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Burundi: Questions on the Financial Sustainability of Performance-Based Financing and Free Health Care

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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

CSLP	Strategic Framework for Growth and Poverty Reduction, second generation
DHO	District Health Office
FHC	Free Health Care
ITN	Insecticide-Treated mosquito Nets
MDG	Millennium Development Goals
MSPLS	Ministry of Public Health and for the Fight against AIDS
NCP	National Contracting Policy
PBF	Performance-Based Financing
PCFHD	Partner Consultation Framework for Health and Development
PHO	Provincial Health Office
PNDS	National Plan for Health Development
PVVC	Provincial Verification and Validation Committee
TFP	Technical and Financial Partners
TU – PBF	National Technical Unit for the implementation of Performance-Based Financing

SUMMARY

This article focuses on the financial sustainability of the strategy linking performance-based financing (PBF) and free health care (FHC), which has been implemented nationwide in Burundi since 2010. It concentrates on the financial resources invested by the government and its technical and financial partners. It seeks to establish whether government resources alone can guarantee the financial sustainability of PBF-FHC or whether other inputs are required.

This article first defines the concept of financial sustainability used in the context of PBF-FHC. It subsequently analyzes financial sustainability based on three indicators: (i) the reliability and stability of financing; (ii) the availability and adequacy of both current and long-term financing; and, (iii) the appropriate and timely allocation of resources by the government.

Through the establishment of a budget line dedicated to PBF-FHC, the government contributes to the reliability and stability of financing. This is further compounded by its formal commitment to provide PBF-FHC with an annual allocation representing 1.4 percent of its general budget. Analyzes show that this government contribution remained stabled; it even exceeded the annual rate of 1.4 percent between 2010 and 2013.

Despite encouraging results, PBF-FHC is faced with an important financial gap which cannot currently be bridged by the government or TFPs. In addition, health facilities are faced with cash shortages – placing them at risk of stock outs of both drugs and other inputs – caused by important reimbursement delays.

Finally, this article examines the approaches recommended to address financial sustainability in the context of PBF-FHC, namely: (i) the reduction of PBF-FHC implementation costs; (ii) the mobilization of government and TFPs resources; (iii) guaranteed regular payment of health facilities' invoices; and (iv) the integration of PBF-FHC in the national health financing strategy, which seeks to increase efficiency by integrating different health financing mechanisms.

The main conclusion of this analysis is that although government involvement and financing are requisite, they are not sufficient to guarantee the financial sustainability of PBF-FHC in Burundi.

CONTEXT

The general health forum held in 2004 underlined several challenges in the health sector, including:

- High maternal, neonatal and child morbidity and mortality;
- Lack of health care personnel;
- Highly mobile and demotivated health care personnel;
- Poor quality of care;
- Weak health system make-up and management; and
- Poor and inefficient health sector financing.[1]

The Ministry of Public Health and for the Fight against AIDS (MSPLS) sought to address these challenges in the 2006-2010 National Plan for Health Development (PNDS I) and, subsequently, in the 2011-2015 PNDS (PNDS II). These strategic documents were prepared to facilitate major reforms, including the decentralization of the health system; the development of a policy and a strategy focused on human resources for health; the improvement of paramedical schools; the improvement of the pharmaceutical sector; as well as the introduction of **performance-based financing (PBF).**

In 2006, Burundi adopted a free health care policy focusing on children under five and deliveries (including caesarians) to accelerate the achievement of the Millennium Development Goals (MDGs), particularly MDG 4 and 5. In 2009, this targeted free health care policy was extended to pregnancies and post-partum related conditions. Its implementation was however constrained by: (i) government delays in paying health facility invoices; (ii) the absence of a verification system capable of ensuring the relevance of incurred expenses and avoiding the overbilling of health services; (iii) the heavy workload and demotivation of health personnel resulting from increased health service utilization; (iv) the heavy administrative burden experienced by health facilities who have to complete many forms – close to 2'000 pages every month – to be reimbursed; (v) and especially, expenses exceeding the allowed annual budget.

