

Performance-Based Financing Drill Down

(Part of the Four-day RBF Workshop for Bank staff)

110210 draft

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Working definition of Performance-Based Financing (PBF)¹:

“Performance-Based Financing is a health systems approach with an orientation on results defined as quantity and quality of service outputs. This approach entails making health facilities autonomous agencies that work for the benefit of health related goals and their staff. It is also characterized by multiple performance frameworks for the regulatory functions, the performance purchasing agency and community empowerment. Performance-Based Financing applies market forces but seeks to correct market failures to attain health gains. PBF at the same time aims at cost-containment and a sustainable mix of revenues from cost-recovery, government and international contributions. PBF is a flexible approach that continuously seeks to improve through empirical research and rigorous impact evaluations which lead to best practices (see footnote).²”

Background: Interest by Bank staff and partners in Results-Based Financing (RBF) has been growing steadily. As part of a two-day Results-Based Financing drill-down course, an extension to the WBI flagship course on Health Sector Reform and Sustainable Financing, this module will expose participants to Performance-Based Financing (PBF), a very common supply-side RBF mechanism in sub-Saharan Africa (SSA). PBF is the dominant RBF mechanism in SSA, and has potential to be applied to other contexts also. It has been scaled up in two SSA countries - Rwanda and Burundi - after successful pilot project phases. The Rwandan PBF program has been documented by a comprehensive impact evaluation (Basinga and Gertler, 2010) and has shown significant results.

¹ As discussed on the PBF googlegroups forum, a discussion forum of the African PBF Community of Practice, final consensus working definition as of 17 August 2010.

² PBF draws from micro-economic, systems analysis, public choice and new institutional economics theories. The effectiveness can be enhanced by demand-side interventions such as equity funds; conditional cash transfer programs, vouchers schemes and obligatory health insurance programs.

Burundi has scaled up PBF as of April 1, 2010, and the PBF approach will be illustrated through a case study. This case study will be analyzed through the prism of the five ‘control knobs’. We chose to showcase Burundi as it is the culmination of 8 years of progressive experience with PBF. The Burundi PBF model is interesting as it has merged the Selective Free Health Care for pregnant women and children less than five years old with the scaling up of PBF nationwide (Meessen et al, 2010). Significantly, it has also introduced equity adjustments. Further phenomena are the important ‘output budget’ (an estimated 20% of total health expenditure), and the creation of an internal market with multiple payers.

Objective: The objective of this PBF drill-down is to examine the institutional set-up of Burundi PBF through the lens of the ‘five control knobs’.

Methodology: (1) introductory power point presentation; (2) group work on case study; (3) plenary presentation of group work and (4) question and answer session. Time: two times 90 minutes.

Number of participants: 20 to 30

Recommended literature:

1. Financial and Other Rewards For Good Performance or Results: A Guided Tour of Concepts and Terms and a Short Glossary. Phil Musgrove (2010)
<http://www.rbhealth.org/rbhealth/news/item/387/financial-and-other-rewards-good-performance-or-results-guided-tour-concepts-and-terms> (accessed 3 September, 210)
2. Splitting Functions in a Local Health System: Early Lessons from Bubanza and Ngozi projects in Burundi. Maria Bertone and Bruno Meessen (2010), The Hague, Cordaid.
3. Performance-based financing: just a donor fad or a catalyst towards comprehensive health care reform? Bruno Meessen, Agnes Soucat and Claude Sekabaraga, (2011) Bulletin of the WHO, 89: 153-156.
4. Performance Based Health Financing Experiment Improves Care in a Failed State. Robert Soeters et all (2011) (accepted in Health Affairs)
5. Paying Primary Health Care Centers for Performance in Rwanda. Basinga, P. et al (2010) Policy Research Working Paper no 5190, Washington DC
http://econ.worldbank.org/external/default/main?pagePK=64165259&piPK=64165421&heSitePK=469372&menuPK=64166093&entityID=000158349_20100126092240 (3 September 2010)

Additional information sources:

1. Manuel des Procédures pour la mise en oeuvre du financement basé sur la performance au Burundi. Version Finale 15 March 2010, MOH (2010) (Burundi PBF user manual, in French)
2. File 'Master costing Burundi v 22 July 2010.xls' shows the costing for the PBF system and the output budget allocations per province
3. Performance-based financing and changing the district health system: experience from Rwanda. Soeters et al (2006) Bulletin of the WHO 84(11)
4. Output-based payment to boost staff productivity in public health centers: contracting in Kabutare district, Rwanda. Meessen et al (2007) Bulletin of the WHO 85(2) 108-115
5. Reviewing institutions of rural health centres: the Performance Initiative in Butare, Rwanda. Meessen et al (2006) TMIH 11(8) 1303-1317
6. Pay for Performance for improved health in Burundi, Jean Francois Busogoro et al, <http://www.rbfhealth.org/rbfhealth/library/doc/371/pay-performance-improved-health-burundi> (accessed 31 Aug, 2010)
7. Brand New Day: Newly Launched Nationwide PBF Scheme in Burundi Reflects the hopes of a Nation, Lindsay Morgan <http://www.rbfhealth.org/rbfhealth/news/item/340/newly-launched-nationwide-pbf-scheme-burundi-reflects-hopes-nation> (accessed 31 Aug, 2010)
8. PBF googlegroups: a discussion forum for the African PBF Community of Practice <http://groups.google.com/group/performance-based-financing?hl=en>
9. Report on the February 2010 Bujumbura PBF conference <http://performancebasedfinancing.wordpress.com/> (in French: accessed 31 Aug, 2010)
10. Cordaid PBF site: <http://www.cordaidpartners.com/address/performance-based-financing/home> (accessed 31 Aug, 2010) contains a host of information on the Burundi PBF program such as reports on household surveys (in French).
11. A personal story: seeking the roots of PBF, Robert Soeters <http://www.rbfhealth.org/rbfhealth/news/item/347/personal-story-seeking-roots-performance-based-financing-pbf> (accessed 31 Aug, 2010)
12. RBF website <http://www.rbfhealth.org/rbfhealth/> (accessed 31 Aug, 2010)
13. Performance-Based Financing toolkit: Checklist for Implementers. Fritsche, G., Soeters, R., Meessen, B., Ndizeye, C (2011). The World Bank, Washington DC (under development)

