Burundi: Transparency and Accountability in the Management of Free Healthcare Using Performance-Based Financing

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This publication is the result of a capitalization process that took place in Burundi in 2014/2015. The aim of capitalization is to surface and generate lessons learned from implementing PBF that can be used by other to learn about new or promising practices or to influence policies on the basis of real-life experiences. The process was facilitated by Jurien Toonen and Christel Jansen from KIT Health .

ACRONYMS

COGE	Management Committee
COSA	Health Committee
CPA	Complementary Package of Activities
CPSD	Consultation and Partnership Framework for Health and Development
DGSSLS	General Directorate for Health Services and the Fight against AIDS
DHO	District Health Office
FOSA	Health Facility
FP	Family Planning
GCHW	Grouping of Community Health Workers
GDPH	General Directorate for Public Health
GDR	General Directorate for Resources
HC	Health Center
LOAS	Local Associations
MPA	Minimum Package of Activities
MSPLS	Ministry of Public Health and Fight against AIDS
NGO	Non-Governmental Organization
NHIS	National Health Information System
PBF	Performance-Based Financing
PHO	Provincial Health Office
PVVC	Provincial Validation and Verification Committee
TFP	Technical and Financial Partners
TU-PBF	Technical unit – Performance-Based Financing

INTRODUCTION

In 2006, the Government of Burundi introduced free healthcare for children under 5 as well as for delivery care, including cesareans. In 2009, it extended this measure to pregnancy-related conditions, starting at conception. The introduction of a free healthcare policy presented many difficulties for health facilities (FOSAs): excessive use of services, demotivation and increased workload for human resources for health, and lack of medicine and equipment. These issues were partly due to the fact that no feasibility study was carried out prior to the implementation of the free healthcare policy. Moreover, overbilling of free healthcare services, the enrollment of non-existing patients and discrepancies between cases declared through invoices and those reported in the national health information system (NHIS). Healthcare providers have a heavy workload, as they have to declare services provided both for the free healthcare scheme and for the NHIS.

At the central level, invoices transmitted by FOSAs are not controlled: claims established by the General Directorate for Resources (GDR) are sent to the Ministry of Finance for payment after a simple arithmetic verification. This issue, coupled with repetitive delays in reimbursing health facilities caused by a lack of allocated funds, considerably compromised the efficient implementation of this measure.

To address these issues, which are frequent when free healthcare policies are applied[1], Burundi through its Ministry of Public Health and for the Fight against AIDS (MSPLS) decided to finance the free healthcare package through Performance-Based Financing (PBF). As a result, PBF was scaled up at the national level as of April 2010[2]. In 2010, the MSPLS as well as Technical and Financial Partners (TFPs) decided to reimburse free healthcare across the country, using PBF. As a result, a consensus statement was developed, a procedure manual was prepared and adopted, and implementation bodies were established. The integrated PBF-free healthcare mechanisms generated positive results, including improving the governance of the free healthcare scheme.

This analysis focuses mainly on how PBF improved two key dimensions of governance in the Burundian health system: accountability and transparency. This analysis builds on the definition of governance created Barbazza and Tello[3], which includes the following sub-functions for the health sector: accountability; partnerships; policy formulation and strategies; information generation and intelligence; adequate organization; participation and consensus; regulation; and, transparency.

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[1] Valéry Ridde, Emilie Robert and Bruno Meessen. Les pressions exercées par l'abolition du paiement des soins sur les systèmes de santé. World Health Report (2010) Background Paper, No 18.

[2] Indeed, in 2006, in parallel to the free health care policy, a national contracting policy had been adopted with the aim of governing contractual relations established between different actors of the health system. In line with this policy, several NGOs were piloting PBF in three provinces. After obtaining convincing results, these pilots were progressively extended, first to 9 provinces as of 2008 and then to the whole country in 2010 (in compliance to the Procedures Manual for the implementation of PBF).

[3] E. Barbazza, J.E.Tello, 2014. A review of health governance: Definitions, dimensions and tools to govern. Health Policy 116; 1–11.

PBF AND THE SEPARATION OF FUNCTIONS

Performance-based contracts and performance-based payment techniques help improve accountability[4]. Through improved data verification and information at different levels of the Burundian health system, PBF increases accountability in the management of free healthcare funds. In line with the principle of function separation, verification is an essential PBF function, especially in terms of: (i) regulation, planning and quality assurance; (ii) service provision; (iii) contracting and verification; (iv) payment; and, (v) community representation[5].

These five functions exist in the institutional framework of the PBF-free healthcare scheme implemented in Burundi. As defined in the PBF procedure manual, they are grouped in four sets of functions: (i) the regulation function, comprising planning and quality assurance; (ii) the service delivery function; (iii) the verification function, which also includes contracting and community representation through community surveys; and, (iv) the purchasing function, related to payments.

This clear distribution of roles and responsibilities as well as function separation enable an objective verification of services and limit conflicts of interests among key actors of the health system[6]. This institutional framework is detailed in Annex 1[7]. It includes all PBF implementation stakeholders: from the central level of the MSPLS up to the community level, including PBF implementation bodies at the operational level (PHO, DHO and PVVC), stakeholders, paramedical schools and health facilities (hospitals and health centres).

PBF AND TRANSPARENCY

The availability and accessibility of verified information is a key condition to control the separation of functions (balance and control). For PBF-free healthcare in Burundi, transparency was improved by making data readily available to guide resource allocation and public expenditures. Transparency was also enhanced because of the availability of verified performance data[8].

In the context of expenditure monitoring carried out by FOSAs, the use of the indice tool[9] guides FOSAs when they determine the portion of net profits that must be allocated to operational activities and to other expenditures as well as establish the proportion to be used to pay staff performance premiums. This information is used by auditors from the central level (General Directorate for Resources) to evaluate the extent to which FOSAs conform to norms regarding subsidies as well as funds generated through their activities. The results of this evaluation are used to help report to management and, when necessary, provide recommendations for improved fund management practices.

Moreover, payment-related data and service delivery-related data are made available on the PBF website[10], enabling close monitoring of results and the measuring of the effect of PBF on health indicators as well as on management-related performance indicators. This information is accessible to all implementing partners and for each person wanting to consult the database, as long as they make the request.

