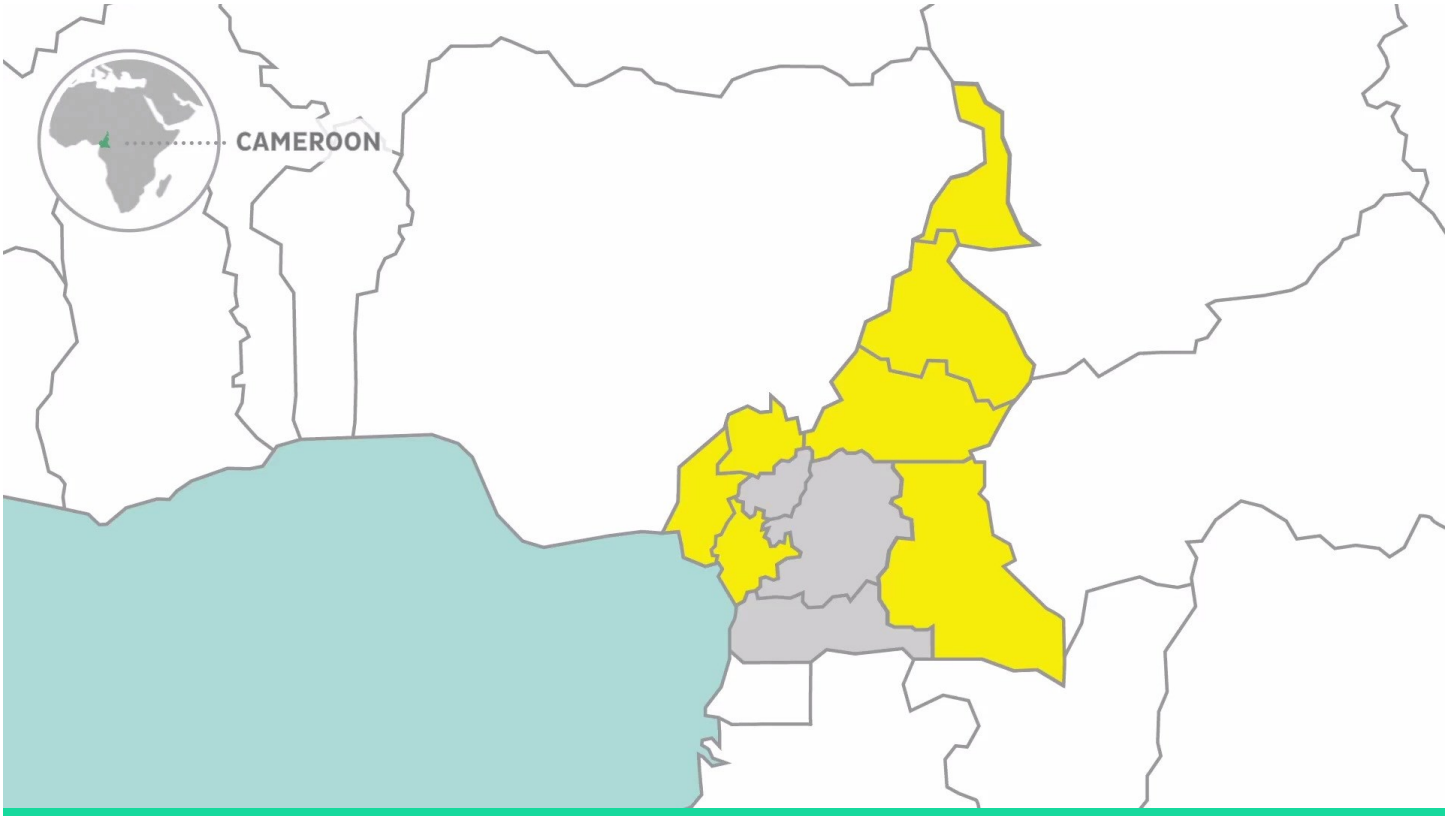

How « Performance-Based Financing » empowers the community and improves access to quality care in Eastern and North-western Cameroon

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Abbreviations

BCC	Behavioural Change Communication
BP	Business Plan
CAR	Central African Republic
CHW	Community Health Workers
DHC	District Health Committee
HF	Health Facility
HC	Health Committee
HD	Health District
IHC	Integrated Health Centre
MC	Management Committee
MoH	Ministry of Health
MDG	Millennium Development Goals
MPH	Ministry of Public Health
NW	North-Western
NIS	National Institute of Statistics
PBF	Performance-Based Financing
PPA	Performance Purchasing Agency
REDSSEC	Re-dynamization of Health services in East Cameroun
Reo-PHC	Reorientation of Primary Health Care
TFP	Technical and Financial Partners
WHO	World Health Organisation

Background

In an effort to improve health system, Cameroon opted in 1987 for the Reorientation of Primary Health Care (Reo-PHC) through the Bamako Initiative. Among other things, this initiative advocated for enhanced community participation through co-financing and co-management of health services. This co-financing implied a shift from a free healthcare system to a fee for service system with regard to the co-management. This involved the active participation of the community in the management of health-related issues through governance structures such as Health Committees (HCs) and Management Committees (MCs), who acted as interfaces between health facilities (HFs) and the community. A HC was composed of two representatives per village or neighbourhood, elected by peers.