During the same year, the MSPLS prepared and adopted a national contracting policy (NCP) for the health sector. In 2006, PBF pilots were initiated in three provinces. In 2008, PBF pilots were extended to six additional provinces. Given the encouraging results achieved, the MSPLS as well as TFPs agreed to reimburse the package of free health services through performance-based financing mechanisms. They also agreed to scale-up PBF at the national level, starting in April 2010. Moreover, the government committed to financing both the PBF approach and the free health care policy targeting children under five and pregnant women.

Several evaluations, joint reviews, external assessments as well as data from the PBF database indicate that PBF-FHC positively influences the health system, attaining encouraging results in terms of governance, service delivery and quality of care indicators.[2, 3, 4, 5, 6, 7] For example, new curative visits increased from 0.69 new contacts per person per year in 2009 to 1.66 in 2013. Further, skilled deliveries increased from 54 percent in 2009 to 74 percent in 2013 [8].

[1] MSPLS (2004) Report on the General Health Forum .
[2] Peerenboom et al. La bonne gouvernance dans la réforme du financement du système de santé au Burundi. Santé Publique, 2014/2 Vol. 26, p. 229-240.
[3] PVVC Validation Minutes for 2010-2013 .
[4] Annual PBF Report 2010-2013, MSPLS, Bujumbura .
[5] Counter-verification reports 2011-2013, External Counter-Verification Agency HDP, Bujumbura.
[6] External review Reports 2010 and 2012; WHO, World Bank, European Union, CORDAID.
[7] Audit reports for World Bank Projects, European Union and Belgian Cooperation, 2010-2013.
[8] Statistical book for health centers and hospitals for 2013.

The government and the MSPLS consider PBF-FHC as a priority national strategy, as demonstrated by the content of several strategies and policy documents[9]. The fact that three of these highly strategic health sector documents recognize PBF as a national priority is important for the institutional sustainability of this approach. Indeed, financing provided by both the government and TFPs draws on the strategic axes described in these documents.

However, after four years of implementation at the national level and given the limited resources available for the health sector, several national and international actors are concerned about the financial sustainability of PBF-FHC. As it is an issue that is regularly raised during in the larger National Technical Unit for the implementation of PBF (TU-PBF) or in Partner Consultation Framework for Health and Development (PCFHD) meetings, the MSPLS was asked to reflect on strategies capable of ensuring financial sustainability. This article analyzes the experience of Burundi in order to contribute to this discussion, particularly focusing on the **government's financial contribution: can it guarantee the financial sustainability of PBF or are other inputs required to achieve financial sustainability?**

METHODOLOGY

The financial sustainability of PBF-FHC was defined as the **"capacity to ensure that long-term financial resources are sufficient and stable and allocated in a timely and appropriate manner to cover direct and indirect costs"**[10]. Subsequently, three variables were selected to analyze this financial sustainability. Detailed in Box 1, these variables have been analyzed through a review of key government and MSPLS strategy documents, including the national plan for health development[11], the national contracting policy for the health sector[12] and, the strategic framework for growth and poverty reduction[13].

Box 1: Analysis of the financial sustainability of PBF in Burundi: variables used and their operationalization

The Reliability and Stability of Financing

To gauge the reliability and stability of financing for the implementation of PBF-FHC in Burundi, an evaluation of budget evolution and actual government and partner expenditures has been carried out for the period extending from 2010 to 2014.

Availability and Sufficiency of Financing

Current and future financing levels – which are required to meet existing needs and bridge the financial gap related to PBF – have been evaluated based on an analysis of forecasted costs linked to implementation for 2014-2016 (elaborated by the National PBF Technical Unit) and a review of budgeted government and TFP financial contributions aimed at paying health facilities.

Allocation of Financing

The PBF manual includes allowable payment delays. The extent to which these delays are respected is assessed by comparing payment dates to the issuing of monthly invoices between April 2012 and March 2013 – using a synthesized PBF counter-verification report. Calculations are limited to one year as these estimations were not previously available (i.e. 2010-2011). Different types of allocations are also considered.