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[4] Ibid.

[5] Cordaid-SINA, PBF Course Manual. Fourth edition. V251113.

[6] MSPLS (2014). Manuel des procédures de mise en œuvre du financement basé sur la performance, 3ème édition, 2013.

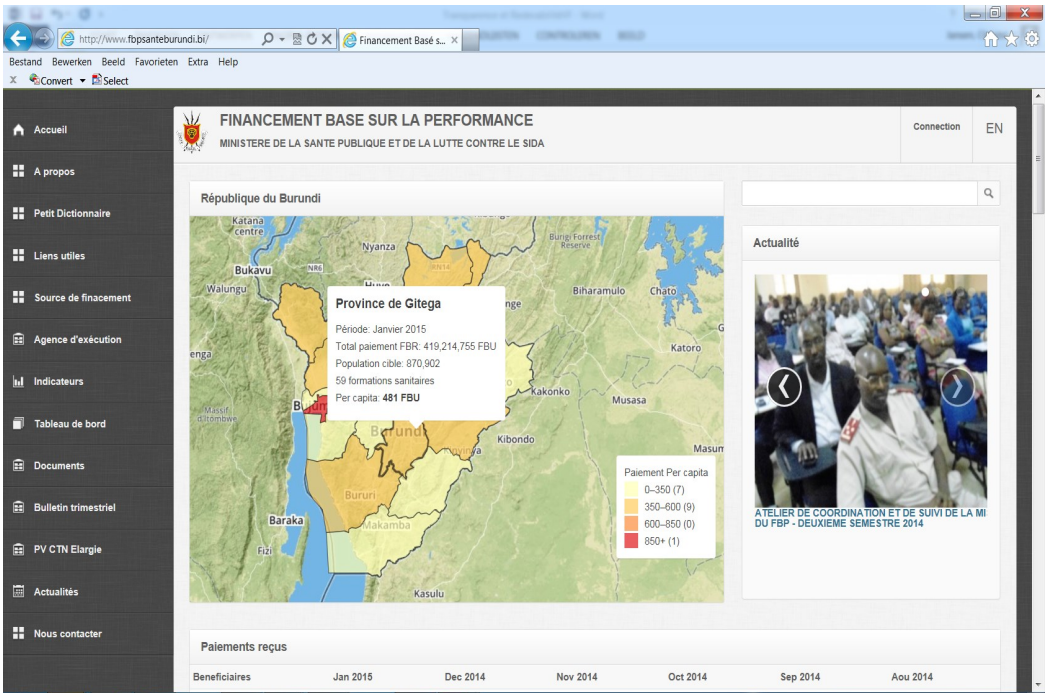
[7] Basenya O, Nimpagaritse M. et.al. Le financement basé sur la performance comme stratégie pour améliorer la mise en œuvre de la gratuité des soins: premières leçons de l'expérience du Burundi. PBF CoP Working paper numéro 5, 2011.

[8] More information on the verification process and on calculations related to health facilities' scores is available at : http://www.rbfhealth.org/publication/verification-performance-results-based-financing-case-burundi

[9] Revenue management tool for health facilities and for partners who participate in the financing of PBF-free health care.

[10] http://www.fbpsanteburundi.bi/

Figure 1 : PBF web site (Source: www.fbpsanteburundi.ni)



Different stakeholders use this information to assess the evolution of different indicators, identify services in need of improvement, and monitor health provinces' budget consumption over time, thereby improving the transparency of PBF implementation. PBF-related data is also used at the central level to increase the accountability of poorly performing provincial officers, identify the activities in need of support, supervision or requiring further research. This data can also be utilized by the MSPLS and TFPs to detect areas requiring support, either in the form of interventions or in the form of financing.

Moreover, service delivery validation reports are achieved at the level of the PVVC and the TU-PBF and can be consulted at any time by PBF implementing bodies at the operational level (HPB, DHO, PVVC), the TFPs intervening in these HPBs and DHOs, administrative officers, or any other person wanting to obtain information on this data. They use the information to monitor FOSA performance, which increases transparency and accountability.

Finally, verification, validation and counter-validation procedures of the PBF system enabled to improve the quality of NHIS data. Indeed, PVVC verify the monthly quantitative invoices based on NHIS reports elaborated by FOSAs.

- The first step of this verification consists in verifying the existence of the NHIS report. If the NHIS report is unavailable, the invoice issued by the FOSA is cancelled for the verified month. The verification however continues.
- The second step involves comparing declared data with data reported in the NHIS. If the NHIS report is unavailable, registry data is used in its stead. Only data linked to data from the NHIS report will be taken into account for the next step of the verification process.
- The third step entails triangulating data obtained from other sources: consultation registries, laboratory and medicine management registries, consultation forms as well as input management forms. It is this last step that provides the verified data that is taken into account for the establishment and validation of invoices (see Figure 2 and 3).