At the Health District (HD) level, the presidents of the HCs formed District Health Committees (DHCs) who elected their "DHC bureau". The HCs met quarterly in their health facility to discuss health-related issues and to undertake actions on the basis of an action plan developed together with the medical staff. These activities concerned both the health facility level (management of the pharmacy) and the community level (social mobilization).

At the start of the implementation process of the Reo-PHC, enthusiasm was manifest. Over time, however, this enthusiasm gave way to despair[i]. First of all because, although the Reo-PHC supposed that HC members provide their services on a voluntary basis, increases in workloads and growing HF incomes motivated HC members to request compensations, which they never received. In addition, in some instance, heads of HFs perceived HCs as restraining their roles and power to the mere monitoring of health facility personnel, which led to conflicts. This situation was exacerbated by the fact that some HC members took on the role of health worker rather than that of community representative. Moreover, some HF officials perceived HC members as outsiders constraining management confidentiality. With time, most HC were not renewed, creating a dysfunction in community participation. As a result, community perspectives were no longer taken into account in the resolution of health-related problems. The Government's introduction of Performance-Based Financing in 2011 helped overcome these shortcomings.

Empowering the Community in the Context of PBF's Implementation Cycle: Results

PBF can be defined as "a transfer of resources based on performance[ii]", as "a performance incentive" , or as "a cash payment or a non-monetary transfer made to a national or sub-national government, a manager, a service provider or health service user based on predefined results that are achieved and verified: payment is subject to measurable actions[4]". The PBF approach can be considered as "a systemic shift involving changes in the relationships between actors, structures and processes[5]" .

The performance-based financing approach or mechanism is anchored in "best practices" or "basic principles", which include the strengthening of community voice and participation. As shown by the PBF's implementation cycle represented in Figure 1 below, the community is involved in the development and evaluation of business plans, the realisation of service delivery and in the implementation of qualitative verifications linked to the perceived quality of care.

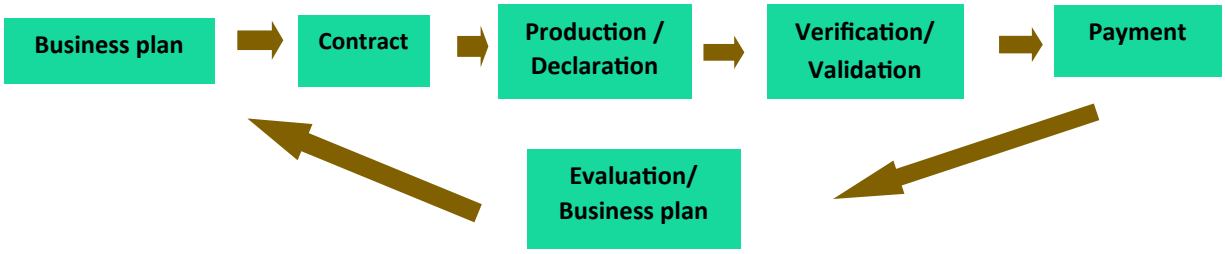

Figure 1: PBF Implementation Cycle

In north-western (NW) and eastern Cameroon, implementing the community participation component of the PBF approach has contributed to improvements in the coverage of health services, particularly in terms of their acceptability and use. In these regions, PBF seeks to strengthen community involvement through the following[6]:

[i]. Annual reports of the project « Redynamisation of Health services in East Cameroon », REDSSEC

[ii]. Witter et al. *Performance-based financing as a health system reform: mapping the key dimensions for monitoring and evaluation.* BMC Health Services Research 2013, 13:367. Available at: http://www.biomedcentral.com/1472-6963/13/367

3. L'incitation à la performance des prestataires de services de santé. Discussion Paper Numéro 1. OMS, 2010. Available at : http://www.who.int/contracting/DP_10_1_FR.pdf

4. Musgrove P: Rewards for good performance or results: a short glossary. Washington, D.C.: World Bank; 2011.

5. Witter et al. 2013

6. Following the concept of community participation developed by Rifkin et al. (1988).

Resource Mobilisation

Service Organisation

Needs Assessments

Leadership

Management of services

1. Organising the sharing of disease-related risk at the community level through mutual health insurances.

2. Identifying poor people to provide them with access to health services, either for free or at reduced cost.

3. Community implementation of health activities on the basis of sub-contracts with HFs.

4. Evaluation and use of the community's perception of the quality of care.

5. Community participation in the development of HFs' business plans.

6. Improving quality of care through recruitment and contracting of qualified personnel by HCs, with technical advice of heads of HFs.

