

# RBF Contribution to the Improvement of Quality of Care: Case of Burkina Faso

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## Introduction

Burkina Faso is committed to achieving the Sustainable Development Goals (SDGs) following the Millennium Development Goals (MDGs). In this context, many initiatives have thus been adopted and implemented since the year 2000. While non-negligible, results obtained remained below expectations and the Ministry of Health, with the support of Technical and Financial Partners (TFPs), chose to implement innovative strategies, including Results-Based Financing (RBF).

This strategy began in the second quarter of 2011 with a pre-test phase in three health districts (Boulsa, Léo and Titao). After 18 months of implementation, three evaluations, one internal and two external, were carried out. Results showed encouraging trends, including the improvement of the quality of care in health facilities. Following this, the Ministry of Health of Burkina Faso received funding from the World Bank (WB) for the implementation of an RBF pilot in fifteen health districts (including the 3 districts of the pre-test phase test) from six regions, namely the regions of the Boucle du Mouhoun, of Center-East, Center-West, Center-North, of the North and South-West.

Launched on December 26, 2013, the strategy aims to purchase the results produced by the healthcare staff. It consists of paying subsidies related to quantity indicators, and a bonus linked to the quality of care, based on a separate list of indicators, both at the level of health facilities, and among the beneficiaries in the community. Thus, this strategy is opposed to conventional financing, in which the state often provided inputs without the opinion of the beneficiaries and without demanding results. In a context marked by the scarcity of resources and the debate about the quality of care in health facilities, the following question can be asked: Has RBF contributed to improving the quality of care and health services?

## Main Objective:

Show RBF's contribution to quality of care improvement in health facilities in Burkina Faso.

## Specific Objectives:

- ✓ Describe the evolution of technical quality scores in RBF health facilities during the first 18 months;
- ✓ Identify factors that could explain changes in these quality technical scores;
- ✓ Describe the effects produced during the implementation of RBF, which have an impact on the improvement of the quality of care;
- ✓ Identify lessons learned during the 18 months of implementation of RBF;
- ✓ Formulate recommendations for improving the quality of care in health facilities implementing RBF.

## Hypotheses:

- Main hypothesis:

The variations observed in the improvement of the quality of care are linked to internal and external factors to the health facilities under RBF.

- Secondary hypothesis:

1. The improvement in the quality of health care is linked to the presence of health facilities, human resources and sanitary equipment which meet the norms and standards of a health facility.
2. There are factors related to health care professionals that determine the improvement of quality of care in the health facilities involved in RBF.
3. The Improvement in the technical quality of health care is effective in health facilities where workers are supported by the supervisory structures.

**Methodology:**

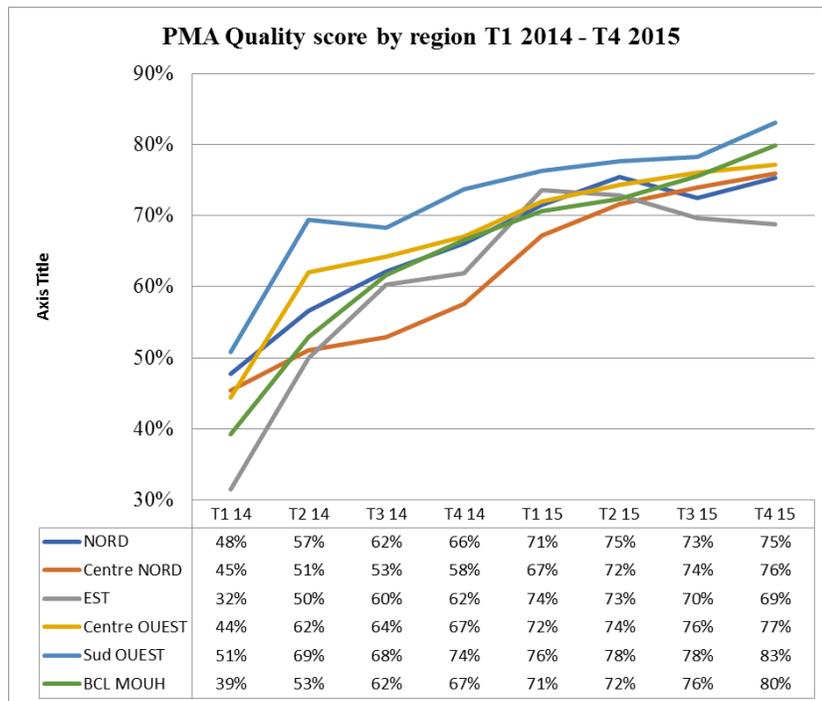
Based on the results of the quarterly qualitative checks carried out in primary and secondary level health facilities, a compilation followed by an analysis of the data was carried out. The minimum acceptable technical quality score from a structure with a qualitative check was 50%.