Figure 2 : FOSA monthly invoice

REPUBLIQUE DU BURUNDI

MINISTERE DE LA SANTE PUBLIQUE
ET DE LA LUTTE CONTRE LE SIDA

FACTURE MENSUELLE DE FORMATION SANITAIRE

PROVINCE : MURAMVYA **FORMATION SANITAIRE :** CDS Bugarama
DISTRICT : MURAMVYA **PERIODE :** Mai 2014

No	Indicateur	Qtté Déclarée	Qtté Vérifiée	Ecart	% Ecart	Qtté Validée	Tarif Unitaire	Montant FBU
1	Nouvelle Consultation Curative (> 5 ans)	685	653	-32	-4.67	653	270	176,310
2	Nouvelle Consultation Curative (	1,112	1,114	2	0.18	1,110	600	666,000
3	Journée d'hospitalisation > 5 ans	37	36	-1	-2.7	36	440	15,840
4	Journée d'hospitalisation	0	0	0	0	0	950	0
5	Petite chirurgie	2	2	0	0	2	2,600	5,200
6	Référence et patient arrivé à l'hopital	7	10	3	42.86	10	2,700	0
7	Enfants complétement vaccinés	91	91	0	0	91	3,500	318,500
8	Femmes enceintes VAT completement vacciné	117	117	0	0	117	1,400	163,800
9	Femme enceinte VIH+ mise sous protocole ARV prophyl	0	0	0	0	0	15,500	0
10	Prise en charge du nouveau né d'une femme VIH +	0	0	0	0	0	15,500	0
11	Dépistage volontaire du VIH/SIDA	75	75	0	0	75	2,000	150,000
12	Nombre de nouveaux cas sous ARV	0	0	0	0	0	15,500	0
13	Nombre de clients ARV suivi semestriellement	0	0	0	0	0	45,000	0
14	Cas des IST traitées	26	21	-5	-19.23	21	1,000	18,900
15	Dépistage des cas TBC positifs par mois	2	2	0	0	2	17,000	34,000
16	Nombre de cas TBC traités pendant une semestre et guéris	1	1	0	0	1	40,000	40,000
17	Nouvelle Consultations Curative Femme Enceinte	35	36	1	2.86	36	3,700	133,200
18	Accouchement eutocique	34	34	0	0	34	21,000	714,000
19	FP: Tot. Nouveaux + Anciennes Acceptantes	94	94	0	0	94	5,500	517,000
20	FP: Implants et DIU	36	36	0	0	36	15,000	540,000
21	Consultation postnatale	19	19	0	0	19	2,000	38,000
22	Consultation prénatale standard (3x)	243	243	0	0	243	2,000	486,000
23	Depistage et PEC malnutrition chez les moins de 5 ans	0	0	0	0	0	3,600	0
	TOTAL							**4,016,750**

Arrêté la présente facture mensuelle du FBP de la Formation Sanitaire de CDS Bugarama pour le mois de Mai 2014 à la somme de **quatre millions seize mille sept cent cinquante Francs Burundais (4,016,750 FBU);**.

Facture établie en deux exemplaires originaux dont un conservé au niveau de la formation sanitaire de CDS Bugarama et un autre au niveau du CPVV de MURAMVYA

Fait à ....., le ...../...../ 2014

Comptable du CDS / Delegue
Nom et Prénom.....

Le(s) Vérificateur(s)

Figure 3 : Quantitative invoice compiled at the provincial level

REPUBLIQUE DU BURUNDI

MINISTERE DE LA SANTE PUBLIQUE
ET DE LA LUTTE CONTRE LE SIDA

FACTURE QUANTITATIVE COMPILÉE AU NIVEAU PROVINCIAL

PROVINCE : MURAMVYA
MOIS : Mai **ANNEE :** 2014

No	Centre de Santé	Total Facture	Banque	Compte Bancaire
1	CDS Bugarama	4,016,750	BANCOBU MURAMVYA	0082458-01-45
2	CDS Bukeye	4,863,488	BBCI SIEGE	500-5246901-50
3	CDS Busangana	2,529,480	BANCOBU MURAMVYA	0082482-01
4	CDS Gasura	2,346,755	BANCOBU MURAMVYA	0082472-01-16
5	CDS Gatabo	2,141,130	BANCOBU MURAMVYA	0081104/02/06
6	CDS Giko	2,348,262	BANCOBU MURAMVYA	0082938-01-90
7	CDS Kanlga	1,860,740	BANCOBU MURAMVYA	0082507-01-89
8	CDS Kanyami	1,724,355	BANCOBU MURAMVYA	82488-01-66
9	CDS Kiganda	3,921,325	BANCOBU MURAMVYA	82451-01-11
10	CDS Kivoga	4,670,677	BANCOBU MURAMVYA	0082480-01-41
11	CDS Marumane	1,228,810	BANCOBU MURAMVYA	0082607-01-62
12	CDS Munanira	5,784,250	BANCOBU MURAMVYA	0082508-01-80
13	CDS Munyinya	1,257,876	BANCOBU MURAMVYA	0082601-01
14	CDS Muramvya	3,164,130	BANCOBU MURAMVYA	0082503-01-28
15	CDS Nyarucamo	2,731,312	BANCOBU MURAMVYA	0082448-01
16	CDS Renga	2,770,730	BANCOBU MURAMVYA	0082574-01
17	CDS Rugari	1,922,726	BANCOBU MURAMVYA	0082577-01-0-41
18	CDS Rusarenda	2,235,818	BANCOBU MURAMVYA	0082469-01-43
19	CDS Rweza	1,357,530	BANCOBU MURAMVYA	0082460-01-27
20	CDS Rwuya	1,697,340	BANCOBU MURAMVYA	0082573-01-62
21	CDS Ryarusera	1,020,755	BANCOBU MURAMVYA	0017772-01-70
22	CDS Shombo	1,099,070	BANCOBU MURAMVYA	0082509-01-71
23	CDS Shumba	2,595,430	BANCOBU MURAMVYA	0082455-01-72
24	CDS Teza	1,487,594	BANCOBU MURAMVYA	0082464/01/88
	SOUS-TOTAL CDS	**60,776,333**		

No	Hopital	Total Facture	Banque	Compte Bancaire
1	HD Kiganda	10,110,000	BANCOBU MURAMVYA	00304/0082292-01-84
2	HD Muramvya	15,150,240	BANCOBU MURAMVYA	081275-01-22
	SOUS-TOTAL HD	**25,260,240**		

Total Facture =86,036,573

Arrêté la présente facture mensuelle FBP de la Province Sanitaire de Muramvya pour le mois de Mai 2014 à la somme de **quatre-vingt-six millions trente-six mille cinq cent soixante-treize Francs Burundais (86,036,573 FBU);**.

Facture établie en deux exemplaires originaux dont dont un conservé au niveau du CPVV de Muramvya et un autre au niveau de la CT-FBP

Fait à ....., le ...../...../ 2014

Préparé par le Médecin Directeur du BPS
Nom et Prénom.....

Signature

Approuvé par le CPVV
Nom et Prénom.....

Signature

This entire process reinforces the transparency and the quality of data collected by health facilities for the routine health information system.