These six points are explained below.

1. Organising the sharing of disease-related risk through mutual health insurances

The Eastern region is home to some of the poorest people of Cameroon. Among them, we can mention refugees from the Central African Republic (CAR), the Baka people and the Bororo people. To cope with fees related to health service utilisation, community members in East Cameroon have organized themselves into mutual health insurances with the support of an NGO (FAIR MED), which provides them with institutional and managerial support). These mutual insurances are for the most part based in areas with high concentrations of Baka people. To obtain funds, members organize income-generating activities and the revenue generated is used, for the most part, to pay for membership fees, benefiting those who worked in income-generating activities.

In addition, when memberships increase, mutual health insurances receive grants from Performance-Purchasing Agencies (PPAs). Although PPAs buy the performance of HFs, the subsidies provided do not allow HFs to cover the additional costs associated with caring for the poor. Medical expenses covered by mutual health insurances and cost recovery mechanisms help compensate for this shortcoming. PPAs hence also buy new memberships: mutual health insurances submit business plans and sign performance contracts with PPAs, who use new memberships as a performance indicator. These subsidies for new memberships represent a large portion of the income of mutual health insurances and enables them to cover medical bills issued by HFs. The role of PPAs as "buyers" of mutual health insurances improves HF performance and provides mutual health insurances with the capacity to welcome more members. In turn, through their contributions, additional members ensure that more money is made available to subsidise poor people, especially the Baka people, thereby facilitating their access to care.

Chart 1 below indicates that mutual health insurances members are increasingly seeking treatment in health facilities. The chart shows the evolution of new memberships as a percentage of new curative consultations, reflecting a slow but progressive increase from 9.65 % in January 2013 to 41.30 % in December 2013.

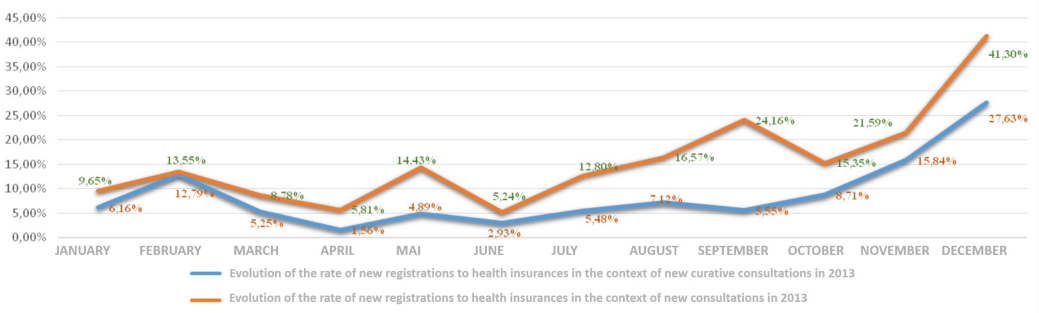

Chart 1: Evolution of the number of registrations to health insurances and in the use of HFs from January to December 2013.

Before PBF, sharing disease-related risk was limited to the wealthy, who registered with expensive private health insurances that were out of reach for the majority of the community. With the advent of PBF and the emergence of independent mutual health insurances, some HFs were able to reduce medical costs. Additional funding generated through the payment of results and increased memberships with health insurances contributed in increasing the population's access to health services. These cash flows are presented in Figure 1.