RELIABILITY AND STABILITY OF FINANCING

The government's financial contribution to PBF-FHC is formalized by a dedicated, longstanding and continuously replenished budget line in Burundi's Budget Law. In 2009, following negotiations with the World Bank, the government further formalized its support by committing to provide PBF with an annual allocation representing 1.4 percent of the national budget.

[9] In paragraphs 568 to 571, the Strategic Framework for Growth and Poverty Reduction, second Generation (CSLP II) recommends strengthening the implementation of health sector reforms, including that of PBF. Indeed, according to CSLP II, PBF is instrumental in rectifying health system malfunctions and improve health systems utilization. The seventh (7th) strategic axis of the 2011-2015 PNDS underlines the need to "strengthen as well as ensure the sustainability of PBF and FHC" to contribute to the improvement of both the supply of and the demand for health care services. In the NCP, the incentivization of health care providers (PBF) is recognized under component 3 as a strategic axis required to improve efficiency.

[10] This definition draws from the following definition of financial sustainability : http://www.cbd.int/protected-old/sustainable.shtml

[11] National Plan for Health Development, 2011-2015, MSPLS, Bujumbura, 2010.

[12] National Contracting Policy for the Health Sector in Burundi, MSPLS, Bujumbura, 2006.

[13] Strategic Framework for Growth and for Poverty Reduction, second generation CSLP II, Bujumbura, January 2012.

Table 1 below shows how both the government and the MSPLS allocated resources from their budgets to PBF-FHC, compared to the government's general budget[14].

Table 1: Proportion of government budget dedicated to PBF compared to the Government's general budget from 2010 to 2014 (budget line) in BIF x 1 000 000. Source: General Budget of the Republic of Burundi

Year	PBF Budget	MSPLS Budget	Gov. General Budget	Common Costs [19]	Gov. General Budget – Common Costs	% Budget of MSPLS compared to the Gov.'s General Budget	% PBF Budget compared to the Budget of the MSPLS	% PBF Budget compared to the General Budget of the Gov. – Common Costs
2010	12 196,2	63 512,1	863 059,7	142 184,9	720 874,8	**7,36%**	**19,20%**	**1,69%**
2011	12 384,6	72 364,4	1 026 173,4	122 254,1	903 919,3	**7,05%**	**17,11%**	**1,37%**
2012	18 223,9	70 079,2	1 211 741,6	148 252,3	1 063 489,4	**5,78%**	**26,00%**	**1,71%**
2013	17 930,4	80 035,3	1 389 902,0	106 493,9	1 283 408,1	**5,76%**	**22,40%**	**1,40%**
2014	18 174,7	80 993,8	1 411 410,3	113 218,4	1 298 192,0	**5,74%**	**22,44%**	**1,40%**
	78 910,0	**366 984,7**	**5 902 286,9**	**632 403,5**	**5 269 883,4**	**6,22**	**21,50**	**1,50**

Table 1 shows that the PBF budget for 2010-2014 is resourced by the MSPLS's budget at a rate of 21.5 percent and by the government's general budget at a rate exceeding the pledged 1.4 percent. In 2011, despite the government's commitment to allocate 1.4 percent of its annual budget to PBF-FHC, its contribution reached 1.37 percent (excluding common costs). In 2012, to counterbalance this low contribution, the government provided resources at a rate of 1.71 (minus common costs). Further, as shown in Table 1, the government exceeded its original 1.4 percent commitment from 2012 to 2014.

