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Effecting performance based financing to improve leadership and governance: the case of Cameroon

Effecting Performance based Financing to improve Leadership and governance, The case of Cameroon

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Introduction

- In 2009, the Ministry of Public Health in Cameroon, working in partnership with the World Bank, funded the Cameroon Health Sector Support Investment Project. The five-year US$25 million initiative was designed to support the provision of key maternal and child health services through performance-based financing.
- In 2014, additional financing of US$40 million through the Health Results Innovation Trust Fund was allocated to support the introduction of PBF in the three northern regions of the country, which have the nation's poorest health outcomes and later the east and NW west region in some 3 districts out of the 19 districts of the NW
- In October 2019, it was declared a nation wide strategy, to include all health facilities.
- Since its introduction, PBF has been improving the availability, accessibility and quality of health services in Cameroon.

Introduction cont.

- The turn of the millennium saw the rise in UHC as an overarching objective shaping the health sector in LMICs ,
- Since the strategies to increase access and coverage to quality health services have been reframed being part of the international movement towards UHC.
- PBF is a health systems reform that moved from an input based to output based purchasing approach.
- As of June 2017, 32 out of 46 (71.7%) of Sub Saharan African countries utilize PBF.(Gautier et al, 2019).

The Problem

- Raising health cost and growing public demand for access to high-quality, affordable care further increases the political pressure to make wise policy choices.
- WHO analysis is of the view that 20-40% is wasted through inefficiency.
- Concerning the path to universal coverage, the report identifies continued reliance on direct payments, including user fees, as by far the greatest obstacle to progress.
- In Cameroon; high child and maternal morbidity and mortality(782 death/100,000 , 103deaths per 1000 in less than 5 years; all these led to inability to meet up with MDGs

Percentage of strengthened districts at 7% instead of the targeted 80%

The Problem

- High rate out of pocket payments for health care with families taking the greatest share 70.4 % and the government takes 20.7%; reprioritization for health is an insidious process with total expenditure at 5.1% instead of the 15% agreed in 2012 Abuja declaration by African states in collaboration with WHO.
- Health Insurance still only at 4%, health risk sharing has been proven to be the best form of health financing in most countries, (HSS- 2016- 2027)
- Lack of clarity regarding legal and financial procedures in the input based financing and the successes registered in the output financing in the pilot phases in the east Regions and some health districts in the North West region of Cameroon and experiences of other countries like Rwanda.