The following areas and verification elements were selected for quality verification in primary and secondary level health facilities, and are presented in Tables 1, 2 and 3 below. In Burkina Faso, there are two types of primary level health facility. The results below show these separately.

**Results**

The following graphs present the evolution of the quality scores from 2014 to 2015 obtained by the lower type of primary level health facility.

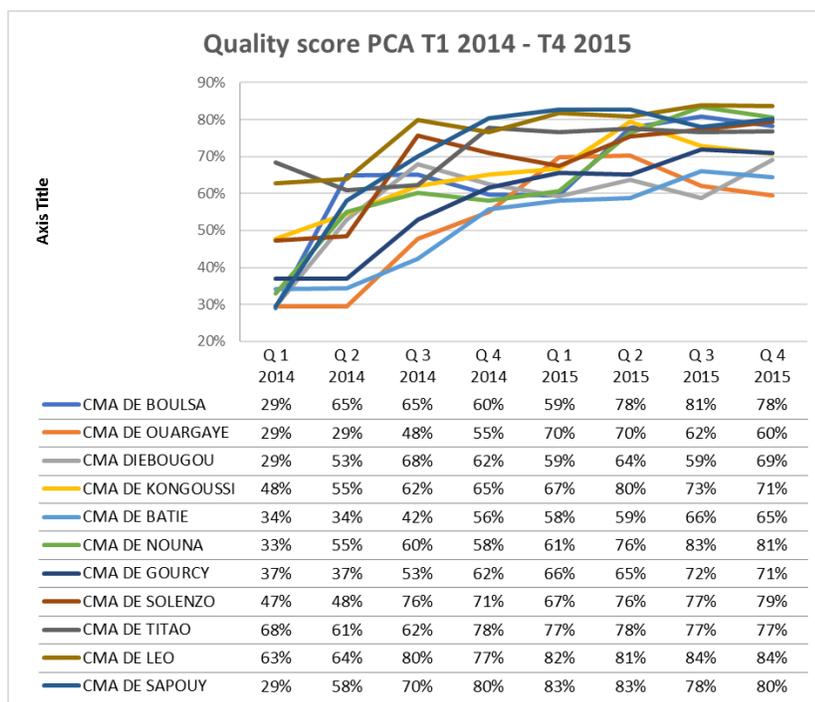
**Results 1: Evolution of Quality Scores from T1 2014 to T4 2015 at the 1st Echelon Level**



We observe an increasing trend in quality scores over these two years of implementation. Indeed, the average quality score for the first quarterly evaluation varied from 32% in the Center-East region to 51% in the South-West. Beginning in the second quarter of the year 2014, the average quality score in all regions remained above 50% and the trend was gradual to reach extremes of 69% and 83% respectively in the same regions.

## Results 2: Evolution of Quality Scores from T1 2014 to T4 2015 at the 2nd Echelon Level

The following graphs present the evolution of the quality scores from 2014 to 2015 obtained by the higher type of primary level health facility (called CMAs in Burkina Faso).