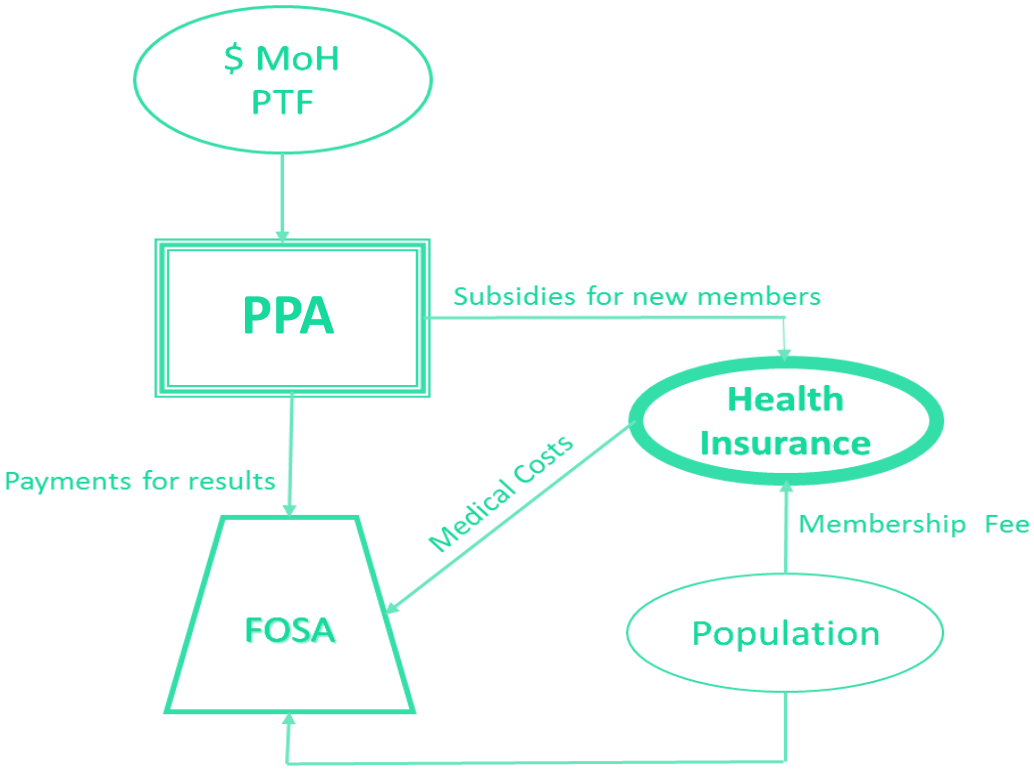

Figure 1: Institutional framework: relationships between the PPA, health insurances and HFs

2. Identification of the Poor

To improve universal health coverage, one of the key objectives of the PBF project in Cameroon is to improve the financial access of poor people to quality health care. With the introduction of PBF, a passive census (when getting into contacts with the health system or with HF) and an active census (carried out in communities by HC members) of the poor were carried out in the two regions[7] . The resulting lists of poor people, validated by HCs, are now available in communities and in HFs. They are dynamic lists that are revised annually given that people's statuses can change over time. Each health team determines its own quotas for free healthcare on the basis of its own dynamic criteria and available financial resources. Improved financial access ranges from completely free services to percentage discounts. As an example of the identification process, the Njinikom Catholic Hospital – supported by the community – set up cards for the poor. Used to identify poor people, these cards along with census lists facilitated poor people's access to healthcare.

Through this, the community encourages the poor to use health services. As a result, the number of poor people using HF services significantly increased as shown in Table 1, below: in the NW region, the number of poor people with access to health services increased from 176 at the beginning 2013 to 2383 in early 2014. In the same period, the number of poor people with access to health services in the East increased by 14 times (!)[8] .

[7] In communities, a poor person is defined as « someone who has nothing »; an individual who lives in difficult conditions and who cannot cover, among other things, his/her medical expenses. For example, epileptic patients are fully covered in most HFs.

[8] The following database contains verified and counter-verified PBF data from Cameroon www.fbrcamroun.org

Poor people with access to health services	1st Quarter 2013	2nd Quarter 2013	3rd Quarter 2013	4th Quarter 2013	1st Quarter 2014
Nord-west	176	724	1 080	2 171	2 383
East	1 229	2 317	6 287	9 109	17 810

Table 1 : Evolution of the number of poor people who used the service between the 1st Quarter of 2013 and the 1st Quarter of 2014 in the north-western and eastern regions.

Table 1 shows that identifying poor people and encouraging them to attend HFs contributed to improving service utilisation. From a supply-side point of view, this in turn increased HFs' financial revenues from performance-based bonuses paid by PPAs on the basis of service utilisation indicators.

3. Implementation of community-based health activities through HF sub-contracting

To improve health service utilisation by the community, community health workers (CHW) were contracted by HFs, especially for attaining the maternal and child health objectives of the HFs. Among other things, these CHW are responsible for the following activities:

- Implementation of a census at village level to identify target populations ;
- Identification of poor people;
- Referrals and patient support;
- Construction and use of latrines;
- Community-based treatment of malaria;
- Growth monitoring of children aged 0 to 5;
- Organisation of Behavioural Change Communication (BCC) sessions with different socio-cultural groups.

HFs remunerate CHWs on the basis of signed referral cards or vouchers. The compensation is performance-based and agreed upon beforehand between CHWs and HFs. This implies that CHWs are paid based on their individual performance during a given period, encouraging CHWs to give the best of themselves. Verification is carried out by HFs and communicated to PPAs. These results are then processed through the PBF cycle of verification and counter-verification. The contribution and involvement of CHWs are to be taken very seriously, especially in rural areas where health seeking behaviour is more likely to be influenced by local beliefs. The activities of CHWs help overcome these utilisation barriers while making very efficient use of local resources.