Community-based verification is ensured biannually by local associations (LOAS) through community-based surveys carried out under the supervision of the verification sub-unit. These surveys aim at: (i) verifying the actual existence of FOSA declared cases; (ii) verifying the authenticity of received care; and (iii) assessing the quality of services delivered by FOSAs as perceived by beneficiaries. After results are validated and community-based surveys are implemented by the PVVC, feedback sessions are organized with FOSA providers and with community representatives

(members of health committees, COSAs), thereby reinforcing transparency. Simultaneously, this process reinforces accountability as results of community-based surveys shed light on quality as perceived by the community – one of the two dimensions of quality evaluated (technical quality and perceived quality). The results of this assessment determine if FOSAs receive performance bonuses or if they are penalized. In addition, COSA also disseminate survey results to the community during general assemblies organized on the hills of Burundi. This also contributes to incentivizing FOSAs to improve service quality (see Figure 4).

Figure 4 : Payment planning for the bill compiled in the health province

REPUBLIQUE DU BURUNDI

MINISTERE DE LA SANTE PUBLIQUE
ET DE LA LUTTE CONTRE LE SIDA

PLANIFICATION DU PAIEMENT DE LA FACTURE COMPILEE DE PROVINCE SANITAIRE

PROVINCE : MURAMVYA **Mai 2014**

No	Formation Sanitaire	Montant	Bonus Q.	Qté+Qlité	VIH/SIDA	A rembourser	Payable	IDA	Coop. Belge	Banque	No de Compte
1	CDS Bugarama	4,016,750	-363,701	3,653,049	168,900	0	3,484,149	1,439,650	2,044,499	BANCOBU MURAMVYA	0082458-01-45
2	CDS Bukeye	4,863,488	0	4,863,488	1,287,000	0	3,576,488	1,477,805	2,098,683	BBCI SIEGE	500-5246901-50
3	CDS Busangana	2,529,480	-594,659	1,934,821	34,000	0	1,900,821	785,419	1,115,402	BANCOBU MURAMVYA	0082482-01
4	CDS Gasura	2,346,755	-763,973	1,582,782	0	0	1,582,782	654,006	928,776	BANCOBU MURAMVYA	0082472-01-16
5	CDS Gatabo	2,141,130	-504,687	1,636,443	194,000	0	1,442,443	596,017	846,426	BANCOBU MURAMVYA	0081104/02/06
6	CDS Giko	2,348,262	0	2,348,262	124,000	0	2,224,262	919,065	1,305,197	BANCOBU MURAMVYA	0082938-01-90
7	CDS Kaniga	1,860,740	0	1,860,740	90,000	0	1,770,740	731,670	1,039,070	BANCOBU MURAMVYA	0082507-01-89
8	CDS Kanyami	1,724,355	-244,844	1,479,511	4,000	0	1,475,511	609,681	865,830	BANCOBU MURAMVYA	82488-01-66
9	CDS Kiganda	3,921,325	0	3,921,325	323,000	0	3,598,325	1,486,828	2,111,497	BANCOBU MURAMVYA	82451-01-11
10	CDS Kivoga	4,670,677	-720,226	3,950,451	417,000	0	3,533,451	1,460,022	2,073,429	BANCOBU MURAMVYA	0082480-01-41
11	CDS Marumane	1,228,810	-406,592	822,218	113,000	0	709,218	293,049	416,169	BANCOBU MURAMVYA	0082607-01-62
12	CDS Munanira	5,784,250	-508,700	5,275,550	800,000	0	4,475,550	1,849,297	2,626,253	BANCOBU MURAMVYA	0082508-01-80
13	CDS Munyinya	1,257,876	-162,827	1,095,049	130,000	0	965,049	398,758	566,291	BANCOBU MURAMVYA	0082601-01
14	CDS Muramvya	3,164,130	-259,474	2,904,656	328,000	0	2,576,656	1,064,674	1,511,982	BANCOBU MURAMVYA	0082503-01-28
15	CDS Nyarucamo	2,731,312	-529,362	2,201,950	147,000	0	2,054,950	849,097	1,205,853	BANCOBU MURAMVYA	0082448-01
16	CDS Renga	2,770,730	-542,608	2,228,122	342,000	0	1,886,122	779,346	1,106,776	BANCOBU MURAMVYA	0082574-01
17	CDS Rugari	1,922,726	-393,420	1,529,306	46,500	0	1,482,806	612,695	870,111	BANCOBU MURAMVYA	0082577-01-0-41
18	CDS Rusarenda	2,235,818	-316,217	1,919,601	119,000	0	1,800,601	744,008	1,056,593	BANCOBU MURAMVYA	0082469-01-43
19	CDS Rweza	1,357,530	-217,544	1,139,986	49,500	0	1,090,486	450,589	639,897	BANCOBU MURAMVYA	0082460-01-27
20	CDS Rwuya	1,697,340	-320,779	1,376,561	10,000	0	1,366,561	564,663	801,898	BANCOBU MURAMVYA	0082573-01-62
21	CDS Ryarusera	1,020,755	0	1,020,755	288,500	0	732,255	302,568	429,687	BANCOBU MURAMVYA	0017772-01-70
22	CDS Shombo	1,099,070	-71,689	1,027,381	1,000	0	1,026,381	424,101	602,280	BANCOBU MURAMVYA	0082509-01-71
23	CDS Shumba	2,595,430	-463,015	2,132,415	81,000	0	2,051,415	847,645	1,203,770	BANCOBU MURAMVYA	0082455-01-72
24	CDS Teza	1,487,594	-179,411	1,308,183	92,000	0	1,216,183	502,527	713,656	BANCOBU MURAMVYA	0082464/01/88
25	HD Kiganda	10,110,000	-747,791	9,362,209	587,200	0	8,775,009	3,625,834	5,149,175	BANCOBU MURAMVYA	00304/0082292-01-84
26	HD Muramvya	15,150,240	0	15,150,240	984,200	0	14,166,040	5,853,408	8,312,632	BANCOBU MURAMVYA	081275-01-22
	TOTAL	86,036,573	-8,311,539	77,725,034	6,760,800	0	70,964,234	29,322,422	41,641,812		

Arrêté la présente facture FBP compilée qualité et quantité de la province sanitaire de Muramvya pour le mois de Mai 2014 à la somme de **soixante-dix millions neuf cent soixante-quatre mille deux cent trente-quatre Francs Burundais (70,964,234 FBU)**;.