[Annex 1: Burundi Case Study](#)

[Annex 2: Case Study Assignments](#)

[Annex 3: Agenda](#)

[Annex 4: PBF Basic Package of Health Service](#)

[Annex 5: PBF Complementary Package of Health Services](#)

Annex 1: Burundi Case Study

Burundi Performance-Based Financing Case Study

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Background

Burundi is a small country in central Africa, with a 2008 population of 8 million people, and a population density of 311 per square kilometer; the second highest in SSA. The annual population growth rate is 2.9%. Since independence in 1962 it has had frequent internal political upheaval with the last war ending around 2007/2008. Protracted war led to brain drain and the collapse of the economy; the 2007 GDP was \$110 per capita, one of the lowest in the world, with a human development index ranking it as 174th from 182 countries (2007). Health indicators are also dismal with a child mortality of 176/1,000 and a Maternal Mortality Ratio estimated at 615/100,000. Household surveys document poor quality general health services, poor household hygiene and inadequate living conditions and a high unmet need for family planning (Cordaid, 2009).

In 2006, the President of the Republic declared a policy of free health care for pregnant women and children less than five years of age. During that year, Performance-Based Financing (PBF) pilots program were introduced in two provinces (Bubanza and Cankuzo) by the international Non Governmental Organization (NGO) Cordaid with financing from the Dutch government and the European Union. A second NGO, Health Net International-TPO and the Swiss Development Cooperation started pilot projects in Gitega and Ngozi provinces. By December 2009, 9 out of 17 provinces had ongoing pilot PBF projects.

The health sector, although underfunded, is getting more attention from the GOB; between 2005 and 2009, the GOB increased the share from its national budget dedicated to the health sector from 2% to 5%. On 1 April, 2010, a national PBF system was launched, a provider payment reform initiative which merged selective free health care with PBF.

Health Finance

Total overseas development aid was \$62.5 per capita per year (2008). The 2007 national health accounts showed a total health expenditure of \$17.4 per capita per year. Households and donors contribute both around 40% (37% out of pocket) whilst the government finances 17% (of which 6% are through funds from the highly indebted poor country initiative). The public health sector -which encompasses public and faith-based institutions - receives about 50% of these funds (21% for the district hospitals; 24% for the health centers and 5% for the tertiary hospitals).

The majority of funds (40%) are used for outpatient curative care whilst preventive and public health services use 22%. Access to health care was poor: it was estimated that, in 2005, 17% of patients did not have access to care and 81% had to incur debts when accessing care (MOH, 2009). The private for profit sector is small and predominantly located in the capital and the larger urban centers.

Providers were reimbursed for selective free health care expenses. However providers had to incur high transaction costs as supportive documents such as photocopies of the original bills had to be sent to the central MOH. Also, the reimbursements were irregular, incomplete and inequitable (MOH, 2010). For instance, tertiary hospitals in the capital consumed large parts of the free health care budget due to high reimbursements for caesarian sections. Also clients were bypassing primary health centers to access the tertiary level in the capital, leading to overcrowding, a lower quality of care and high costs to the GOB. In addition, reimbursements were versed in the 'drug account' and facilities were not authorized to use these resources for other than drugs expenses, leading to situations of large unutilized resources pooled in such accounts.

The selective free health care policy has had some notable successes such as increasing the portion of women delivering in health facilities from 22.9% in 2005 to 56.3% in 2008 (MOH, 2010).³

Input funding was highly inequitable: a 2007 WB health financing study documented a factor 60 difference between the best financed, and the worst financed province (Mwaro \$0.1/c/yr against Ruyigi \$6/c/yr). Apart from inequity in input funding, output funding proved also not equitable.

A mapping of PBF and free health care inflows for 2009, showed large inequities in resource flows. Whilst the average inflow through output financing was \$1.96/c/yr, the difference between the best and the worst financed province was a factor 16 (Buja Marie \$0.34/c/yr against \$4.45/c/yr in Makamba). It appeared that the PBF provinces were capturing a relatively large part of the free health care budget due to a better output (quantity and quality wise). Established PBF provinces captured on average \$1.39/c/yr free health care funds whilst non-PBF provinces \$0.81/c/yr attracted of these funds. The three tertiary hospitals were gaining \$2.87/c/yr from the available free health care funds.

³ However, a household study carried out in PBF and non-PBF provinces measured an increase in institutional deliveries in PBF provinces, but not in those without PBF (*Delivering equitable and quality health services through performance based financing. An intervention – control study from Burundi*, Soeters et al, 2010 – submitted for publication).