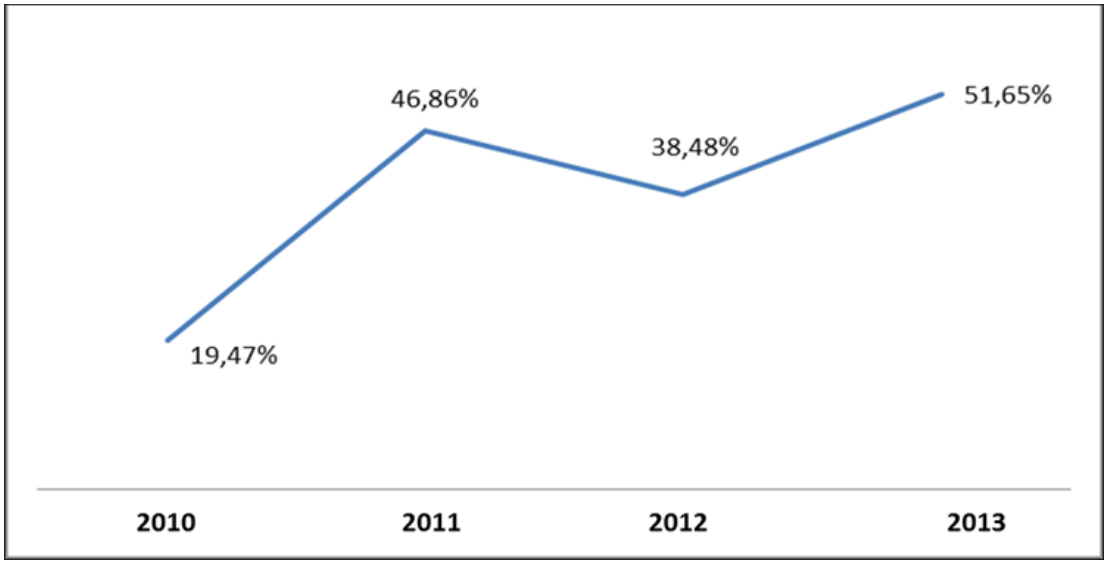
During the same period, the relative contribution of the government to the budget of the MSPLS decreased while the relative contribution of the MSPLS to PBF-FHC increased. This signifies that the relative financial contribution derived from the government's budget (excluding common costs[15]) to PBF-FHC remained stable (1.4 percent) – thanks to an increased MSPLS contribution. The MSPLS considers PBF-FHC as a priority.

The government is not the only donor for PBF-FHC financing. As indicated in Figure 1, from 2010 to 2013, **the government's contribution to actual PBF expenditures (including operational costs linked to the payment of health facilities and regulation bodies) ranged from 19.47 percent in 2010 to 51.65 percent in 2013.**

It should be underlined here that the combination of PBF and FHC started in April 2010. The low contribution of the government in 2010 can be explained by the fact that the government dedicated a high proportion of PBF funds to cover 2009 arrears linked to FHC. PBF funds were also used to cover free health care services for the first quarter of 2010.

[14] Project Appraisal Document, Proposed Grant for the Republic of Burundi for a health sector development support project, World Bank, May 2009.
[15] Common costs include unexpected costs, exemptions as well as debt interest and amortization.

Figure 1: Evolution of the government's contribution to PBF based on actual expenditures – 2011- 2013.



In 2013, the government's contribution peaks; this can be explained by the fact that some TFPs fully consumed their budget before the end of the year, compelling the government to absorb costs by tapping into its 2014 budget. The high budget burn rate experienced by TFP is partly due to the upward revision (January) of the unit cost of incentivized indicators. This revision resulted in general invoice increases – 62 percent compared to 2012 – while government and TFPs budgets remained unchanged. This situation can be explained by the length of TPF financial planning processes – at least three years – which limit their capacity to adapt to cost changes/revisions[16].

Table 2: Contributions of the Government and of TFPs to actual PBF expenditures in BIF (x 1 000 000) from 2010 to 2013 (1 USD = 1 530 BIF)

	2010	%	2011	%	2012	%	2013	%	TOTAL	%
Government	4 712	19%	15 268	47%	13 397	38%	27 648	52%	61 026	42%
TFPs	19 485	81%	17 314	53%	21 418	62%	25 882	48%	84 098	58%
Total	24 197	100%	32 582	100%	34 815	100%	53 530	100%	14 512	**100%**

In 2010-2014, close to BIF 145 billion (around USD 95 million) were used for PBF implementation – 42 percent were covered by the government. The government's financial commitment (shown by the positive trend in the government's absolute and relative contributions, and the fact that PBF-FHC is considered as a national priority, as indicated in the National Plan for Health Development and shown by the Government's commitment to allocate yearly 1.4 percent of its budget to PBF-FHC) constitutes an important sustainability vector for PBF-FHC: the government is involved in financing as well as in implementing PBF-FHC and partners can trust its political will.