Ce plan de paiement de la facture est établie en deux exemplaires originaux dont un conservé au niveau de la CT-FBP et un autre à la Direction Générale des Ressources

Fait à ....., le ...../...../ 2015

Elaboré par la CT-FBP
Le Coordonnateur de la CT-FBP
Nom et Prénom : Dr Jean KAMANA.

Signature

Approuvé par la Direction Générale des Ressources
Le Directeur Général des Ressources
Nom et Prénom : Anny Yvette MUNEZERO.

Signature

Lundi, 30 Mars 2015. 14:15 1 de 2

Increased transparency improved the situation with regard to fraud, especially service overbilling, non-existent patients and NHIS data falsification, resulting in increased invoices that could neither be verified for accuracy nor paid in full.

DISCUSSIONS AND RECOMMENDATIONS

The separation of functions in PBF-free healthcare in Burundi resulted in a clear definition of roles and responsibilities of implementation actors.

The separation of functions contributed to improving accountability as in the PBF system, each level of implementation is evaluated periodically on the basis of an action plan, which is a way to make providers accountable. Evaluation reports contain a lot of information that can help devise corrective measures if necessary (upward accountability). Moreover, downward accountability can be observed when the needs of the population are taken into account during planning sessions at the level of HCs in which members of COSA (who represent the population) participate actively. Community surveys and their restitution also to this type of accountability.

1. Reinforce the separation of functions

It appears that at some levels, some organs ensure more than one function at the time and that the principal of separation of functions could be compromised (see Annex 1; Table 1). It is the case of the PHO which is both a regulator and a verifier of quality for HCs which has indeed motivated changes at this level. Also, the TU-PBF assumes the role of "regulator" and ensures validation. As a regulator, the technical unit elaborates and revises a procedures manual as well as all tools. It also sets the cost of indicators. At the same time, it provides the last signature required for validation reports and invoices, despite the separation of purchasing and regulation functions are basic principles of PBF.

However, this principle does not necessarily indicate that each actor should only assume one function. In this context, more than one function can be ensured by the same entity as long as there is no conflict of interest or negative overload that could prevent effective operation of the system. This is noticeable at the central level where there is no independent body such as the PVVC capable of assuming purchasing functions for national hospitals and this thus weakens the principle of separation of functions. However, national hospitals are particular in the institutional arrangements of PBF in Burundi, explaining the departure from the separation of functions. Indeed, national hospitals are tertiary level health structures necessitating different arrangements to better respond to the principles of PBF. With regard to these arrangements, it was thought that purchasing performance at this level would limit the evaluation of quality as it would take the form of an accreditation evaluation of hospital with an appropriate evaluation grid. At the end of the quality evaluation, a quality score would be attributed based on a ranking of hospitals following a star system: ranking categories are determined and each category provides points (scores). This score is then used to calculate the bonus to attribute to the hospital.

2. Reinforce upward accountability

Thanks to the improvement of transparency in the declaration and the payment of services provided by FOSAs, the MSPLS and TFP involved in the implementation of PBF have access to the same information, enabling them to request corrections in case of errors in the declaration system, and the payment of invoices and even to take/request sanctions against individuals guilty of misconduct. These sanctions range from the application of a penalty on the amounts that have to be paid to FOSAs, the imposition of disciplinary sanctions to the cancellation of the FOSAs bill. This increases upward accountability of the PBF-Free Healthcare system with regard to all stakeholders.

However, functional limits remain with regard to upward accountability as sometimes corrective measures are not implemented following insufficiencies reported by the PBF monitoring-evaluation system. Observed discrepancies

between NHIS data and PVVC verified data can be subject to specific monitoring by the central level (by the DNHIS, DHSFA, etc.). Efforts are still needed in this area as many identified frauds during the data validation and verification.

The absence of administrative sanctions would be a cause of the constant diminishing of FOSA performance as reported by the counter-verification mission[11]. Moreover, even if the involvement of the elements of the health system (PHO and HDO) in the verification and validation process fosters the education of providers, it also comes with a risk of complacency in verifying services delivered. This is how, for example, approximately one third of services declared by health facilities remain inaccurate at the end of the verification process[12]. We think that a verification team chosen outside the health system could operate more independently and objectively.

3. Reinforce downward accountability

Transparency in the context of PBF implementation is reinforced through the production of a quarterly newsletter which informs citizens about the main results of PBF-Free healthcare. These quarterly newsletters can be consulted through the following link: http://www.fbpsanteburundi.bi/bulletin.html (see Figure 5).

Figure 5 : Quarterly Bulletin

REPUBLIQUE DU BURUNDI

MINISTERE DE LA SANTE PUBLIQUE
ET DE LA LUTTE CONTRE LE SIDA

BULLETIN TRIMESTRIEL SUR LE FINANCEMENT BASE SUR LA PERFORMANCE (FBP)

FBP ET RENFORCEMENT DES LABORATOIRES : ETAT DES LIEUX ET PERSPECTIVES

I. INTRODUCTION

Le projet East African Public Health Laboratory Networking (**EAPHLN**) financé par la Banque Mondiale au niveau des cinq pays de la Communauté de l'Afrique de l'Est en vue du renforcement du réseau de laboratoire est mis en œuvre au Burundi depuis deux ans. Six laboratoires sont impliqués dans cette mise en œuvre dont quatre appartenant aux hôpitaux de district de Kavanza. Makamba, Muvinga et Rumonge, le laboratoire du Centre Hospitalo-Universitaire de Kamenge ainsi que le Laboratoire National de Référence de l'Institut National de Santé Publique. La composante FBP de ce projet est exécutée depuis le quatrième trimestre 2013. A la fin de l'année 2014, les laboratoires impliqués dans la mise en œuvre ont déjà été évalués pour quatre trimestres successifs. Une évaluation initiale pour fixer la ligne de départ avait été réalisée en 2013. Dans ce numéro du « Bulletin trimestriel des nouvelles FBP », la CT-FBP présente au public cible les performances des structures impliquées, les défis ainsi que les perspectives en vue d'une meilleure mise de cette composante dans l'avenir.