In general, the implementation of these community-based activities contributed to a significant improvement in indicators, as exemplified by the Integrated Health Centre (IHC) of Achain located in the Health District (HD) of Fundong in the NW region. To improve service utilisation, staff in this HF decided to subcontract indicators (highlighted in Chart 2 below) to CHWs. As a result, CHWs identify patients or clients eligible to receive care or service in the HF and encourage them to seek these. The CHW hands in a signed voucher for each patient or client referred to the HF. At the end of each month, the number of vouchers submitted by the CHW is counted to determine the level of compensation, and the CHW is paid accordingly.

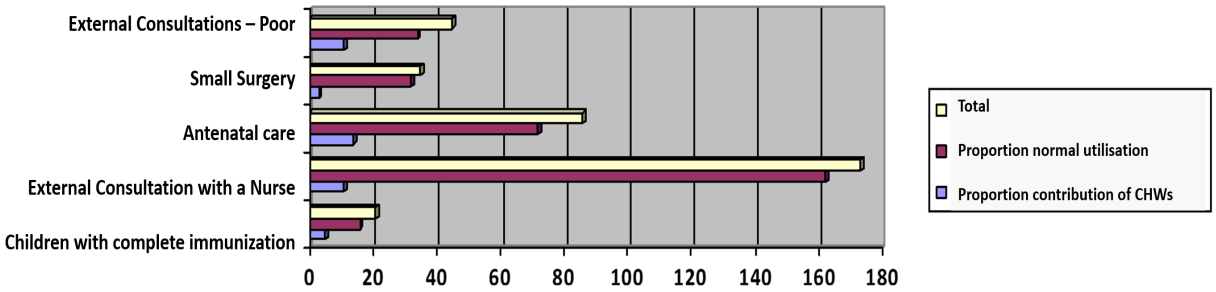

Chart 2: Proportion of patients going to the Achain IHC on their own and proportion of those referred by CHWs during the month of November 2013.

Chart 2 shows the proportion of patients who used the IHC of Achain on their own and the proportion of patients with vouchers who were referred by CHWs during a month. It shows that CHWs have contributed to a 10 percent increase in service utilisation experience. More research would however be needed to determine whether CHWs also improved the total utilisation of services (or: whether they brought in patients that would not have visited the health facilities would the CHW not have been there).

Chart 3 below indicates that the CHW realized HF revenues worth FCFA 52'000 by bringing in patients. From this gain, FCFA 15 000 were used to pay CHWS, producing a net HF profit of FCFA 37000.

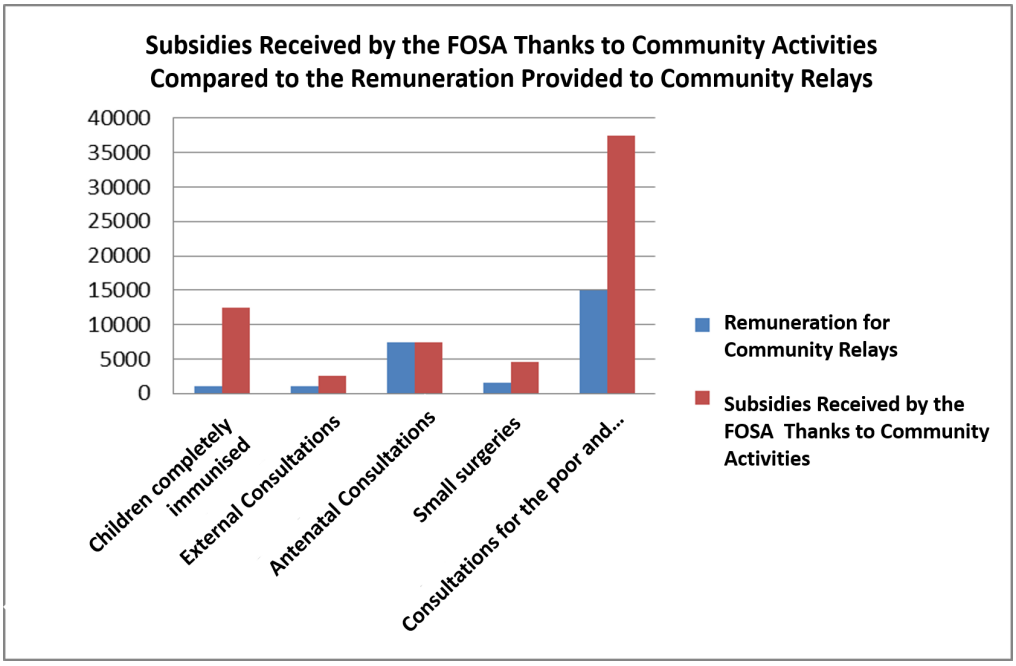

Chart 3: Financing brought to the HF through interventions implemented by community workers compared to the remuneration of CHWs in the HF.