THE AVAILABILITY AND SUFFICIENCY OF FINANCING

As shown in Table 3, actual expenditures can exceed the annual budget forecasted by the government (presented in Table 2), as was the case in 2011 and 2013. This situation can be observed when the financial contributions of the government and TFPs are insufficient to cover all monthly PBF-related invoices during the year.

[16] This increase in the cost of FHC indicators for children under 5 and pregnant women was instigated based on the findings of a cost study which indicated that all applied costs were below actual production costs, causing a revenue shortfall for health facilities.

Table 3: Actual expenditures and Government budget for PBF in BFI (X 1 000 000) for 2010 – 2014 (1 USD = 1 530 BFI)

Government contributions	2010	2011	2012	2013	2014
Payments (January – December)	4 712,3	15 268,4	13 397,2	27 648,4*	*Not known*
Budget (January – December)	12 196,2	12 384,6	18 223,9	17 930,4	18 174,7
DIFFERENCE	7 483,9	-2 883,7	4 826,8	-9 717,9	*Not yet known*
Expenses/Budget (%)	39%	123%	74%	154%	*Not yet known*

** A portion (September to October) was paid with the budget planned for 2014.*

The government and the World Bank agreed that PBF contributions should be managed in a strategic and synergetic manner: the budgets of both the government and TFPs were used to pay invoices from January to August; when these budgets were fully consumed, the budget of the World Bank was used to cover the rest of the year. In the event that the budgets of the government, the World Bank and other partners cannot cover all monthly payments during the year, the government is required to cover the remaining months using the budget of the following year. For instance, in 2013, September to December invoices were covered using the government's 2014 budget, given the World Bank could not cover the existing financial gap.

In this context, the 2014 government budget (minus the proportion used to pay 2013 invoices) was fully consumed once January-March 2014 invoices were paid. After that, the World Bank's budget took over. It was entirely used to cover April-June 2014 invoices. As a result, if an alternative solution is not found, the 2015 government budget will have to cover July-December 2014 invoices.

This means that government resources are not sufficient to continue implementing PBF at current costs. This is especially true given the growing Burundian population and increases in the quality and utilization of PBF-targeted health services. The financial gap is thus augmenting.

The MSPLS determined the financial needs linked to PBF for 2014-2016, as indicated in the table below[17].

Table 4: Financing needs for the implementation of PBF, in BIF (X 1 000 000) for 2014-2016 (1 USD = 1 530 BIF)

STRUCTURES	2014 (BIF)	2015 (BIF)	2016 (BIF)	TOTAL BIF	TOTAL USD
Health Facilities	48 591,2	51 980,8	54 644,5	155 216,5	101 914 971
PHO	617,5	617,5	617,5	1 852,5	1 216 349
DHO	1 474,6	1 474,6	1 474,6	4 423,8	2 904 642
PVVC	1 200,1	1 200,1	1 200,1	3 600,2	2 363 883
Central Level	1 124,1	1 124,1	1 124,1	3 372,3	2 214 258
Community-based associations	280,0	280,0	280,0	840,0	551 536
Verification	499,1	499,1	499,1	1 497,4	983 211
Counter-verification	510,3	510,3	510,3	1 530,8	1 005 117
Paramedical schools	152,0	152,0	152,0	456,0	299 393
Capacity building	100,0	100,0	100,0	300,0	196 980
Monitoring and Evaluation TU-PBF	250,0	250,0	250,0	750,0	492 449
Permanent technical assistance	178,2	178,2	178,2	534,6	351 018
Surveys and research	50,0	50,0	50,0	150,0	98 490
Community-based PBF		6 800,0	6 800,0	13 600,0	8 929 744
PBF laboratory	617,9	670,1	722,3	2 010,3	1 319 963
	55 644,9	65 886,7	68 602,7	190 134,4	124 842 005

Table 5 shows resources pledged by the government and several TFPs. Comparing forecasted resource needs with resources pledged by the State and different TFPs for 2014-2016, the forecasted financial gap is BIF 69'524'957'609 (i.e. USD 45'650'005). This financial gap is quite important and can threaten the financial sustainability of PBF-FHC if measures are not quickly taken to implementation control costs and to simultaneously mobilize additional funding.