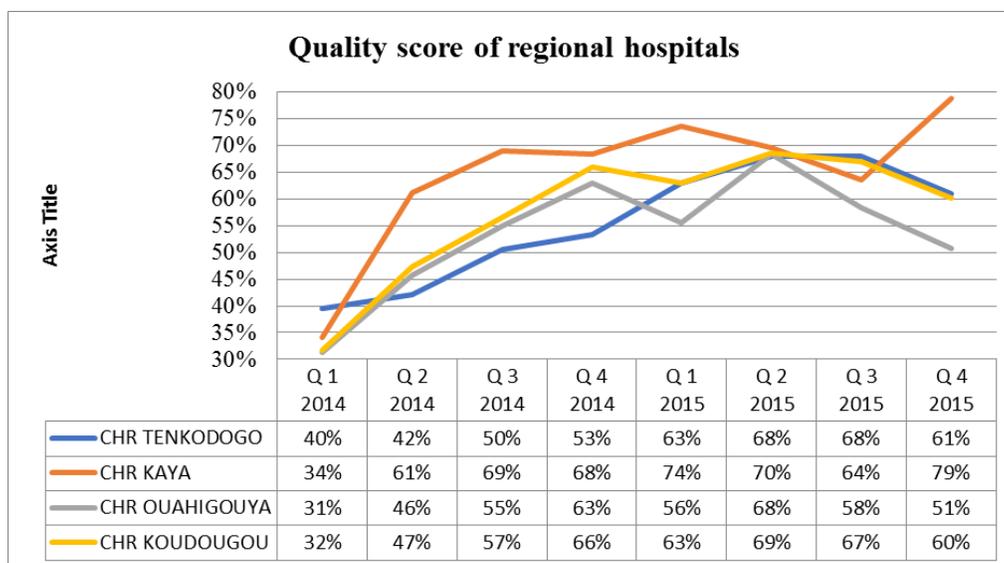
The shape of the curves is ascending in all the health facilities and is increasing.

Quality scores rose from lows of 29% (in the CMAs of Sapouy, Dédougou, Ouargaye respectively in the Center-West, South-West and Center-East regions) and 68% (at the CMA of Titao in the North region), and by the last quarter of analysis reached 60% (at the CMA of Ouargaye in the Center-East region) and 84% (at the CMA of Leo in the Center-West region). All CMAs crossed the 50% threshold of the quality score at the end of the first year of implementation and since then, the score has remained relatively high.

Between Q2 2014 et Q2 2015, we can see a positive increase in the curve, showing an improvement in the quality score. However between Q3 and Q4 2015, the scores stayed constant which could be linked to the modifications to the quality checklist, put in place by the RBF Unit in order to encourage greater effort on th part of the service providers.

## Results 3: Evolution of Quality Scores from T1 2014 to T4 2015 at Level 2

The following graphs show the evolution of the quality scores from 2014 to 2015 obtained by secondary level health facilities.



The quality scores are also upward in the two years of implementation at the secondary level.

In the regional hospitals, the first qualitative assessment gave initial quality scores varying between 32% in Ouahigouya and Koudougou and 40% in Tenkodogo. The threshold of 50% of the quality score was passed by all the CHRs from the third quarter of 2014. The evolution thereafter was different from one CHR to the next.

In general, the average technical quality scores of the facilities have increased little or not at all between the second quarter and the fourth quarter of 2015. This is partly due to the movement of health workers to other regions for personal reasons, and especially vocational training. On the other hand, it is the period when the subsidies that were to be used to finance the performance improvement plans of the same period were transferred. This has led to a demotivation of certain agents. Hence, some facilities have been able to maintain their level of performance, while others have decreased.

Hypotheses that Could Explain the Results:

*The Question May Be Asked: What Might Explain the Improvement in the Quality Score?*

We observe an improvement in quality scores, which could be explained by staff motivation, continuing training and coaching through quality checks, development and implementation of Performance Improvement Plans (PIPs), the forecasting of financial reserves in the index tool for reinforcement of equipment facilities, the assessment of beneficiaries through the community survey, the existence of availability of qualified staff, the availability of medicines and the existence of a stable socio-political environment.

