BURUNDI'S NATIONAL PERFORMANCE BASED FINANCING (PBF) PROGRAM

# Results Based Financing At The World Bank

PREPARED BY KATHRYN BOATENG (HDNHE) AND GYÖRGY BÈLA FRITSCHE (HDNHE). CLEARED BY: ANDREW SUNIL RAJKUMAR (TBD)

**PROJECT NAME:** Burundi's National Performance Based Financing (PBF) Program

**PROJECT ID:** P101160

**UNIT:** AFTHE

**TIME PERIOD:** 2009-2012

**TTL:** Andrew Sunil Rajkumar

**AMOUNT (USD):** $25 million

**LENDING INSTRUMENT:** IDA Grant (IDA is an estimated 24% of total available funds for the period 2010-2012)

**RBF COMPONENT OR PROJECT:** Project

**PILOT (Y/N):** No

| Characteristic | Description |
|---|---|
| CONTEXT AND RATIONALE | Burundi's national PBF program was introduced in April 2010. It is the second sub-Saharan African Country – after Rwanda- to scale up its PBF program nationwide. In 2006, a PBF pilot was implemented in one province by the international non-governmental organization (NGO) Cordaid. By the end of 2009, 9 out of 17 provinces were covered by PBF pilot programs, through the work of three implementing international agencies (although only a limited number of districts in the province were covered in many cases). The program was merged with the previous 'selective free health care' policy, which provided free health care to children under 5 and to pregnant women. The government is one of the main financiers of the program ensuring that providers of previously free health services are subsidized more effectively. Government's involvement has also been important to ensure that emphasis is put on the strategic purchasing of basic essential health services necessary for reaching the Millennium Development Goals. |
| OBJECTIVE OF PROGRAM | The program's objectives are to: (i) improve utilization of maternal and child health care services offered to the population; (ii) increase the presence of health personnel in peripheral areas; (iii) motivate and stabilize the existing personnel; (iv) increase quality of care at the health facility level; (v) overcome weaknesses in organization and management of the health care system; (vi) increase health center autonomy; and (vii) make health care more financially accessible for the population. |
| BENEFICIARIES | Currently, the program is covering the entire nation's population. It contracts public and faith-based organizations, and sub-contracts private-for-profit providers to deliver services such as curative care and family planning services. The intervention has been implemented throughout the entire health system: beginning with the community and health center level where a basic package of health services is provided to first-level referral hospitals that provide a complementary package of health services. National (tertiary) hospitals are also included in the performance scheme. A web-enabled database has been created and allows for accurate and transparent data collection, data analysis, strategic purchasing, contract management, and invoicing. |
| TYPE OF RBF INTERVENTION | Performance-Based Financing (PBF)—a supply-side RBF program; a 'fee-for-service–conditional-on-quality of care' mechanism that rewards hospitals and health facilities with monthly payments determined by service utilization levels and performance on quality measures. |
| TYPE AND AMOUNT OF INCENTIVE PROVIDED | This program applies the 'carrot and carrot' method, whereby a health facility can earn up to 25% more of its regular monthly earnings if it attains 100% of its quality-related target goals. Accordingly, if the facility achieves less than 100%, it receives only a fraction of the 25% bonus payment. There is no bonus payment for scores between 50% and 70%. The facility is penalized for a score below 50% by losing 25% of its previous quarter earnings. The quality measure is calculated using 60% of the score obtained through the quantitative quality checklist, and 40% of the score from the community client satisfaction surveys. Some adjustments will soon, however, be introduced for the method of calculating the quality-related bonus payment. |