Moreover, following the political situation which prevailed in 2015, most partners officially announced suspending their financing for PBF-FHC. The only guaranteed financiers for 2016 are the government, the World Bank and Gavi. Informal discussions indicate that partners would like to continue financing PBF-FHC through non-state entities such as Non-Government Organizations and UN organizations. Confirmations have however yet to be received. In this uncertain context, the Ministry of Health plans to considerably increase the government's contribution in 2016 to mitigate the risk of financial shortfalls. Further, discussions with the Ministry of Finance are ongoing.

Table 5: Available budget and financial gap in the context of the implementation of PBF in Burundi

SOURCE OF FINANCING	AVAILABLE BUDGET FOR 2014-2016 (USD)	RELATIVE CONTRIBUTION
Government	33 000 000	42%
World Bank	30 000 000	38%
Dutch Cooperation/CORDAID	5 000 000	6%
Belgian Cooperation	3 360 000	4%
European Union	3 332 000	4%
GAVI	3 000 000	4%
USAID/FHI 360	1 500 000	2%
TOTAL AVAILABLE BUDGET	**79 192 000**	100%
NEEDS 2014-2016	**124 842 005**	**100%**
GAP	**45 650 005**	**37%**

[17] In Table 4, costs exceed annual expenditures shown in Table 3 since they represent anticipated expenditures for the MSPLS and its TFPs while Table 3 only shows government expenditure, representing about 40-50% of total expenditure.

It is important to note that the financial gap mainly results from the costing prepared in April 2010, which was based on financing hypotheses rather than on available funds. It also underestimated service utilization, which increased faster than forecasted. Moreover, in January 2013, following complaints made by health facilities, indicator prices were increased – but fund availability did not change, thereby worsening the existing financial gap.

RESOURCE ALLOCATION

Delays were observed in the reimbursement of PBF-FHC invoices, and these delays challenge health facility and hospital operations. According to the revised PBF manual[18], invoices submitted monthly by health facilities have to be reimbursed within 50 business days, following the month in question. Nevertheless, the average delay period reached 17 business days (beyond the allowable 50 business days) from April 2012 to March 2013 (see Table 6).

Table 6: Payment delays in terms of business days from April 2012 to March 2013[19]

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Average
Gov.	37	26	11	35	29	11	10	10	3	20	12	10	**17,83**
TFP	21	36	34	4	3	28	20	10	4	21	10	18	**17,42**

These delays intensified during 2013 and at the beginning of 2014: government payments experience delays of 2-3 months. This can be explained by the shortage in liquidity experienced at the national treasury level, resulting from (i) a decrease in tax revenue and from (ii) dependency on external financial resources (i.e. representing 50 percent of the government's budget).

DISCUSSION

In Burundi, PBF positively influenced governance as well as service delivery and quality indicators and, the financial contribution of the government for the implementation of PBF-FHC is manifest. With a contribution of 42 percent between 2010 and 2014 coupled with an annual commitment reaching 1.4 percent of its general budget, the government is a key financier for PBF-FHC. This crucial role makes TFPs more receptive to supporting PBF-FHC and thus enables the government to further mobilize resources.

In Rwanda, where PBF was scaled up at the national level, the contribution of the Government is as significant as in Burundi, covering 60 percent of PBF costs and contributing USD 11 million annually[20]. In other countries where PBF is only at the pilot stage, the contribution of the government is symbolic or inexistent. For example, in Zimbabwe, it is forecasted that the government will contribute USD 5 million in 2014[21]. Conversely, in Benin, discussions pertaining to government financing are ongoing, but not formalized. In other countries, the government does not participate financially.

In Burundi, many TFPs support PBF-FHC, and their contributions are quite significant (more than 50%) and align with national priorities, in line with the principles of the Paris Declaration.