Sub-contracting has shown the following effects:

- Strengthened collaboration between the community and the HF;
- Resolution of the Reo-PHC problem linked to volunteerism by financing community results;
- Improved HF indicators and increased revenue generation, profits and capacity to remunerate CHWs.

4. Perceptions of the quality of care taken into account by providers

As part of the institutional set-up of PBF, a local association was selected and trained to conduct community surveys and gather information on community perceptions on the quality and responsiveness of services delivered by HFs. At the same time, the surveys are used to confirm that patients indeed received care as reported by the HF, and to collect suggestions for improving services. Each survey enables 3 to 5% of patients, selected randomly, to give their opinions on the quality of care in a HF, especially with regard to assisted deliveries, prenatal care, outpatient care, immunisation, and hospitalizations. The administered questionnaire contains questions about waiting time, hospitality, costs of care, cleanliness, etc. Implemented quarterly, it contributes to overall quality scores of HFs, used to calculate and pay quality bonuses. Taking collected suggestions into account enable HFs to address access barriers related to e.g. financial, technical, socio-cultural and relational aspects.

Example 1: Quarterly surveys, administered in 2012 in the IHC of Mentang in the HD of Fundong in the NW region, showed that patients were very critical of the deteriorated condition of the HF and of the lack of drugs and basic equipment, preventing its use. On the basis of these comments, HF officials devised strategies to resolve the highlighted issues and integrated them into the Business Plan (BP). As a result, the lease for the building used by the HF was terminated in January 2013 and new premises were rented. This is a temporary solution pending the construction of a new building (see pictures below). The new building features a pharmacy providing drugs as well as basic medical equipment.

As a result of these changes, the HF has been experiencing since January 2014 an increase in patient attendance as well as an increase in revenue. These increases prompted the HC to construct a new and permanent building; its foundation is shown in the picture below.

Figure 3: Rent 1, Rent 2 and Foundations of IHC of Mentang

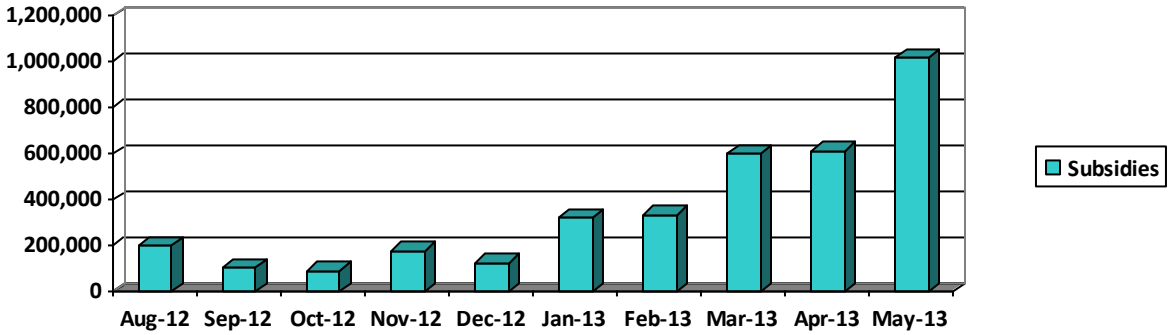

Chart 4: Evolution of subsidies in the IHC of Mentang from **October 2012 to May 2013**

Example 2: In the Dja Reserve, located in the HD of Yokadouma in the eastern region, the Baka people (pygmies) – who do not frequent cities for cultural reasons – asked the Sister heading the Catholic Health Centre of Massea for their surgeries to be carried out on site. To facilitate access of Baka people to quality surgery, the Sister established an operating theatre in the health centre and contracted freelance doctors to provide surgery. After the first month, 12 Baka people benefited this service, which is still available today.

Example 3: In 2006, the first community PBF survey conducted in the Catholic Health Centre of Batouri in the eastern region and in the IHC of Achain in the NW region, revealed that the community did not want male staff members in maternity wards. Consequently, heads of HFs replaced male staff members by female staff, resulting in a significant increase in the number of institutional deliveries, as shown in Chart 5 below.