| Characteristic | Description |
|---|---|
| **PAYMENT RULES AND MECHANISM** | Health facilities receive payments based on quantitative and qualitative measurements. Utilization-related quantitative payments are paid monthly, while quality-related payments are paid in quarterly bonuses. Each quarter, these quality bonus amounts are paid as a lump sum together with the facility's monthly PBF earnings. Facilities have considerable management autonomy in allocating the payments to the staff or to service quality improvements. However, there is a limit on the percentage of each payment in any given month that can go toward individual staff incentive payments. The remaining percentage must go towards service quality improvements, such as purchasing drugs, improving the functioning of the health center and to other investments. PBF related payments constitute only part of a health facility's overall income; the remainder comes from government subsidies for salaries and drugs, out-of-pocket fees and other sources. |
| **INDICATORS/SERVICES AND STRATEGIC PURCHASING** | There are 24 indicators and services included in the basic health care package. These include new curative consultation (under five years of age and above five years of age); one in-patient day (under five years of age and above five years of age); minor surgery; referral and patient arrived at the hospital; fully vaccinated children; tetanus 2-5 for pregnant women; distribution of insecticide treated bed nets; latrines constructed; HIV+ pregnant woman put under ART protocol; child born to an HIV+ mother taken care off; VCT; new clients put under ART treatment; clients under ART followed up six-monthly; STD treated; diagnosis of an AFB+ PTB patient; PTB patient cured; new curative consultation for a pregnant woman; institutional delivery; family planning: total of new and existing users accepting a three-month course of modern FP methods; family planning: implants or IUD; postnatal consultation and three ANC visits.<br><br>The complementary service package comprises of 24 indicators and services. These include: new curative consultation by an MD (under five years of age and above five years of age); new curative consultation for a pregnant women by an MD; counter-referral arrived at the health center; major surgery; minor surgery; institutional delivery; CS; complicated delivery; one admission day (for children under five years and above five years of age); HIV+ pregnant woman put under ART protocol; child born to an HIV+ mother taken care off; VCT; new clients put under ART treatment; clients under ART followed up six-monthly; STD treated; diagnosis of an AFB+ PTB patient; PTB patient cured; total of new and existing users accepting a three-month course of modern FP methods; family planning: implants or IUD; family planning: BTL and vasectomy; postnatal consultation and ANC visit.<br><br>Quality indicators are organized through a quantified quality checklist or balanced scorecard. The scorecard is calculated to generate one composite quality measure. The health center quality checklist contains 109 composite indicators with hundreds of data elements. These are across 14 service areas which include administration and financial management, but are predominantly clinical service areas. The hospital quality checklist contains 110 composite indicators with hundreds of data elements. These are across 12 service areas including management, financial management, planning and stock management.<br><br>Sixty percent of the quality performance comes from these quality checklists; forty percent comes from community client surveys assessing (a) the accuracy of the quantitative data reported; (b) the absence of phantom patients; (c) the actual delivery of the services reported; and (d) user satisfaction. If the score totals 100%, the health facility can earn a bonus of 25% of the total earnings over the past three months.<br><br>The provincial verification and validation committees also known as the Comité Provincial de Vérification et de Validation (CPVV) negotiate purchase contracts and business plans with health facilities. The business plans are an integral part of the purchase contracts, and health facilities are required to give detailed accounts of how they plan to achieve certain quantitative targets (volume targets) across all 24 indicators and services while improving quality. The CPVV's manage the purchase of contracts through issuing, and if need be, through quarterly amendments. The contract amendments, and the actual unit fees of these services, can be managed easily through the web-enabled application. Also, CPVVs are able to allocate higher sets of unit fees (within a range of 0%-40% in four increments) to poor health facilities, thereby ensuring that more money goes towards those facilities that need it the most. |
| **MONITORING AND VERIFICATION PROCESS** | CPVV controllers conduct monthly verification of reported data. Random quarterly community client satisfaction surveys are undertaken by local grassroots organizations to verify if service has actually been provided. District and provincial health offices, the Central Technical Support Unit, and the CPVV, operate under output-based performance frameworks, with significant financial incentives. An independent third party agency randomly counter-verifies the reported performance at all levels of the health system. |

