBF programmes are designed with the principles discussed in this paper kept in mind, RBF can be a good choice for programme funders who want to ensure equity and improved healthcare outcomes for all.

ENDNOTES

- 1 United Nations. (2015). *Millennium Development Goals Report 2015*. Retrieved from United Nations Website: [http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20\(July%201\).pdf](http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf).
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- 3 Under-five child and maternal health, HIV/AIDS and malaria.
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- 7 This paper focuses on donor-funded RBF programmes which aim to incentivise health provider organisations to improve results; these programmes are distinct from performance-related pay programmes in which incentives are offered directly to individual health workers. Programmes operating at the organisational level (usually a health clinic or government institution managing a network of clinics) aim to improve the functioning of the entire organisation and allow it to iterate and adapt its model in order to improve health results.
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- 10 These theories for how RBF could work are discussed in the following report: Perakis, R and Savedoff, W. (2015). *Does Results-Based Aid Change Anything? Pecuniary Interests, Attention, Accountability and Discretion in Four Case Studies*. Retrieved from Center for Global Development Website: <http://www.cgdev.org/publication/does-results-based-aid-change-anything-pecuniary-interests-attention-accountability-and>.
- 11 This approach is known as an advance market commitment (AMC). One AMC agreement exists to increase the availability of pneumococcal vaccines for developing countries; under this agreement, official and private donors committed funds to guarantee the price of vaccines as an incentive for pharmaceutical companies to invest in research and development and provide vaccines at a price affordable to developing countries. Learn more: <http://www.gavi.org/funding/pneumococcal-amc/how-the-pneumococcal-amc-works/>.
- 12 International Bank for Reconstruction and Development (IBRD)/The World Bank (TWB). (2013). *Results-Based Financing for Health*, prepared for Africa Health Forum 2013: Finance and Capacity for Results, Washington, D.C. 2013. Retrieved from World Bank Website: <http://siteresources.worldbank.org/INTAFRICA/Resources/AHF-results-based-financing.pdf>; Grittner, A. (2013). *Results-based financing: Evidence from performance-based financing in the health sector* (Discussion Paper 6/2013). Retrieved from German Development Institute Website: <https://www.die-gdi.de/en/discussion-paper/article/results-based-financing-evidence-from-performance-based-financing-in-the-health-sector/>; Eichler, R. and R. Levine (eds.). (2009). *Performance Incentives for Global Health: Potential and Pitfalls*. (Washington, DC: CGD Books). Retrieved from <http://www.cgdev.org/publication/9781933286297-performance-incentives-global-health-potential-and-pitfalls>.
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- 21 For example, povertytools.org (USAID) and progressoutofpoverty.org (Grameen Foundation) provide tools to identify programme beneficiaries by wealth quintile using a simple set of questions.
- 22 Learn more about poverty measurement and targeting techniques here: <http://microcreditsummit.org/poverty-measurement-tools.html>.
- 23 Mumssen et al., 2010.
- 24 www.saludmesoamerica2015.org
- 25 Mumssen et al., 2010; Grittner, 2013; World Bank, 2013.
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1101 15th Street NW, Suite 1200
Washington, DC 20005
Tel +1 202 783 4800
General Inquiries info@action.org

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