II. EVOLUTION DE LA PERFORMANCE DEPUIS LA PRMIERE EVALUATION

Les quatre évaluations de la performance des six laboratoires ont été réalisées à l'aide de l'outil standard conçu par l'OMS et le CDC d'Atlanta (Checklist SLIPTA), de même que l'évaluation initiale réalisée en 2013. Toutes ces évaluations ont été exécutées par des experts en laboratoire formés sur l'utilisation de la checklist.
Les résultats sont présentés sous la forme des pourcentages obtenus en appliquant le total des points obtenu à un maximum fixé dans la grille. Le pourcentage obtenu permet de déterminer le nombre d'étoiles à attribuer à la structure. Ce même score est utilisé pour calculer le montant des subsides par rapport à plafond déjà déterminé. Signalons que l'attribution des subsides à la performance tient également compte du contenu d'une note technique élaborée au début de la mise en œuvre et révisée en juin 2014 qui fixe un certain nombre de critères à prendre en compte dans le calcul du montant à attribuer.

[11] Health, Development and Performance, 2014, Rapport final de la contre vérification du FBP des provinces du 5ème tour (2013-14)

[12] Adrien Renaud. Vérification de la performance dans le cadre du financement basé sur les résultats : le cas du Burundi. Rapport de consultance, juillet 2013, 47p.

However, additional efforts will have to be deployed for this transparency to result into downward accountability. Indeed, decentralization in the health sector in Burundi is ahead of administrative decentralization; and no administrate entity corresponds exactly to the geographic coverage of a health district. This entails that no downward accountability exists to control health districts and ensure they play their roles appropriately (there are no administrative departments, no departmental councils or municipal councils as might be the case in other countries in central and west Africa).

This downward accountability seems to be progressively implemented at the level of health centers where there is a Health Committee (COSA) which participates to the management of the health center and serves as a bridge between health centers and the community in their area of responsibility.

However, the functionality of these COSAs often remains low and their power is restricted by several factors: the role of COSAs is often ignored by their members and by FOSAs themselves; their importance is often ignored by basic administration and by some community members; the training level of their members is often too low to allow them to play their roles appropriately and their motivation is almost inexistent. As a result, community perspectives are not taken into account when health committees are either not operational or inefficient.

Even if community members participate in the evaluation of perceived quality through surveys and results are considered in the calculation of the amounts received by FOSAs, no mechanism is forecasted to enable communities to make FOSAs accountable and, when necessary, to penalize them.

4. Improve financial sustainability and the efficiency of payments

The existence of a database for reporting amounts payable by service providers is undoubtedly a very good practice for transparency in the management of financial resources. Moreover, contributions from the various partners involved in PBF funding clearly appear on this database, which helps avoid double payments while providing visibility to the fulfillment mutual commitments.

However, this system of co-payment, which allows different TFPs to manage their funds according to their own administrative procedures, because of problems with the health facilities especially when the payment terms agreed and defined in the FBP Procedures Manual are not respected. Despite payments being made directly into beneficiary accounts, with no intermediary, delays are still occurring. These delays are the result of fund unavailability among partners. This causes FOSAs to no longer being able to distinguish which invoice was paid by whom, especially since some partners pay in small installments. This is compounded by the fact that bank system do not provide sufficient information, enabling to identify the specific source and timing of payments made.

CONCLUSION

The introduction in 2006 and implementation of PBF in Burundi, inspired by the experience of neighboring Rwanda, aimed to improve the quantity and the quality of health services to accelerate the achievement of MDGs. It is a unique model which integrates a free healthcare mechanism, targeting children under 5 and deliveries, including caesareans. The PBF model in Burundi is unique as it is integrated with a free healthcare mechanism targeting deliveries, including caesareans, and children under 5. These two funding mechanisms have two different but complementary objectives: while PBF improves the delivery of quality health services, free healthcare removes financial barriers to health service utilization. Their integration helped correct some dysfunctions related to free healthcare observed prior to April 2010.

Accountability challenges remain. There are however opportunities to strengthen the separation of duties; take corrective measures to resolve reported challenges by using PBF's monitoring and evaluation system; and above all, use downward accountability. The latter could be gradually corrected by strengthening the role of COSAs and management committees (COGES) and by enabling communities to hold health facilities accountable or, when appropriate, penalize them. Downward accountability remains limited at the district level as there is no framework at the district level enabling the community to make health districts and health system regulators accountable.

Even if accountability challenges remain, the verification and validation mechanisms used in the PBF-Free healthcare model in Burundi, the involvement of various stakeholders (civil servants, NGOs, administrators) in the verification and validation process, the use of the INDICE tool for resource allocation, regular reporting and the existence of the PBF-free healthcare database contribute to enhancing transparency. Information related to the implementation of PBF-free healthcare helps monitor FOSA performance, funds used to purchase services as well as system malfunctions.

This information – which was unavailable prior to PBF – attests to the fact that the transparency of health financing improved. Moreover, available information is also used to sanction fraud and, implement administrative penalties. In this context, the accountability of the health system in Burundi was reinforced through PBF.