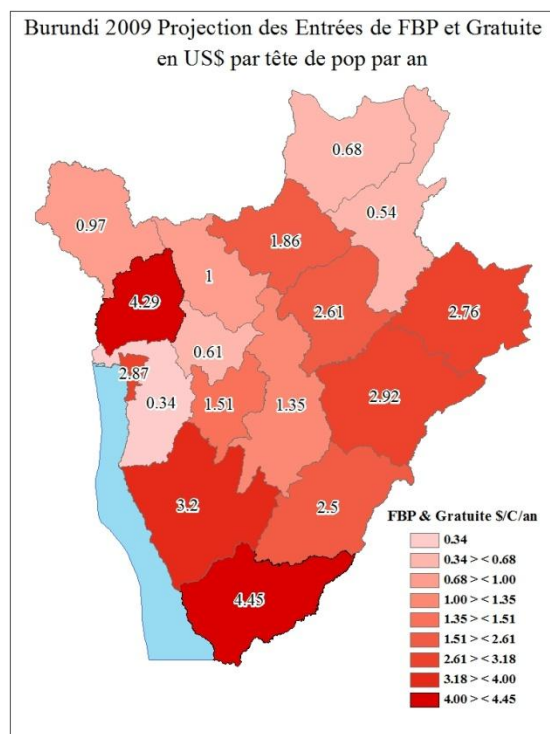


Figure 1: a thematic mapping of output financing for 2009, combining PBF and free health care reimbursements in USD per capita per year

The above figure shows for 2009, using thematic mapping, the estimated combined output budget for PBF and free health care reimbursements. Large inequalities in output financing are obvious.

In the new combined PBF/selective free health care system, all available PBF monies for three years were pooled virtually (an estimated \$100m); this consisted of IDA; EC and the government's free health care budget. This translates to about \$3.55/c/yr PBF budget. This budget estimate is conservative, other sources will be added. For instance, the budget of WB-MAP will be used to purchase HIV services.

In order to 'protect' the provinces that were worst off, and to advance the notion of *horizontal equity*,⁴ a system of equity adjustments was introduced. The available output budget was allocated to provinces based on five criteria (inhabitants/health center; population density; number of health workers per inhabitant; poverty score and travel time to the capital). The worst off province receiving 42% more output budget than the best off province (\$2.07/c/yr for Buja Mairie versus \$2.97/c/yr for Ruyigi). Provincial PBF output budgets were ring fenced, whilst

⁴ "Horizontal equity means providing equal healthcare to those who are the same in a relevant respect (such as having the same 'need'), A.J. Culyer (1995)." "Need — the Idea Won't So — but We Still Need It" *Social Science and Medicine*, 40, pp. 727–730

within each province the share going to health center and community against first level referral hospitals was 2:1.

A set of 24 services are purchased at the health center level, and a set of 24 services at the hospital level. Services purchased are predominantly those that are known to be of importance for reaching health related MDGs. These are mostly preventative services, and include HIV services at both levels. The complementary package at the first level referral hospital was, at the request of the MOH, also applied for the three tertiary hospitals in the capital. This is an issue which is under review.

Provider Payment

Staff working in health facilities is either a public employee or a contract worker. A large faith-based organization (FBO) service delivery network exists, although they are considered part of the public health system. MOH staff also work in FBO health facilities, but there are less such staff than in 'pure' MOH clinics. The private health sector outside the major urban areas is not large, bar in some rural areas along the Tanganyika Lake (Rumonge, Nyanza Lac and Makamba). Health facilities receive subsidies from the state through salaries, minor operating costs and for drugs (at the hospital level, but not at the health center level). Since 2006, health facilities are reimbursed for free health care delivered to pregnant women and children less than five years of age. Contract workers are paid through income generated from out-of-pocket expenses, and from PBF in those provinces where PBF was operational.

On 1 April 2010, a provider payment reform initiative combining free health care funds and PBF funds was launched nationwide. Providers sign purchase contracts with semi-autonomous purchasing bodies ('*Comite Provincial de Vérification et Validation*' (CPVV)), in which three monthly an amendment stipulates the new fees for a defined set of services (24 for the basic package of health services, and 24 for the complementary package of health services). The purchasable services have been standardized nationwide; however, the unit fees differ.

Each CPVV has been provided a certain annual global prospective budget, which in essence consists of two parts which are each 'ring fenced'; one for its health centers, the other for its hospitals. The budget for health centers is ring-fenced at about 2/3 of the total provincial output budget. For both levels, a set of five unit fees has been provided. The CPVVs are authorized to determine which health facilities are in each of the categories '0%-10%-20%-30%-40%', in which the middle 'unit fee set' of 20% corresponds to a forecasting based on available budget.⁵ The CPVV's can therefore 'push' more of the output budget to those health facilities within their province which they consider to be the most destitute.

⁵ The entire budget has been modeled into the fee categories '0%-80%' and each of the 17 provinces have thereafter been put into one of five 'fee-set' categories. Each CPVV has been provided a set of five fees (which cover a range of 5 ten percent increases). The forecasting model is available from the author, for those who wish to study the model more closely.

The CPVV's have been trained to apply an Excel based forecasting tool to follow population based targets. A web-enabled application has been designed which allows the CPVV's to enter performance data for their facilities; this will enable them to follow budget consumption and results achieved. The CPVV's will be held accountable for the level of budget disbursement (they need to disburse available output budget to its maximum possible extent) whilst they have the authority to change unit fees depending on results achieved. For instance: they can lower or increase unit fees in the purchase contracts, based on results achieved. These results can be of a positive nature such as reaching performance targets, or can be a lack of results in certain areas, possibly due to moral hazard or insufficient effort. Insufficient effort is dealt with through a combination of increased incentives and explicit negotiations on certain targets ('business plan' see below).