#### 1. Staff Motivation:

Motivation can be external. The external motivation of the staff is none other than the financial incentives paid in the form of subsidies in which an individual premium calculated based on the criteria defined in the index tool belongs to each provider regardless of the wages that are regularly paid by the State. This individual premium is variable and depends on the productivity of the structure in terms of quantity and quality on one hand and the individual contribution of each provider on the other hand. Also, the quarterly presence of teams of quality auditors is also a definite aspect of the external motivation of the staff. This could explain the trend towards continuous improvement of technical quality scores in our case.

Motivation is also internal. Indeed, the obstacles to quality are first human. Quality cannot be decreed in an office. It is not enough to write a procedure, a standard or a protocol to make things move forward. RBF created a business dynamic in health facilities where providers are pleased to see their business grow. This could explain the correct appropriation of standards and protocols and especially their respect, the upgrading of structures, the improvement of users' reception conditions; all of which contributes to the improvement of the quality of care.

## 2. Qualitative Assessments

They measure the discrepancies between the desired quality (contained in the RBF quality criteria) and the achieved quality (the level obtained by the structures implementing the RBF). They also assess the discrepancies between the expected quality (mainly represented in our context by the welcome at facilities) and the perceived quality of the satisfaction of the users. Thus, they highlight the dysfunctions that the facilities work to solve by a virtuous circle of quality approach, namely to plan, implement, verify and act to improve quality. This RBF mechanism, which is consistent in our context, could partly explain the progress of the quality scores obtained during this period of RBF implementation in Burkina Faso and could positively impact the quality of care.

## 3. Some Effects that Can Improve the Quality of Care

During the implementation of RBF, several effects were noted:

- The improvement of the welcome of users of health services, with the creation and identification of a reception service, the purchase of benches and chairs for patients, curtain and screen manufacturing to ensure visual discretion;
- The improvement of the care supply with the purchase of medical and technical equipment (e.g. oxygen balloon, pedal vacuum cleaner, beds, mattress, delivery table, consultation table, etc.), the use of mosquito nets by all patients placed under observation or hospitalized and contracting with qualified agents to carry out quality care;
- The reinforcement of infrastructures with the construction of stores for the sale of essential generic medicines, housing for agents and standardization of certain centers (construction of clinic or maternity);
- The reinforcement of transport through the acquisition of motorcycles for prevention activities in catchment areas.

## Limitations

The mixing of process and outcome indicators in the assessment of quality scores could be a limit to linking the high-quality score to the quality of care.

## Lessons Learned

One can retain the following from the implementation of RBF in Burkina Faso:

The high level of technical quality scores obtained under conditions combining staff motivation, which is itself supported by regular quarterly assessments and the allocation of subsidies, necessarily produces effects in the improvement of quality of care.

## Conclusion

RBF is an innovative financing strategy for Burkina Faso. Its implementation has contributed to improving the quality of care in the light of the increasing evolution of quality scores in the pilot facilities. However, there are limitations to the implementation of RBF in Burkina Faso, and actions should be taken to get rid of them, which would optimize the achievement of health objectives.