ANNEXE 1: INSTITUTIONAL SET-UP OF PERFORMANCE-BASED FINANCING IN BURUNDI

Figure 6 : Institutional Set-Up of Performance-Based Financing in Burundi

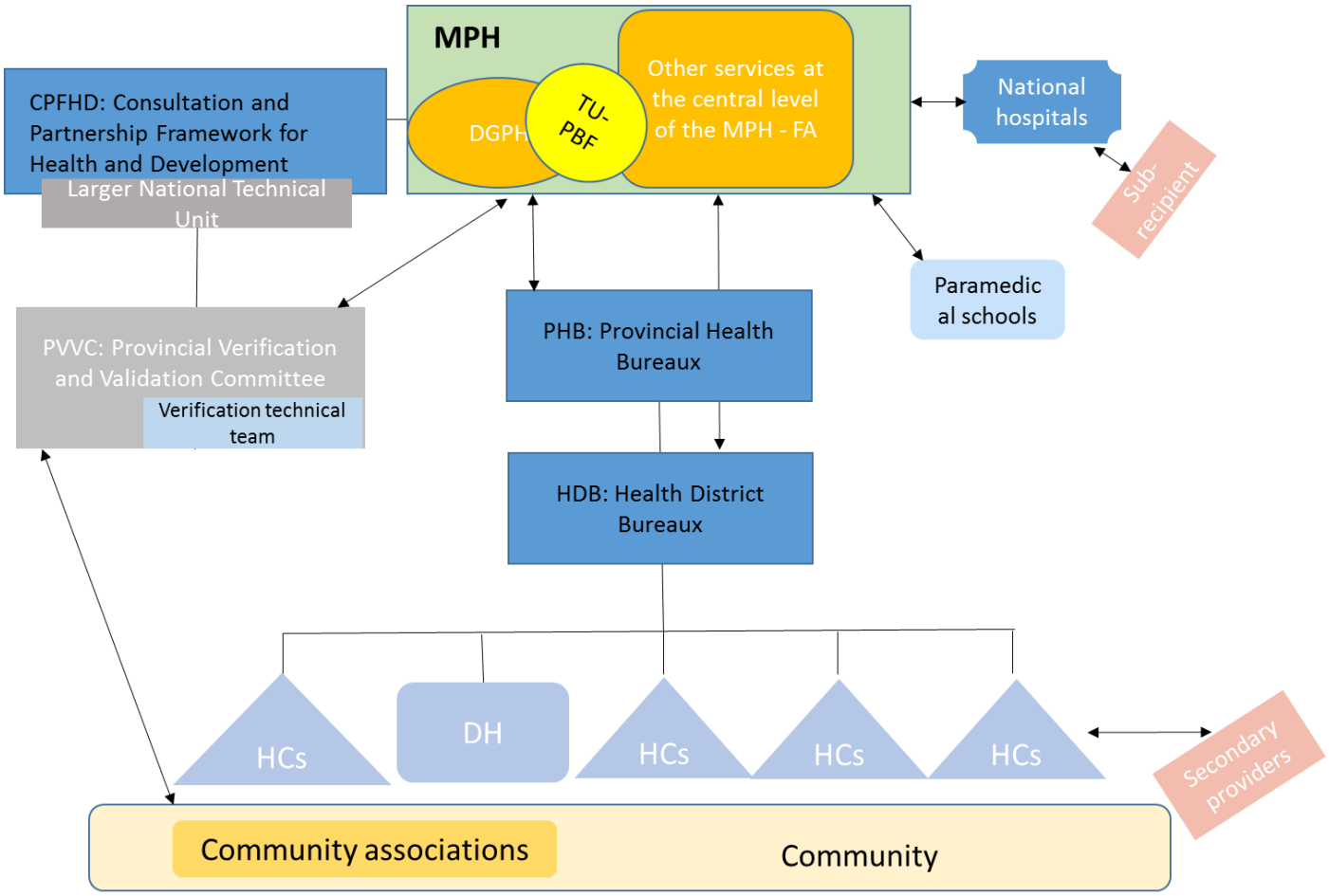


Figure 6 represents the institutional set-up of the PBF model in Burundi. It shows key actors participating in the implementation, including (from bottom to top):

- The community represented by local associations;
- FOSAs represented by Health Centers (HCs) and district hospitals;
- Provincial Verification and Validation Committees (PVVC);
- Provincial Health Bureaux (PHO) ;
- Health District Bureaux (HDO) ;
- Consultation and Partnership Framework for Health and Development (CPSD) and the larger Technical Unit; and,
- MSPLS, represented here by the General Directorate for Public health (GDPH, currently called General Directorate for Health Services and the Fight against AIDS, DGSSLS), the national technical unit (TU – PBF) and other services at the central level;
- National hospitals; and,
- Paramedical schools.

Contractual relations linking actors as well as their different roles and responsibilities are explained in detail in the table below and within the description of the different functions (regulation, provision, verification and purchase) of the Burundian PBF-Free Healthcare model.

Table 1 : Separation of functions in the PBF institutional framework in Burundi

Type of verification	Provider	Buyer	Verifier	Validation and Regulation	Payment	Frequency
Quantitative services	HCs and district hospitals	PVVC	PVVC verification sub-unit	PVVC verification sub-unit	**FOSA** ↓ **Verification and validation** ↓ **TU – PBF created the compiled bull by FTPs** ↓ **GDR controls and declares claims** ↓ **Minister's Cabinet signs** ↓ **Finance Minister and TFP pay FOSAs**	Monthly
	National hospitals	DGSSLS	Larger TU-PBF	CT-FBP		
Technical quality of services from providers' perspectives	HCs	PVVC	Management team of PHO, *but those become NGOs*	PVVC verification sub-unit		Quarterly
	District Hospitals	PVVC	Peers (with the facilitation of the larger TU- PBF), *but those become NGOs.*	PVVC verification sub-unit		
	National Hospitals	DGSSLS	Larger TU-PBF	TU-PBF		
Quality of services as perceived by beneficiaries and verification of declared cases and care provided	HCs and hospitals	PVVC	Local associations under the supervision of the verification sub-unit of the PVVC	PVVC followed by a restitution for providers and COSAs		Biannual
Counter-verification of declared cases, care provided, all data and respect of the procedure manual	HCs and hospitals	N/A	External independent body	Larger TU-PBF		
Results of various entities and PBF implementation	PHO ; HDO ; PVVC	DGSSLS	TU-PBF / Larger TU-PBF	TU-PBF		Quarterly
	TU-PBF	DGSSLS	Commission with members of the CPFHD			

The Control Function

The control function is performed at the national level by the MSPLS through the TU-PBF and by the PHO and DHO at the operational level. The TU-PBF is a technical body implementing PBF-free healthcare; administratively, it is under the authority of the Directorate General for Health Services and the Fight against AIDS (DGSSLS); it is composed of seven civil servants and three technical experts from implementing TFPs. These experts do not work full-time at the Ministry but they are made available to support the TU-PBF. The larger TU-PBF provides a technical framework in which monthly exchanges between TU-PBF members, executives from other departments at the central level at the MSPLS as well as TFPs representatives take place. The larger TU-PBF collaborates and supports the TU-PBF in the context of technical decisions pertaining to PBF. Representing another framework which focuses on general health policy decision-making, the CSPD pilots the PBF-free healthcare mechanism. It includes MSPLS senior executives and representatives from TFPs and coordinates the overall activities of the health sector.