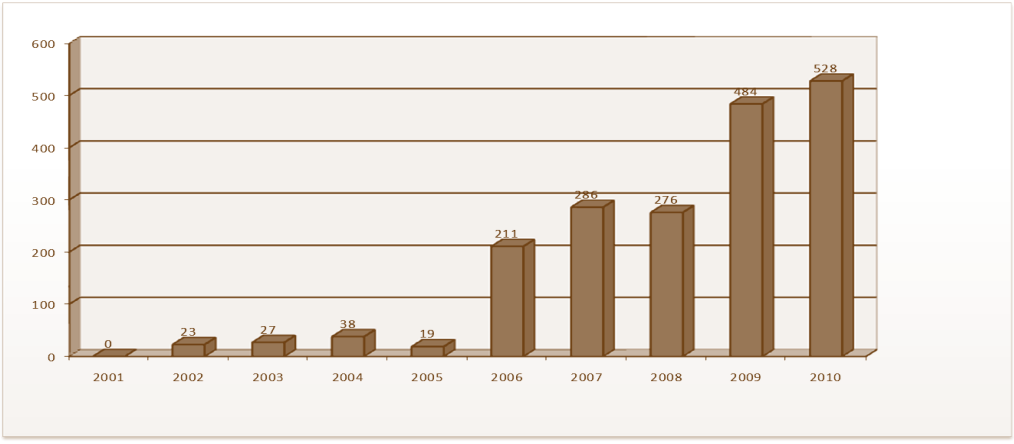

Chart 5: Evolution of the annual number of deliveries in the Catholic Health Centre of Batouri in the eastern region, before and after the introduction of PBF in 2006. Source: Annual Rapports of the Catholic Health Center of Batouri – these data were verified and counter verified.

5. Business Plan (BP) Development

The business plan is a quarterly forecast developed by the health structure, represented by health workers, members of HCs and other key resource people such as mayors. The BP is used to facilitate negotiation and guide the establishment of contracts between HFs and PPAs. HC members and health personnel were trained on PBF good practices and on the development of business plans. Provided with decision-making power, they participate in the process on a quarterly basis, bringing a community perspective when devising strategies to overcome health-related problems. Required to sign off on the business plan, the head of the HC can either approve or refuse activities and/or expenses based on their perceived relevance. To ensure their representativeness, HCs are composed of two village representatives elected by their peers (inhabitants of the village or neighbourhood). The HC bureau is elected for two years. Representatives can however be changed ad interim in case of in-activity or resignation.

A new business plan is developed once an evaluation of the previous business plan has been completed. This community-based intervention showed the following results:

1. A good understanding of health issues with appropriate prioritization;
2. Community contributions to the selection of context-specific strategies;
3. Commitment to implement community activities through the business plan;
4. Monthly monitoring of business plan implementation;
5. Monthly monitoring and evaluation of HF resource utilisation, using the INDICE tool.

The following illustrates the results attained through community participation. In both the eastern and the NW region, the business plan needs to be approved by the head of HC. It first entails that former business plans are evaluated and that budget implementation levels are determined. Then, community representatives (HCs and MCs) participate in developing a new business plan, in monitoring its implementation and in evaluating results. At the start of the project, however, some HCs did not exist. For those who did exist, their role was limited: they often signed off on BPs without actually participating in their development or mastering their content. This was the case at the Polyclinic MAEH (secular private clinic), located in the Bertoua Health District in the eastern region, where the HC president refused to sign the business plan because he was not involved in its development. This created a conflict that was resolved by the PPA, who instructed business plans to be developed with the full participation of the HC. As a result, a new document is now being elaborated. This shows how PBF contributed in reviving community participation through HCs.

Furthermore, with the “INDICE” tool (a transparent PBF financial management tool in which all revenue sources and expenditures are identified simultaneously and budget implementation levels are determined), the management of financial resources has become more rational. The tool is an integral component of the business plan and enhances accountability of health personnel towards the community.

This implies an efficient allocation of funding which, for example, benefits the technical facilities in terms of equipment, the quantity and quality of staff, the availability of medical drugs and in terms of the continuity of services. For example, in a particular HF, women asked for the delivery table to be changed. Moreover, prior to the project, most health centres were often staffed by one unqualified person only. This situation is currently improving: a study carried out in 149 HFs (18 hospitals and 131 health centres) in the eastern region of Cameroon shows that progress was made between the first quarter of 2013 and the first quarter of 2014[9]. The details are presented in table 2 below.

	1st Quarter of 2013	1st Quarter of 2014
HFs staffed by 2 people or less	54%	11%
HFs with a motorcycle in good condition	57%	60%

Table 2 : Evolution in the percentage of HFs staffed by 1 or 2 people and in the percentage of HFs with a motorcycle in good condition between the first quarter of 2013 and the first quarter of 2014

[9] Rapport of the 2014 baseline survey conducted among PBF contracted health facilities in Eastern Cameroun.

Table 2 shows an increase in the percentage of HFs staffed by two people or less, from 54 percent during the first quarter of 2013 to 11 percent a year later, due to recruitment of health personnel by HCs. Although this situation does not yet meet the standards established by the Ministry of Public Health, requiring each HF to have at least 6 staff members, it does prevent HFs from having to cease all activities when a staff member leaves – as was the case before. In parallel, the number of HFs with a motorcycle in good condition also increased from 57 % to 60 % in the same time frame.