Nevertheless, concerns about PBF's financial sustainability remain: will the Government continue to allocate 1.4 percent of its budget to PBF? How long can the MSPLS guarantee this 1.4 percent allocation if the budget allocated to the MSPLS continues to decrease? Will TFPs maintain their current financing levels? How can the financial gap be filled to ensure the financial sustainability of PBF-FHC, implementing PBF at current costs while covering costs linked to population growth and increased health service utilization and quality?

The budget was forecasted in April 2010 without considering fund availability, reducing the financial feasibility and resulting in the existing financial gap. Moreover, estimates were based on an under-estimation of service utilization, which increased much faster than expected. In addition, in January 2013, FHC indicators experienced a price increase which was not correlated with an increase in available budgets.

[18] PBF Procedures Manual, revised version, September 2011.
[19] Comprehensive synthesis of the third PBF counter-verification in Burundi (2013-2014).
[20] PBF reports Rwanda, 2012 and 2013.
[21] Zimbabwe expenditure estimates, 2014.

Payment delays reduced the amount of resources available to health facilities and accentuated issues pertaining to financial viability. This situation is especially notable in hospitals, where decreases in revenue caused structural and organizational challenges such as service underpricing (rates date back to 2001); an aggregate payroll (tripled since 2009[22]) and other reimbursement arrears. Delays do not have the same consequences in health centers and in hospitals: as hospital personnel are not paid by the government, low service rates have a significant impact there. Conversely, some health centers can save resources to cover operational costs in the event of reimbursement delays. Conversely, some health centers can save resources, which allows them to cover operational costs in the event of reimbursement delays. The pressure experienced at the level of the Public Treasury could be partly alleviated through a rationalization of health system resources, including a reduction of excess human resources and of available resources at the health center level.

In the long term, if these delays continue and intensify, especially in the context of existing structural and organizational problems, health facility operations could be significantly impacted – especially with regard to the supply of medical drugs and other inputs. **Payment delays undoubtedly constitute a major barrier in ensuring the financial (and social) sustainability of PBF-FHC in Burundi.**

Aside from payment delays, the fragmentation of payments remains an issue. Despite the government mobilizing TFPs for additional resources, **payments are carried out through a virtual basket funding approach whereby partners pay according to their respective commitment. This payment approach for PBF-FHC entails that health facilities receive two to three payments at different times, depending on the number of donors present in the province. The issue here is that it is difficult for health centers to plan based on fragmented payments; it hampers their capacity to achieve action plans within required timeframes.**

In summary, the important challenges are:

- A lack of consideration for funding availability;
- A sub-optimal use of resources in the health system; and,
- An occasional lack of liquidity at the level of the Public Treasury for the timely payment of invoices. This is partly due to:
  - The use of a virtual common basket of funds; and
  - The reduction in the government's total revenue caused by the prevailing political and security situation.

In 2011, different approaches were proposed to control PBF-FHC-related costs and bridge the existing financial gap: increase resources for health as well as control – and even reduce – expenditures. Proposed measures include[23]:

1) Reducing the cost of PBF indicators: in provinces where budget ceilings were exceeded, cost reductions are planned. However, given the existing financial gap, a considerable reduction of all costs at the health facility level is envisioned starting in January 2015.

2) Removing some PBF community-based indicators (construction of latrines at the community level and distribution of Insecticide-Treated mosquito Nets) which were integrated in the community-based package; removing indicators related to "antenatal and postnatal visits" at the hospital level as they pertain to the Minimum Package of Activities delivered and financed at health center level.

3) Establishing and respecting each province's financial envelope. This entails determining a financial envelope specific to each province and based on individual health center's targets and available resources, and deciding on a yearly envelop that should not be exceeded.

4) Reducing operational costs (transaction costs) linked to the implementation of PBF-FHC.

5) Preventing and correcting the misuse of FHC as it appears that patients overuse available services, especially within the under-five group. It is possible that some children over five are using these services to benefit from FHC.

6) Operationalizing referral and counter referral systems that respect all levels of care.