The Service Delivery Function

The service delivery function is carried out by HCs and hospitals who sign primary contracts with the PVVC, which acts as a buyer for HCs and district hospitals. The delivery function is also realized by national hospitals who sign a service contracts with the DGSSLS. In turn, HCS and hospitals can sign contracts with secondary providers: these are private, faith-based or non-profit health facilities providing health services in specific catchment areas who can help prime contractors implement the minimum package of activities (MPA) in the case of HCs and the complementary package of activities (CPA) in the case of district hospitals. Sub-contracted health services include family planning activities (FP) for faith-based health facilities and targeted free services for private health facilities who accept delivering those services. By signing a sub-contract, the primary contractor (the HC or the hospital) commits to supervisor the implementation of activities included in the contract. As such, the performance of primary contractors is somewhat linked to that of sub-contractors, making primary contractors accountable for sub-contractors.

Aside from HCs and hospitals, the service delivery function is also implemented by community health workers through the implementation of community-based PBF. Burundi is currently implementing pilot community-based PBF projects in three provinces out of the 17 provinces of the country: Makamba, Gitega and Mwaro. In community-based PBF, community-based activities are mainly linked to community referrals, communication for behavioral change, community-based distribution and care for conditions such as malaria and pneumonia are carried out by community health workers assembled in community health worker groups (GASC). These GASC sign a service delivery contract with the PVVC which, after verifying service delivery, purchases their services. If these community-based PBF pilot projects prove to be conclusive, they will be scale up at the national level. Burundi also plans to extend community-based activities by contracting nutritional activities at the community level through interventions such as “Mamans Lumières” or “Nutritional Learning and Rehabilitation Schemes” (FARN).

The Verification Function

At the operational level, the quantitative delivery of services (by both HCs and district hospitals) are verified and validated monthly by the PVVC verification sub-unit before. The technical quality evaluation (from a professional point of view) of these health facilities was carried out quarterly by PHO management teams for HCs and by peers – under the mentoring of the larger TU-PBF – for hospitals. To reinforce quality in HCs and hospitals as well as avoid that PHOs act both as quality verifiers and quality regulators, quality evaluations were assigned to non-governmental organizations (NGOs). With regard to PBF implementing bodies (TU-PBF, PHO, DHO and PVVC), the verification function is carried out quarterly in the form of a performance evaluation by the TU-PBF supported by the larger TU-PBF as well as by a commission nominated by the Minister and composed of members from the CPSD. The results of these evaluations are validated by the TU-PBF.

Community verification is ensured biannually by local associations (LOAS) through community-based surveys under the supervision of a member of the verification sub-unit responsible for community-based surveys. These surveys are implemented to (i) counter-verify the existence of cases reported by FOSAs; (ii) counter verify the authenticity of received care and (iii) assess the quality of services as perceived by beneficiaries. After survey results are validated by the PVVC, a feedback session is organized to discuss results with service providers and community representatives (members of health committees, COSA), thereby reinforcing transparency. At the same time, accountability is being strengthened by the fact that community survey results represent a form of community sanction (positive or negative according to results) toward providers: results from community-based surveys represent the quality perceived, which is one of the quality dimensions (technical and perceived) of the quality evaluation carried out among health facilities. This evaluation enables health facilities to receive a bonus or a penalty. In addition, COSAs report survey results to the community during general "hill" assemblies, which can also contribute to incite health facilities to increase service quality.

Counter-verification is carried out but an external independent body. It is conducted quarterly and enables the counter-verification of verified qualitative and quantitative PBF data as well as assess the extent to which the procedure manual is being respected at all levels to resolve issues identified in verification and validation mechanisms. The counter-verification is carried out on a sample of operational bodies in the implementation of PBF.

The Purchasing Function

For HCs and provincial hospitals, the purchasing function is carried out by the PVVC. The PVVC is composed of representatives of all stakeholders in the health sector at the provincial level: one representative of the Governor of the province, NGO representatives, and civil society, the Provincial Director of Health, district chief medical officers as well as district and province health information system officers. The PVVC is presided by a member of civil society, a representative of institutions in the health sector or a representative of the Governor. To minimize conflict of interest, provincial health sector's medical director as well as district chief medical officers are excluded from the PVVC presidency.

The PVVC includes a verification sub-unit (mixed verification team composed of Government civil servants and NGO contractors intervening in the province) which is responsible for the verification of service provision at FOSA level as well as for quality verification – quality as perceived by beneficiaries. The validation sub-unit (all members of the PVVC that do not carry out verification) validates verified services together with the verification team, analyzes the evolution of indicators, validates the provincial invoice and transmits the validation report as well as the provincial report to the TU-PBF. Following the validation process, the verification team enters data in the PBF web database and ensures that feedback is provided to relevant health facilities by sending them the results that will help future planning. In parallel, the PVVCs transmit these results to the TU-PBF by sending validation meeting minutes at the same time as well as compiled provincial invoices. In turn, the TU-PBF analyzes results through a quarterly data analysis. It sends the general directorate of health services of the Ministry.

In Bujumbura's 5 national hospitals – as opposed to district hospitals – the purchasing function is realized by the DGSSLS which signs service delivery contracts. For PBF regulation entities (PHO, DHO and PVVC), the purchasing function is carried out by the DGSSLS. After receiving all validation reports and all provincial invoices, the TU-PBF – which is responsible for validating all provincial and hospital invoices establishes a compiled invoice of all health facilities to distribute payment among partners. This compiled invoice is then transmitted to the General Directorate for Resources to ensure its compliance with the procedure manual and to issue claims. These claims are submitted for approval to the Ministry's cabinet and subsequently, transmitted to the Ministry of Finance, or TPFs depending on the specific context, to be paid: the compiled invoice is distributed between the Government and different TFPs, based on their respective contributions.