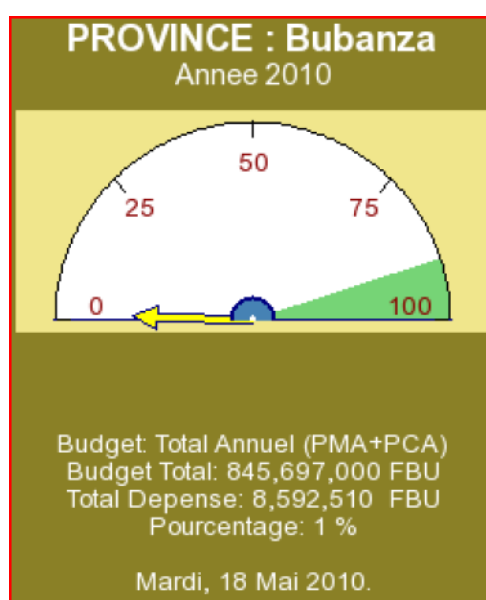


Figure 2: a dashboard for disbursements

The above image shows a screenshot of one of the budget disbursement graphical aids, a dashboard accessible through the web-application.

The quarterly amendment to the purchase contract is integrally linked to a '*business plan*' in which providers have to indicate what resources they would commit, and which strategies and level of effort they propose to reach the proposed results. The purchase contracts are negotiated, and 'contestable' in the sense that there is a real pressure for following through on the deliverables. There remains a possibility to lose the main contract, which can be a signal for the public health administration to take managerial action (an action as for instance replacing the head of the health center).⁶ Qualitative elements linked to these services are an explicit part of the business plan.

⁶ Heads of health facilities are Gov employees.

Providers are paid through a ‘carrot and carrot’ method: on top of the earnings through pre-established fee schedules for defined services, they can earn up to 25% more each quarter, if they score 100% through the quality checklist **and** if they score 100% on the community client satisfaction surveys. The community client surveys are weighted 40% on the quality score (see below on the ‘regulation knob’).

Providers can use up to 30% of the health facility income (from all sources; out-of-pocket; insurance; PBF etc) for bonus payments to their staff. A special excel tool called the ‘*indice*’ has been created for this purpose, and providers have been trained in its use.

Technical assistance to the CPVVs is provided through embedded technical assistants, and through the central technical support unit (CTN). A web-enabled database will allow the CTN to map the share of each payer to each province. This enables the CTN to maximize and to coordinate the use of all available PBF output budgets in the entire country. Pre-formatted payment orders are extracted and sent to the payer. For instance, the NGO Cordaid is sent its share of the output bills for the provinces it works; the remainder is paid by the CTN/MOH. As a further example: the WB-MAP is sent, directly, all HIV services from the basic and complementary package, from the entire country, for payment. Payments flow directly from the fund holders to the health facility bank accounts.

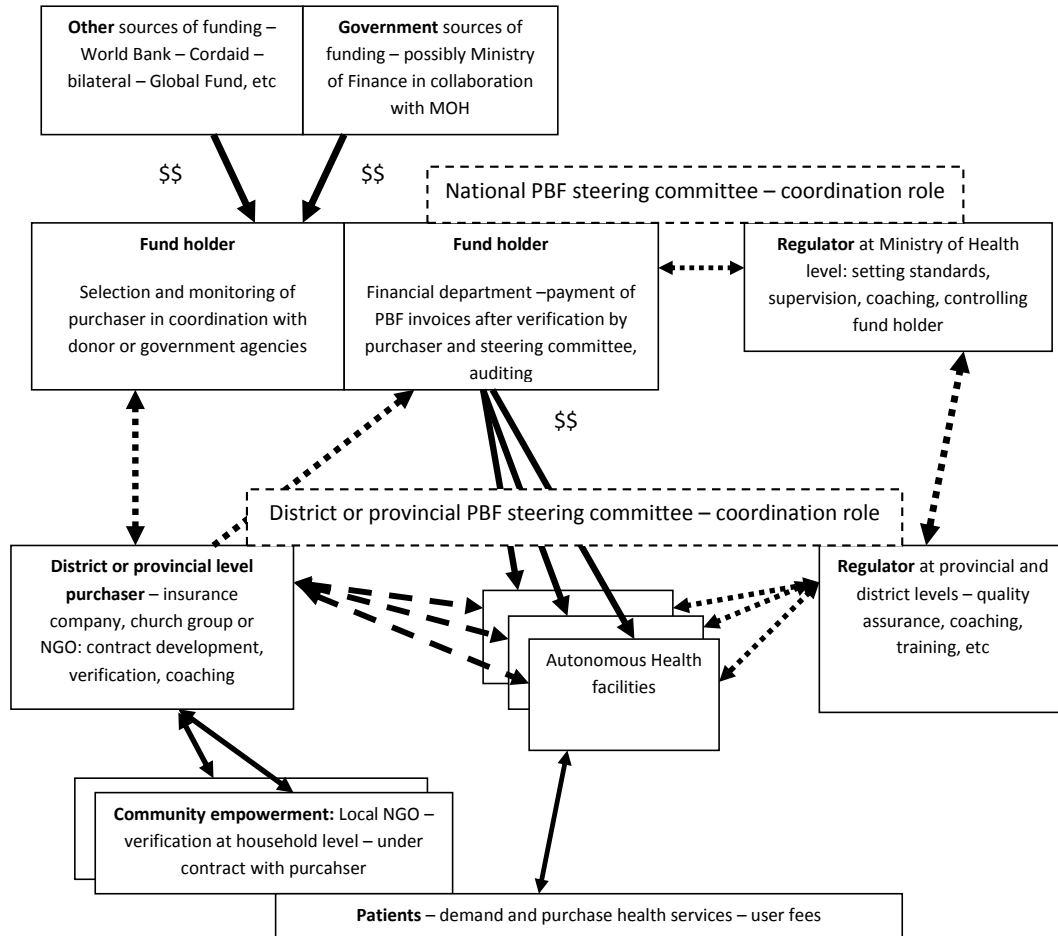
Transparency and accountability are assured; all CPVV’s, the CTN and payers have access to the performance data for the entire country, including the financial data and information related to payments.