| Characteristic | Description |
|---|---|
| **INSTITUTIONAL ARRANGEMENTS AND ROLES** | The institutional mechanisms of the national PBF system in Burundi are determined by a series of nine contracts. In collaboration with the central Ministry of Health (MOH), the CPVV is responsible for strategic purchasing, verification and coaching of health facilities. CPVV contracts grassroots organizations to conduct community client satisfaction surveys under performance-based frameworks. Administrative structures are paid on a quarterly basis, depending on their performance results. Civil society and non-state actors are engaged at the central and provincial levels for technical assistance and capacity building, and at the grassroots level for the community client surveys. |
| **CONTRACTUAL ARRANGEMENTS** | An internal/quasi-market using a contracting-in modality has been created, and is characterized by a set of nine contracts or service agreements. These arrangements are between the following entities: MOH and the Central Technical Support Unit; MOH and the CPVVs; MOH and the provincial and district health bureaus; CPVVs and the health providers; and CPVVs and local grassroots organizations. Primary contract holders can sub-contract other providers for defined services. Horizontal equity is made operational by ring-fencing provincial PBF output budgets: the best financed province receives 41% more budget per capita than the least financed one based on a set of five criteria. Within provinces, there are two separate ring-fenced budgets: one for the basic package and one for the complementary package of health services, with a ratio of 2/3 going to the basic package, and 1/3 going to the complementary package. The CPVVs put their health facilities in five categories, of which the worst-off health facility receives 40% higher unit fees than the best-off. The rationale for structuring the system this way is to provide more money to health facilities in the poorer regions, where the lowest baselines related to infrastructure and staffing can be found. |
| **EVALUATION STRATEGY AND RESULTS** | The program is in its early stages and no impact evaluations have been conducted. A large longitudinal household survey (2006-2010) documenting changes in PBF and non-PBF provinces, is available. In addition, baseline nationwide surveys of households and health facilities were conducted just before the national rollout in April 2010. Furthermore, a comprehensive review overseen by a team of external experts (with precise recommendations provided) took place in September 2010, and will be followed by similar reviews once every six months. |
| **STATUS REPORT** | Regular inter-agency assessments began in September 2010. Other pipeline initiatives planned for the program include smaller scale comparative studies, using both quantitative and qualitative analytical tools. Early evidence points to significant increases in utilization in a relatively short period of time: for example, curative care utilization rose from 1.16 visits per child in 2009 to 1.6 visits per child in 2010; institutional deliveries increased from 51% to 62%; and the number of monthly VCT tests increased from 36,356 to 45,495. |

**LINKS TO REFERENCES AND OTHER WEB RESOURCES**


**Peerenboom, P.B. (2010)**. "Montage institutionnel Burundi. Niveau provincial". Présentation; "Manuel des procédures pour la mise en œuvre du financement base sur la performance au BURUNDI." Ministry of Public Health: 2010, can be accessed through http://performancebasedfinancing.wordpress.com/

**Basenya, O. (2009)**. "Le financement de la santé basé sur la performance au Burundi. Des expériences pilotes à la mise à échelle."Presentation. Pay for Performance for Improved Health in Burundi (USAID, HS 20/20, 2010), can be accessed through http://performancebasedfinancing.wordpress.com/

**Bertone, M. and Bruno Meessen (2010)**. "Splitting Functions in a Local Health System: Early Lessons from Bubanza and Ngozi Projects in Burundi". Cordaid, can be accessed through http://performancebasedfinancing.wordpress.com/

**Busogoro, Jean-Francoise and Alix Beith (2010)** Pay for Performance for Improved Health in Burundi. Available at http://www.healthsystems2020.org/content/resource/detail/2575/

**Fritsche, G and Vergeer, P (2010)** Performance-Based Financing Drill Down (Burundi case study part of the two-day RBF extension to the WBI flagship course on Health Sector Reform and Sustainable Financing). Copy on file with authors.