[22] In 2009, a strike of health care personnel occurred and the Government accepted to triple salaries. The Government asked hospitals and especially national hospitals, which are autonomous and pay their own personnel, to cover this increase. The Government proposed that hospitals could be reimbursed through increased subsidies the following year. Such a reimbursement never happened.

[23] PBF-FHC cost control memorandum, MSPLS, September 2011.

In 2014, these measures were revised to include additional measures[24]:

1) Reinforcing quantitative verification by introducing a triangulation of verified data on the basis of different documents (stocks, financial documents, activity reports, daily consumption of medical drugs and other inputs, requisition booklets for drugs and other inputs as well as all other relevant documents).
2) Capping the targets of incentivized indicators beyond which payments cannot be made.
3) Reinforcing verification mechanisms to assess quality by introducing new quality check lists, improvised service quality evaluations in a sample of health facilities, verification of quality by independent entities to avoid collusion as well as an annual evaluation including penalties if set criteria are not met.
4) Quality assurance with regard to secondary PBF contractors with the introduction of a quarterly verification of technical quality and an annual accreditation assessment including penalties if set criteria are not met.

In 2013, in parallel to these cost reduction proposals, the MSPLS launched a new strategy to mobilize additional resources from the Government and from TFPs. It is in this context that the project Amagara Meza financed by the European Commission agreed to allocate a portion of its 2014 budget to the payment of invoices produced from September to October 2013, while waiting for a new program estimate for July 2014 and a new fund for PBF-FHC for 2015. This amount is already included in Table 5, showing resources pledged by the government; this amount however does not help bridge the remaining financial gap of 37 percent for 2014-2016. Aside from the resources pledged (indicated in Table 5), the government asked the World Bank to shorten the duration of the current PBF project (initially scheduled to end in 2018). This would enable the government to have more resources and help reduce the 2014-2016 financial gap of 37 percent. At a later stage, the government and the World Bank could initiate a new PBF project for 2016-2018.

Negotiations with TFPs are ongoing to further support PBF-FHC: Gavi Alliance, the Global Fund to fight AIDS, Tuberculosis and Malaria and KfW (German Bank) are respectively expected to provide support in 2015, 2016 and March 2015. Moreover, following the political situation which prevailed in 2015, most partners officially announced suspending their financing for PBF-FHC. The only secured financing for 2016 is that of the government, the World Bank and Gavi. Informal discussions indicate that partners would like to continue financing PBF-FHC through non-state entities such as NGOs and UN organizations.

At medium term, at the national level, the comprehensive health financing strategy is foreseen to evolve towards Universal Health Coverage (UHC). This strategy will help integrate different health financing mechanisms and prevent both duplication and wastage. It will help determine how the population can contribute to health financing and help define how different actors (i.e. government, private insurances, local administrations, technical and financial partners) will finance health care, therefore reducing costs linked to the implementation of PBF-FHC. With regard to the implementation of UHC, adjustments to PBF-FHC will be considered to include a pooling of UHC resources capable of reimbursing free services. In this context, a "second generation" PBF is envisaged, particularly focusing on improving service quality, increasing service quantity at the HC level, and resolving key health system bottlenecks[25]. The integration of PBF-FHC in the national health financing strategy aims at increasing efficiency by integrating different financing mechanisms and improving the financial sustainability of the PBF-FHC approach. Free health care – even in the context of UHC – will not only be financed by the government but also through national resources (i.e. government, contributions from the population and from local administrations, cross-subsidies from insurances, etc.) as well as by external resources. For now – and before UHC which can only be envisaged for 2020 given the current situation – the coupling of PBF and FHC will be maintained and will be financed by the government and TFPs.

Despite the efforts deployed to reduce PBF implementation costs and to develop a resource mobilization strategy, the existing financial gap represents a short and medium term threat to the financial sustainability of the PBF-FHC scheme in Burundi. Any intervention to be sustainable should be planned based on the short term (2 years maximum) availability of resources; it should be based on a hypothetical mobilization of additional resources or on cost reduction strategies, which could also undermine the credibility of the intervention.

[24] Cost control strategy for the implementation of PBF, July 2014.
[25] Second Generation PBF : vision of the National PBF Technical Unit.