Figure 3: a screenshot of the web-enabled application portal

The GOB has thus created an internal/quasi market for Performance-Based Financing. Decentralized strategic purchasing for important health related MDG services has been made operational.

Organization



The above figure depicts the set-up of the Burundi PBF administrative system. The institutional structure of the Burundi PBF system is circumscribed by a set of eleven contracts.⁷

1. Service contract between the MOH and the CPVV (delegation of power)
2. Service contract between the MOH and the Provincial Health Office (BPS)
3. Service contract between the MOH and the District Health Office (BDS)
4. Service contract between the MOH and the tertiary hospital
5. Service contract between the MOH and the central MOH departments

⁷ The manual is available -from the author- in French. The most significant performance frameworks are available in English; a translation of the manual in English is being worked upon.

6. Service contract between the MOH and the CTN (PBF central technical support unit)
7. Service contract between the MOH and the paramedical training institutions
8. Purchase contract between the CPVV and the health facility (health center or district hospital)
9. Purchase contract between the health facility and a second tier provider (whether non-for-profit, or for-profit)
10. ‘Motivation’ contract between the health facility and the individual health worker
11. Contract between the CPVV and the grass root organization (for community client satisfaction surveys)

The rules and regulations of the new PBF system are well described in the above contracts (MOH, 2010). Provincial Verification and Validation Committees (CPVVs) have been established. Their staff is drawn from a mix of Provincial Health Office (BPS) staff, and contracted technicians. Their office is located in the BPS.

This CPVV has an impressive set of tasks. These tasks are basically drawn from the NGO ‘fund holder model’ (Soeters et al, 2006; Soeters et al 2010), whilst the CPVV is not managed by an NGO, but in essence by an incentivized provincial health administration (see ‘regulation knob’).⁸ A few tasks have changed though, as compared with the NGO fund holder model. Firstly and importantly: the CPVV does not manage the payment function. This payment function has been delegated to the various payers. However, the CPVV has retained the ‘*purchaser* role’; it has been given the authority to negotiate and sign the purchase contracts. The CPVV also *verifies* the reported production of services.

This verification, a monthly task, consists of CPVV staff visiting the health facilities and verifying the reported production in the various registers. They essentially *re-count* the reported production, and triangulate the figures with the figures for these same services reported in the monthly EPISTAT report, the national health management information system, at the source.

The regulatory role related to quality has been conferred to the Provincial Health Office and the District Health Offices. This function ought to be carried out by a different team than the ones that are part of the CPVV, which is done to prevent or decrease potential conflict of interest situations. The quality role is done quarterly, and in collaboration with the District Health Office staff. Each quarter, each health facility is subject to a quality checklist. Its results impact on the service volume payments. The maximum amount health facilities can earn as bonus payment on top of their volume payments is 25% of achieved earnings.

⁸ This is a novel arrangement, and the institutional arrangements are monitored closely.

A ‘*motivation contract*’ stipulates the tasks of a health worker, and is written between the health facility management and the employee. It indicates which ‘share’ of the ‘bonus budget’ allocated by the health facility, the employee is entitled to get on top of her regular monthly take home salary, **if** she performs according to requirements. This is an important tool for the management to manage its human resources.

A so-called ‘*indice*’ which can be used as a paper-based or an excel-based tool, is then used to share the ‘bonus budget’ among the health workers. Payment for performance is monthly, so health workers earn a regular significant variable (depending on the overall health facility results and also on their personal role-adherence) bonus payment on top of their salaries. Management has an incentive to use existing human resources efficiently, to ensure sufficient earnings; however, they have to negotiate target based deliverables through their ‘business plans’. The ‘indice tool’ is an Excel-based tool, which enables the management to manage all resources, income and expenditures, including income from PBF, in a holistic fashion.

The GOB has effectively created an internal/quasi market in which a package of basic and complementary services can be purchased by a multitude of purchasers. There has been a fair amount of attention paid to the development of the indicators (see the ‘persuasion knob’), which also capture HIV and STD related services.

In the dominant PBF pilot project, which informed the national model, a separation of functions was instituted. This was a separation of functions between the purchaser/fund holder (an independent institution), the regulator and the provider. In the national model a semi-autonomous body was created which has taken over all the original fund holder functions, except physically holding the funds (see ‘persuasion knob’).

NGO and bilateral agency technical assistants have been mobilized to assist the GOB to roll-out and to make operational the national PBF model. Conceptually this can therefore be described as a ‘contracting-in’ situation, in which technical assistants assist the Gov to implement a program.

Increased autonomy is an important pillar of the Burundian PBF system. Health managers can manage resources in an integral fashion. Although still a contentious issue, when drugs or medical supplies run out in the provincial medical store drug revolving system, health managers do purchase items from the private sector. In fact, health facilities are judged through the quality checklist on a series of performance measures related to drug management, among which the availability of tracer drugs. Managers will therefore ensure using whatever means to their disposition, to score as high as possible on the quality checklists, and therefore, will purchase missing drugs from the private sector if need be.⁹

⁹ Price ought also to play a role; under conditions of comparable quality, managers should not be obliged to buy from the public distribution center if the public distribution center is more expensive.