## ANNEXES

Table1: Elements of quality verification at the first echelon

N°	Areas	Elements of verification
1	General indicators	General indicators
		Maintenance of data collection tools
2	Infrastructures – Equipment – Infections prevention	Users' reception conditions
		Availability of the medico-technical equipment
		Infections prevention
3	Medicines consumables and	Medicines, consumables and inputs management
		Consumables preservation standard compliance and of some activities implementation
4	Financial planning and management	Financial management
		performance improvement plan (PIP)
5	Home visits	
6	Curative consultations and observation	Support of new consultants of 5 years and over, received in CCI
		Care for sick children from 2 months to under 5 years
		Patients' observation
7	Children's health	vaccination of children from 0 to 11 months,
		consultation of healthy newborns from 0 to 11 months
		consultation of healthy newborns from 12 to 23 months
8	Mother's health	prenatal consultations
		post-partum consultations
		delivery
		PF (any method)
9	Malnutrition	Care of malnourished children from 6 to 59 months (MAM)
		Care of malnourished children from 6 to 59 months (MAS without complication)
10	HIV/AIDS	HIV infection screening
		Care of HIV - positive pregnant woman
		Follow up of PLWHIV under ARV
		PTME protocol application for newborns of HIV-positive mothers
11	Tuberculosis	Tuberculosis screening
		Care of treated and cured cases of TB (TPM+)

N°	Areas	Elements of verification
TOTAL		

Table 2: Elements of quality verification at the second echelon

N°	Areas	Elements of verification
1	General indicators	General indicators
		Maintenance of data collection tools
2	Infrastructures – Equipment – Infections prevention	Users' reception conditions
		Availability of the medico-technical equipment
		Infections prevention
3	Medicines and consumables	Medicines, consumables and inputs management
		Standard compliance, some activities implementation
4	Financial, equipment and property planning and management	Financial management
		Performance improvement plan (PIP)
5	Out-patient consultations and contraindications	Out-patient consultations
		Contraindications implemented and forwarded to the CISSE/SIM
6	Children's health	Care of children from 29 days to 59 months (per the TETU approach)
		Newborns' emergencies response
		Qualitative evaluation of the care of severe acute malnutrition cases with complications
7	Hospitalization and surgery	Hospitalizations
		Major surgical interventions
8	Mother's health	Assisted normal delivery
		Caesarian section
		Care of EPs
		Dystocic deliveries
		Prenatal consultations
		Post-partum consultations
		Post-abortion care
		Care of users of PF (Oral contraceptives, injections, IUD, implants)
		Care of users of PF (tubal ligation)
9	HIV/AIDS	Voluntary HIV infection screening
		ARV protocol application for pregnant women with HIV
		Care of newborns of HIV+ women
		Initiation of PLWHIV to ARV
		Follow up of PLWHIV under ARV

N°	Areas	Elements of verification
10	Tuberculosis	TPM+ cases screening
		Care of treated and cured cases of TB (TPM+)
<b>TOTAL</b>		

Table 3: Elements of quality verification at the 2nd level

N°	Areas	Elements of verification
1	General indicators	General indicators
		Maintenance of data collection tools
2	Infrastructures – Equipment – Infections prevention	Users' reception conditions
		Availability of the medico-technical equipment
		Infections prevention
3	Medicines and consumables	Medicines, consumables and inputs management
		Standard compliance and some activities implementation
4	Financial, equipment and property planning and management	Financial management
		Performance improvement plan (PIP)
5	Out-patient consultations and contraindications	Out-patient consultations
		Contraindications implemented and forwarded to the CISSE/SIM
6	Children's health	Care of children from 29 days to 59 months (per the TETU approach)
		Newborns' emergencies response
		Qualitative evaluation of the care of severe acute malnutrition cases with complications
7	Hospitalizations and surgery	Hospitalizations
		Major surgical interventions
8	Mother's health	Assisted normal delivery
		Caesarian section
		Care of EPs
		Dystocic deliveries
		Prenatal consultations
		Post-partum consultations
		Post-abortion care
		Care of users of PF (Oral contraceptives, injections, IUD, implants)
Care of users of PF (tubal ligation)		
9	HIV/AIDS	Voluntary HIV infection screening

N°	Areas	Elements of verification
		ARV protocol application for pregnant women with HIV
		Care of newborns of HIV+ women
		Initiation of PLWHIV to ARV
		Follow up of PLWHIV under ARV
10	Tuberculosis	TPM+ cases screening
		Care of treated and cured cases of TB (TPM+)
<b>TOTAL</b>		