The participation of the community in the development of business plans allows health interventions to be more responsive, notably to specific socio-cultural aspects. For example, in Mbitom in the HD of Betare-Oya, immunisations are now carried out on market days to reach as many people as possible. Similarly, in the NW region, community-based activities are considered to be more effective if implemented during the traditional mandatory day of rest.

6. Personnel Recruitment

The community also plays an important role in recruiting staff. As public HFs did not have a legal status, they encountered problems in recruiting personnel. As a result, the task was entrusted to HCs by virtue of their legal existence. HCs recruited and contracted qualified staff under the technical advice of the head of HF. Staff remuneration is covered by the HF's revenue, obtained through cost recovery and through PBF.

Management autonomy and the presence of subsidies allowed these health facilities to improve the availability of human resources. As a result, the number of staff increased from **673** in 149 HFS in the first quarter of 2013 to **791** in 159 HF in the first quarter of 2014. This represents an increase in the average number of staff per HF, from 4.5 per HF in 2013 to 4.9 per HF in 2014. Increasing the number of qualified staff might have contributed to improving the overall quality of care, which increased from 64% (January-March 2012) to 72% (January-March 2014) in eastern Cameroon. Chart 6 shows technical quality scores (red curve), community quality scores (the blue line) as well as the average of these two sets of scores (green curve).

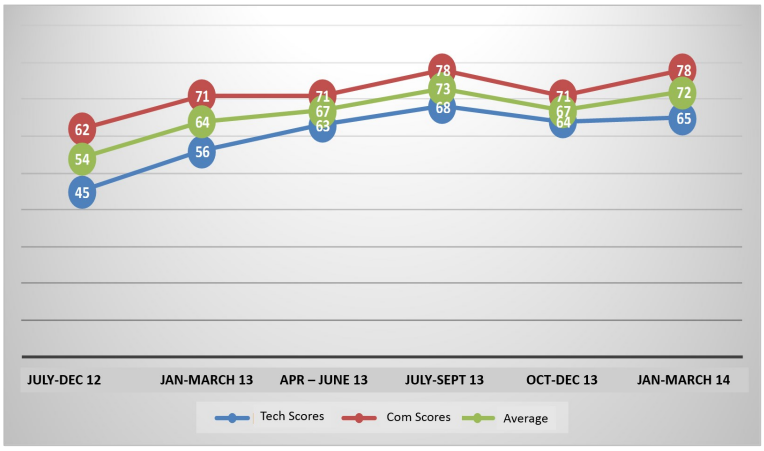

Chart 6: Evolution Quality Scores in the eastern region of Cameroon

Discussion

PBF effectively strengthens community participation. First, community perceptions on the quality of care directly influence HF service delivery. Even though it is the HF that finally decides whether or not to take community recommendations and comments into account, the community has the power to influence health facility revenues through community quality scores that are directly linked to performance payments made to the facility. In addition, the role of HCs in the context of business plans gives the community the capacity to influence HF strategies. Together, these elements incentivise HFs to provide **acceptable quality** services – as shown for example by the new on-site operating theatre staffed by freelance physicians for Baka people in the eastern region.

Moreover, PBF payments enable HCs to recruit qualified personnel, thereby improving service availability as well as the **quality and acceptability** of staff: the quality of personnel is guaranteed by the fact that the head of the HF is the one who establishes recruitment needs; acceptability is ensured by the fact that the community recruits personnel. In parallel, as PBF payments enable HFs to contract CHWs, they further involve the community in direct service delivery. The example of the Integrated Health Centre (IHC) of Achain in the HD of Fundong in the NW region demonstrated that contracting CHWs directly influenced **service utilisation**.

Along with improvements in service affordability through community sharing of disease-related risks (mutual health insurances) and the identification of poor people to facilitate their access to health care (free or at reduced cost), PBF also contributed significantly to universal health coverage (availability, accessibility, acceptability, utilisation and quality of services)[io].

In short, community involvement takes the form of a voice and a right to oversee (in case of the business plan, recruitment of staff, quality of care delivered, and identification of the poor) as well as that of a direct contribution (through mutual health insurances, cost recovery and CHWs). This participation provides the community with significant power with regard to HF activities. Moreover, PBF also gives an opportunity to further expand the power of the community, for example by assigning the right to co-sign business plans (‘ex ante' approval) and/ or to influence results-based payments decisions (approval "ex post"). Such a mechanism shifts the role of the community from advisor to decision-maker, thereby further guaranteeing effective health service coverage. Taking community participation into account when designing the PBF project provides an excellent opportunity to revitalize the principle of community participation to contribute to better universal health coverage.

[io] Coverage was defined by Tanahashi (1978) as the availability, accessibility, utilisation and quality of services.