CPVVs also select and contract grassroots organizations GROs, and train select members in community client satisfaction surveys. The GROs are paid on a performance base: per client found and correctly interviewed in the community. Apart from verifying their existence (to detract ‘phantom patients’), clients are also asked a host of questions related to the level of out-of-pocket payments and satisfaction with services received. These results are converted into a quantitative score, and contribute each quarter to 40% of the composite quality score of the health facility.

Providers are allowed to sign sub- contracts with other providers, both non-for-profit and for-profit, for certain parts of the health packages that they have been contracted to provide. Increased health facility autonomy, which allows management to manage resources in a holistic fashion, is part of the reform. This approach in fact incorporates the private for profit sector in the public health system, which allows leverage on quality assurance in the private sector. This is a win-win situation as the private sector will benefit from the subsidies.

The PBF central technical support unit in the central MOH, the ‘*cellule technique nationale*’ (CTN) is staffed with dedicated bureaucrats, and contracted workers. Technical assistants are added progressively by various partners (WB; EC; Cordaid; Belgium). This CTN has an important role in the oversight and coordination of the system. It recently created a ‘*CTN élargie*’, which is modeled on Rwanda’s ‘extended team’ mechanism. This coordination mechanism is created to bridge the gap between policy and implementation.

Finally, the CTN is also the secretariat of the national PBF steering committee (‘*plateforme nationale*’), a higher level policy and strategy making body. An interesting element of the CTN is that it is itself under a performance framework, applied each month, and a larger one each quarter. Result payments for the MOH staff working in this unit are very significant. The first payment that the GOB did to its health facilities was made 20 days faster than the officially indicated time frame in the project management manual. This was way before any one of the other payers paid its share.

Persuasion

The first Burundi PBF pilot project was started in 2006. Actors involved in the successful PBF pilot projects in Rwanda (2002-2005), after scaling up in Rwanda (2006), moved to Burundi and DRC to replicate these interventions. The need for early advocacy and capacity building within the MOH were some of the lessons learned from the scaling up processes in Rwanda. The NGO Cordaid started with early capacity building, and provided funding for a central coordination unit in the MOH with concomitant capacity building of MOH staff linked to this coordination function, and successfully lobbied the MOH for including PBF in national policy documents. Proof of this activity can be found in the 2006-2010 national health strategy document (PNDS), in which PBF was put forward as one of the strategic priorities.

The Burundi MOH therefore, was quickly convinced of the utility of PBF for strengthening their health system. Frequent high level missions to neighboring Rwanda, 2007-2009, where the scaling up had been accomplished successfully, also informed the MOH of the nuts and bolts. Various actors, international and local with field experience in Rwanda played a part in the knowledge transmission in Burundi. Human resources from Burundi, working in Rwanda, also contributed their bit in the quick acceptance of PBF as a valuable health system intervention.

Various development partners were requested by the MOH to convert their programming into output based financing mechanisms. Such was the case with the Swiss Development Cooperation. The issue with these requests was that such agencies were not financially or technically prepared to do PBF (Bertone and Meessen, 2010).

Also, a large classical health strengthening program, along input lines, financed by the EC was converted into PBF. This did not go very smoothly. Reasons for these wobbles can be explained through a combination of a ‘clash of paradigms’, a ‘clash of ideas’ and a ‘clash of characters’.

The innate contradiction in input financed programming versus results based financing programming led to this ‘clash of paradigms’. There is a deep divide in planning systems, strategic approaches, and financing methods in both approaches.

Having worked an entire career in ‘input financing’ projects, some actors were challenged conceptually, but also in some instances, did not embrace this new financing method emotionally. The ‘clash of ideas’ revolved around conceptions of how to improve the quality; this issue has an interesting resemblance to similar conflicts in the scaling up processes in Rwanda. The largest conflicts in Rwanda also surrounded the issue of how to measure, to evaluate and to pay for quality performance.¹⁰ Finally, the ‘clash of characters’ was about individuals strongly engaged in health reform processes, here, also, interesting parallels can be drawn with the Rwandan experience. It might be that the inherent nature of these fundamental reforms leads to these types of conflicts.¹¹

The MOH, although it had embraced PBF as their key strategy to reform their health system, had different ideas on how to organize this than its partners. Most partners proposed to follow the ‘NGO fund holder PBF approach’, in which the purchasing and the funds were held by non-state entities. This vision was fundamentally based on the insurance company model as the purchaser and fund holder, such as in the Netherlands. The MOH did not share this vision at the time.

A team of independent mediators was brought in to negotiate a solution to this institutional challenge. A week of negotiations between the various actors led to a consensus agreement,

¹⁰ The lessons learned here are that if such processes are not well-managed, that the danger lies in the phenomenon of ‘you do not like my indicator, so you do not like me’

¹¹ Health Policy, An Introduction to Process and Power, Gill Walt (ed) (1994), London, Zed Books Ltd.

which was ratified during a national workshop in Bujumbura in March 2009. This consensus agreement proposed a hybrid arrangement, a so-called provincial verification and validation committee (CPVV), in which incentivized bureaucrats would work alongside contracted staff.

The WB was involved significantly in preparatory work, for instance in the legal agreement which in essence showed the way how to engage in Performance-Based Financing mechanism through WB procurement mechanisms. An IDA grant to support the GOB's health reforms worth \$25M for three years was signed 8 May, 2009; the financial agreement was signed July 7, 2009.

