PERFORMANCE AND RESULTS BASED FINANCING OF HEALTH SERVICES IN BURUNDI

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The problem

- Insufficient and poorly trained staff, unequally distributed
- Poorly motivated staff with high turnover and attrition rates
- Poor quality of health services
- Lack of reliable health information
- Frequent stock-outs of essential medicines
- Excessive administrative centralisation
- Lack of involvement of the community in the management of health services
- Weak health sector coordination

Health system inefficiencies
The manifestations

- High rates of malnutrition < 5: acute malnutrition 6-17%; severe acute malnutrition 1.1-4.1%
- Rising incidence of infectious diseases:
  - TB incidence per 100,000: from 294 in 1994 to 328 in 1998.
- Maternal and child health indicators on the red side:
  - Very high MMR
  - Very high <5, infant and neonatal mortality rates
The causes

- War: deceased, displaced, poorly trained and paid human resources, brain drain of specialized health personnel
- Difficulties in health technologies and supplies
- Extreme poverty
- Lack of efficiency of service delivery
- Low institutional and organisational capacity
- Lack of intersectoral collaboration
The consequences

- Magnitude and impact on health policy objectives:
  - humanitarian and emergency health system, no development of health system
  - Poor coordination of health actors

- Distributional consequences
  - Local NGOs (HIV/AIDS) and international NGOs benefited
  - Ethics: Discharged patients remained detained in the hospitals
  - Vertical health programs and parallel supply channels

- Victims
  - Health workers: poorly trained, working in inadequate facilities located in remote areas without necessary equipment and drugs.
  - Population: obstacles in accessing health services including financial barriers, thus the need for stimulating the ‘demand side’.

Health system inefficiencies
Health system financing reforms

- Presidential Decree establishing free health care for children under 5 and pregnant women (2006)
- National policy on contracting health services delivery (2006)
- Beginning of first pilots on PBF in some provinces (2006)
- National consensus declaration on merging PBF and free health services in a single strategy (2009)
- Scaling up nation wide of PBF (2010)
- Revision of legal texts relating to the « Carte d’Assistance Médicale » - CAM (May 2013)
- Procedures Manual I and II
1. Performance-based financing (PBF)

- Where to start?
  - Why fund the demand if the system is inefficient? Why strengthen the supply if barriers prevent access?
  - Original response by the GoB: Financing reforms that strongly deviate from pure ‘input based financing’.

- Definition:
  - A cash payment or non-monetary transfer to manager, provider, payer or consumer of health services after predefined results have been attained and verified

- Actors:
  - MoH or delegated bodies and a wide range of service providers

- Principles:
  - Separation of regulation, control, service provision, financing.

Health system reforms
2. Free services (pregnant women & children <5

- Combined with PBF, aiming at fulfilling MDG 4 and 5
- Sudden dramatic increase in the utilization of health services
- Health system performance deteriorated; not prepared for sudden surge in demand
- Central administration had difficulties in coping with a sudden influx of invoices and administrative charges
- Merging with PBF improved efficiency of reimbursement, and application of verification system
- Reimbursement time dropped from 84 days to 45 days.

Health system reforms
3. Carte d’Assistance Médicale (CAM)

- A precursor to a medical insurance card to improve access to care for the people in the informal sector (Carte d’assistance médicale” - CAM: 1984, 1992)
- Underfunded, 56 Billion to 7.5 Billion available from government and subscription fees
- Renewal of subscription less than 1%
- Fate: Risk of a second collapse if no corrective measures taken.

Health system reforms
Addressing the problem

- High level forum of the health sector that identified the problems
- Free health care decree for pregnant women and <5 children
- PBF pilot phase
- National policy on contracting out health services adopted
- National consensus between the GoB, civil society and donors
- Implementation done by experienced international NGO
- Joint management of the process by government, civil society and donors
Effects of the reform

- Success: utilization rate, quality of care, permanent services, autonomy, staff distribution, stability of staff, etc.
- Negative aspects: neglect of non-subsidized services
- Origin of the success: political will, coupling with free health care
- PBF improved planning, HMIS, autonomy, business, motivation, beneficiary voice and community participation
- Consequences: Jealousy from other public services, pervert effects
- Outcomes: Access to health services increased significantly; which specific proportion is unknown?
PBF: Policy implications and lessons

- Policy implications: PBF is being explored in education and agricultural sectors

- Lessons learned from PBF combined with free health care:
  - Human Resources: the PBF improved stability of personnel and autonomy of health facilities. More effective decentralisation
  - Essential medicines availability improved
  - Health information system improved greatly
  - Governance improved by internal and external evaluations, cost studies, newsletters, and annual reports
  - Planning and budgeting
  - Community involvement
  - Quality of care
  - Accountability, PPP, etc.

Lessons learned
Lessons from CAM

• CAM objective: extend social health insurance of services not included in free care to the informal sector.

• Questions:
  o A system of fixed annual contributions on a voluntary basis requires a heavy administrative system, subscription very little;
  o CAM designed for the very poor: errors of inclusion and exclusion in a country with very high poverty levels;
  o CAM: transition for the development of a national social health insurance system, but with 2% of the population = over ambitious
  o CAM weakness: does not address inequities in the health system with its uniform fixed subscription for the very poor and well-to-do people.
THANK YOU