A draft PBF manual was prepared by a consultant. This PBF manual was further elaborated during a retreat with all stakeholders in August 2009. In September 2009, a workshop was held, in which, using a modified Delphi technique, the services to be bought at the health center and hospital levels was determined. Also, their relative weights were decided using the Delphi technique, and a costing was done based on these findings. During this period, intense consultations were held with the MOH/CTN on how to integrate the selective free health care funds in PBF. In September two consultants worked with a group of technicians to design a training curriculum using the PBF manual. Training was done through a snow-ball methodology. Between January and April 2010, the trainings were done in the entire country, and contracts were signed at all levels.

In Nov/Dec 2009 a mission looked at the issue of equity, and proposed a way forward (see the health finance knob). The costing was done December 2009-March 2010. A web-enabled application and a website through which to access this application was created between Jan-June 2010. A server location in Bujumbura had been selected also. The new PBF system was launched April 1, 2010, nationwide.

Regulation

The role of the regulator in PBF belongs to the MOH, and the provincial and district health offices. The CTN/MOH has a clear stewardship role; it manages the contracts with the CPVVs, with the BPS's and the BDS's, the paramedical training schools, the four tertiary care institutions and with the third party counter-verification agent. The CTN also coordinates the development partners, functions as the secretariat of the national PBF coordination committee (PN), and organizes (and presides) the 'CTN *élargie*'.¹² It is also managing the web-site and the web-enabled database, and is involved in operational research and information dissemination related to PBF.

Key functions of the CTN have been incentivized through a performance framework. This framework is applied monthly, whilst each quarter a larger performance framework is applied.

¹² The CTN 'élargie', is an implementation oriented coordination mechanism, modeled on the Rwandan 'extended team' mechanism. It is presided by the CTN, and it incorporates MOH/CTN and technical staff from non-state agencies involved in providing technical assistance to the provinces.

Core MOH staff in leadership and technical positions in this CTN are held accountable for a couple of key deliverables, such as for instance the speed with which the payment orders are approved.

The Provincial Health Office, in conjunction with the District Health Offices in its province, is responsible for applying the quality checklists to the health centers in a timely manner. This function is incentivized through a performance framework, which also includes supervisory tasks of the District Health Office, their role in the drug revolving fund (provincial pharmacy), their planning and coordination role, and their role in the health management information system. The District Health Offices, on their turn, are held accountable through a performance framework for a series of tasks also.

The incentives linked to these tasks represent a significant sum of money: if the tasks are carried out correctly (100% performance), then each bureaucrat can potentially earn double to triple her (admittedly low) base salary. These performance based bonus payments could potentially elevate the take home earnings to a comparable level with the contracted technicians in the CPVV.

A third party verification agent, HDP, has been hired to check the validity of all performance measures throughout the system, each quarter. From the CTN performance frameworks all the way down to the community client satisfaction surveys. This is done ex-post, that is, after the payments have been made. Ex-ante control is significant, and at all levels of the system also (see ‘organization knob’).

Note: this case study has been reviewed by Petra Vergeer, Robert Soeters, Sunil Rajkumar and Montserrat Meiro-Lorenzo. I am indebted to Robert who was so kind to supply the image of the Burundi PBF institutional design.

Annex 2: Case study assignments

Divide in five groups; one for each of the five ‘control knobs’ (Health Finance; Provider Payment; Organization; Persuasion and Regulation).

Read the case study, and answer the questions related to your control knob. If you have specific questions, try to find an answer by reading bits from the text of the other control knobs or contact a facilitator.

Your assignment is to make a short 10 min presentation in plenary about your group’s control knob, as applied to the Burundi PBF case study. Below are a couple of specific questions to guide your group work, grouped by control knob. These questions are illustrative, more can be asked.

- **Health Finance:**
 - Examine the health financing situation prior to the introduction of the provider payment reform initiative, and comment
 - What is your opinion on Selective Free Health Care in Burundi?
 - How is the new PBF system financed?
 - Examine how the GOB has tackled the issue of horizontal equity
 - How is strategic purchasing done?
- **Provider Payment:**
 - How are providers paid?
 - What are providers paid for?
 - How are fees set?
 - Purchasing services through fee-for-service could lead to Moral Hazard from the side of the providers. Examine how this issue is dealt with in Burundi PBF and provide your opinion
 - Examine whether there could be an issue of Supplier Induced Demand, and provide your opinion
- **Organization:**
 - Examine the level of autonomy and degrees of freedom of providers in Burundi
 - Examine the level of autonomy of the CPVV

- Examine the internal market/quasi market
 - How is the separation of functions made to work in Burundi PBF? What is your opinion?
 - Examine how the voice of the community is made operational and provide your opinion
 - The MOH in Burundi at all levels (central; provincial and district) has staff that are underpaid, and who rotate frequently. Nevertheless they have been given a significant task in the accountability and governance processes of PBF. Examine the way this has been tackled, and express your opinion.
- **Persuasion:**
 - PBF is a significant departure of ‘business as usual’ in development financing. Examine the way it was introduced in Burundi, and draw some tentative conclusions
 - After the successful scaling-up of PBF in Rwanda (2006 onwards), some observers opinioned that due to strong leadership in Rwanda, the policy lessons related to PBF will not be replicable in other countries. Burundi is classified as a fragile state, and its institutions have been damaged through prolonged internal turmoil. Discuss this issue and provide your opinion.
 - Examine the way the NGO Cordaid persuaded the MOH related to PBF.
 - Discuss how PBF can best be introduced by the Bank and what role the Bank could play in persuasion, if any.
 - Discuss the conflicts surrounding the separation of functions, and the role of the provincial purchasing body (CPVV). What is your opinion on the consensus solution?
 - **Regulation:**
 - How is the regulatory task organized? What is your opinion of the fact that (a) the bureaucrats carrying out the regulatory task are incentivized and (b) the checklists with which they assess the quality of care, are incentivized [*see sample checklist health center; sample output framework for CPVV*]
 - A third party has been contracted through a competitive tender, to carry out a counter-verification of results at all levels (community; health facility; province and central levels). Assess this phenomenon: what is your opinion?

Annex 3: Agenda

Time	Topic	Presenter/method	Desired Outcome
5 min	Introduction to the session, explanation of the literature list	Plenary (PV)	Understanding of the session objectives
30 min	Introductory power point	PowerPoint 20'; QA 10'; plenary (GF)	Introduction to PBF, and Burundi PBF
10 min	Explanation of group work assignments; creation of groups	PV	Creation of five groups
70 min	Case study	Group work (PV and GF)	More advanced understanding of the application of one specific control knob for each group: deepening the understanding of the Burundi PBF case study
60 min	Presentation of group work 'control knobs'	Each group: 5*10' ; 10' wrap up (PV)	Understanding of the five control knobs as applied to the Burundi case study
5 min	Wrap up	(GF)	

Annex 4: PBF Basic Package of Health Services

US\$ 1 = FBU 1,235 (Sept 2010). The unit fees are valid for this specific health center, for the second quarter of 2010.

Rapport PMA Centre de Sante							
Etablissement Sanitaire: CDS Bubanza I		Remarque:					
Province: Bubanza		<input type="text"/>					
Periode: Avril-2010 Trimestre: 2							
Total du rapport: <input type="text" value="0"/>							
#	Indicateur	Quantité	Tarif	Total			
1	Nouvelle Consultation Curative (> 5 ans)	0	300	0			
2	Nouvelle Consultation Curative (< = 5 ans)	0	700	0			
3	Journée d'hospitalisation > 5 ans	0	520	0			
4	Journée d'hospitalisation < = 5 ans	0	1,050	0			
5	Petite chirurgie	0	1,300	0			
6	Référence et patient arrivé à l'hopital	0	1,700	0			
7	Enfants complètement vaccinés	0	3,000	0			
8	Femmes enceintes VAT complètement vacciné	0	1,300	0			
9	Distribution des MII	0	1,300	0			
10	Latrines construites dans l'aire d'attraction du CDS	0	1,700	0			
11	Dépistage des cas TBC positifs par mois	0	17,000	0			
12	Nombre de cas TBC traités pendant une semestre et guéris	0	43,000	0			
13	Dépistage volontaire du VIH/SIDA	0	1,700	0			
14	Femme enceinte VIH+ mise sous protocole ARV prophyl	0	13,000	0			
15	Prise en charge du nouveau né d'une femme VIH +	0	13,000	0			
16	Nombre de nouveaux cas sous ARV	0	13,000	0			
17	Nombre de clients ARV suivi semestriellement	0	43,000	0			
18	Cas des IST traitées	0	875	0			
19	Accouchement eutocique	0	6,000	0			
20	FP: Tot. Nouveaux + Anciennes Acceptantes	0	2,500	0			
21	FP: Implants et DIU	0	8,500	0			
22	Nouvelle Consultations Curative Femme Enceinte	0	2,600	0			
23	Consultation prénatale standard (3x)	0	850	0			
24	Consultation postnatale	0	850	0			
TOTAL							
Sauvegarder							

Annex 5: PBF Complementary Package of Health Services

US\$ 1 = FBU 1,235 (Sept 2010). The unit fees are valid for this hospital, for the second quarter of 2010.

Rapport PCA Hopital				
Etablissement Sanitaire: HD 1. Bubanza		Remarque:		
Province: Bubanza		<input type="text"/>		
Periode: Avril-2010 Trimestre: 2				
Total du rapport: <input type="text" value="0"/>				
#	Indicateur	Quantité	Tarif	Total
1	Nouvelle Consultation Curative Médecin (> 5 ans)	0	1,300	0
2	Nouvelle Consultation Curative M (< = 5 ans)	0	2,200	0
3	Journée hospitalisation >5 ans	0	1,100	0
4	Journée hospitalisation < = 5 ans	0	2,200	0
5	Contre-référence arrive au CS	0	2,200	0
6	Chirurgie majeure	0	32,000	0
7	Petite chirurgie	0	2,200	0
8	Dépistage des cas TBC positifs par mois	0	22,000	0
9	Cas TBC traité pendant semestre et guéris	0	54,000	0
10	Dépistage volontaire du VIH/SIDA	0	2,200	0
11	Femme enceinte VIH+ sous protocole ARV prophyl	0	16,000	0
12	Prise en charge du nouveau né d'une femme VIH +	0	16,000	0
13	Nombre de nouveaux cas sous ARV	0	16,000	0
14	Nombre de clients ARV suivi semestriellement	0	54,000	0
15	Cas des IST traitées	0	1,100	0
16	Accouchement eutocique	0	7,500	0
17	Césarienne	0	64,000	0
18	Accouchement dystocique	0	49,000	0
19	FP: Tot. Nouveaux + Anciennes Acceptantes	0	3,500	0
20	FP: Implants et DIU	0	11,000	0
21	PF: ligature trompes - vasectomie	0	44,000	0
22	Nouvelle Consultations Curative Femme Enceinte	0	5,400	0
23	Consultation prénatale standard	0	1,100	0
24	Consultation postnatale	0	1,100	0
TOTAL				