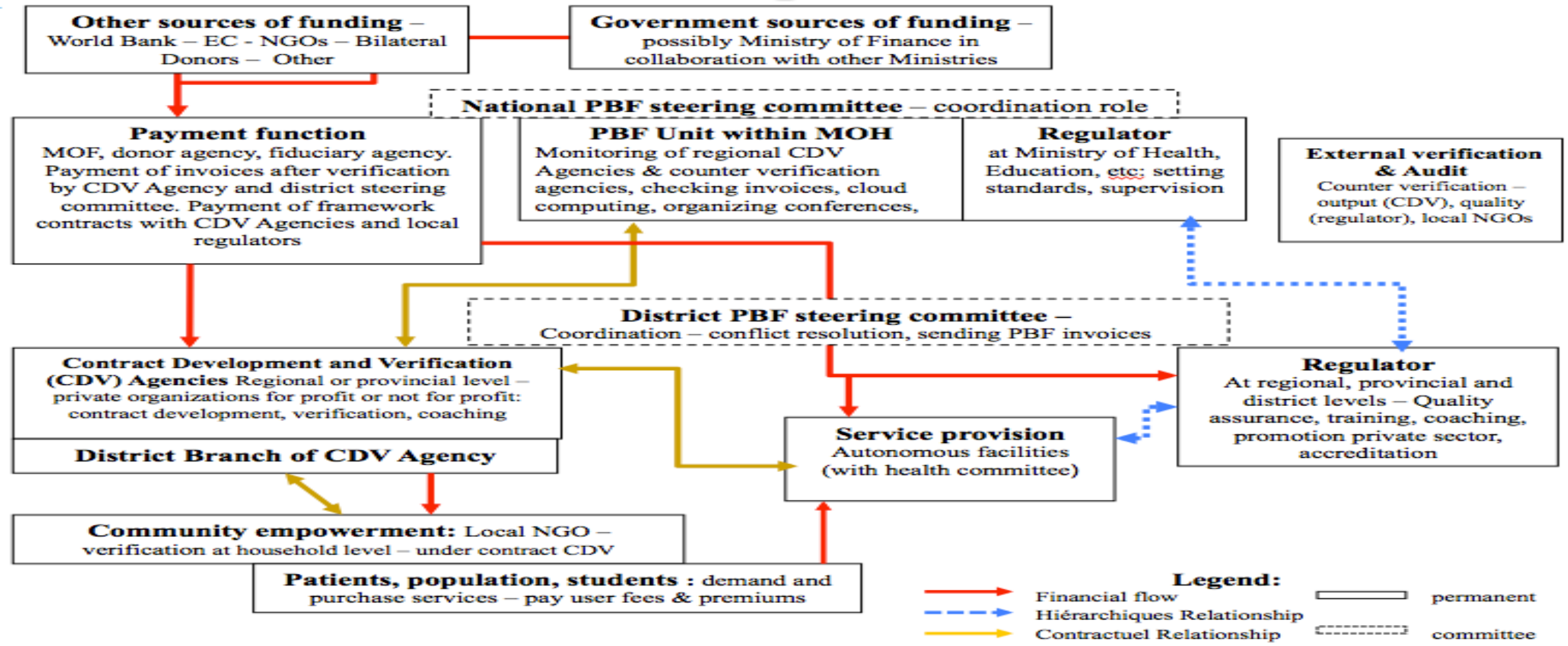
The problem

- Inadequate HRH and the need for innovative strategies to strengthen health funding.
- Slow infrastructural development.
- Lack of an integrated approach and insufficient coordination in financial management and financial productivity of health facilities not properly monitored to help the optimal use of public funding.
- Extreme hierarchical nature of interventions leading to inefficiencies.
- Risk of concentrating on incentivized than on un-incentivized activities

The problem

- A lot has remained unknown about the exact mechanisms triggered by PBF arrangements;
- Financing is centre to efforts in improving health and health systems.
- The 17 SDGs and especially goal 3 aims to ensure healthy lives and promote wellbeing for all and Universal health coverage.
- This improvement often requires substantial changes in the organization and governance of health systems, in the face of limited human and financial resources.
- As a result, decision-makers identified the lack of a suitable health financing policy as an important issue that needed to be addressed. The change in the political discourse toward more accountability made room to test new mechanisms

Concepts of interest- institutional design of PBF in most countries- www.sna-health.com 2017



Concepts of interest

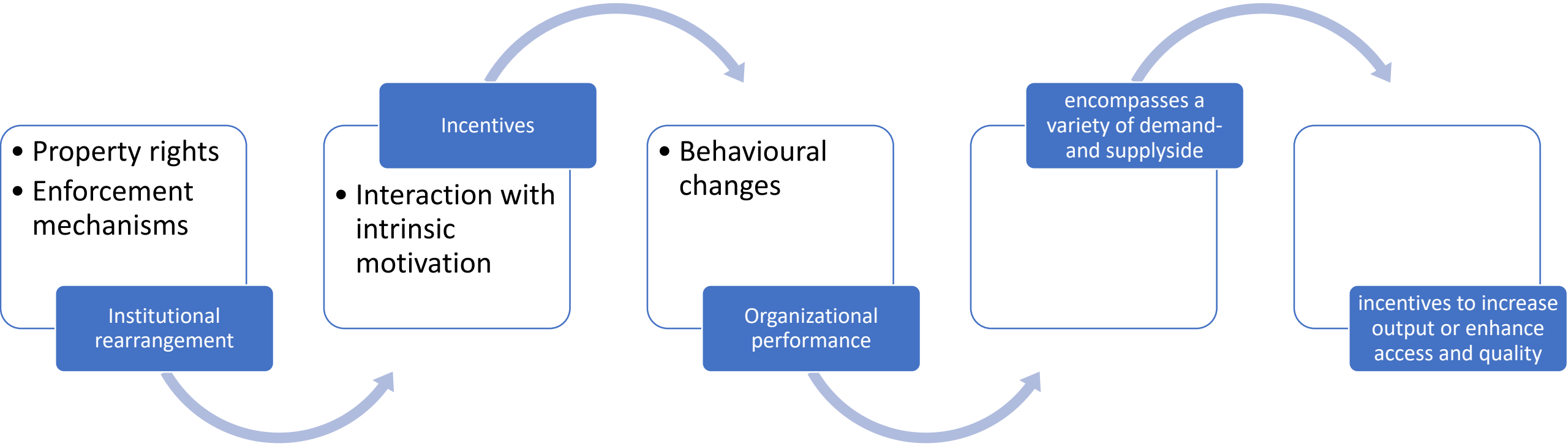
- Performance based financing or pay for Performance or Results based financing encompasses a variety of demand- and supply side incentives to increase output or enhance access and quality.
- A key feature of performance-based financing is that payments are conditional on performance, often defined in terms of process or output indicators- quantitative indicators (incentivized) done by verification agent and quality indicators – done by peers or regulator, a community survey which is also paid for in the form of quality bonuses.

Health leadership and governance focus

- Evidence –based policy making.
- Efficient and effective service provision arrangements , regulatory framework and management systems.
- Responsiveness to public health needs and preferences of citizens
- Transparency in policy making; allocation of resources and performance.
- Responsible leadership to address health priorities
- Institutional checks and balances.
- Accountability

Improved governance and leadership can contribute to an array of downstream effects especially in managing the performance of health systems.

Conceptual framework-Incentives matters- (Meesen 2013)



Methodology

- Systematic review
- Empirical view : Regional Hospital Bamenda

Empirical view of the Regional hospital Bamenda

- Started PBF timidly in June 2017 and it was fully effected in October 2017.
- Rising performance in quantitative indicators evaluation from 75% to presently 98%
- Quality scores from 55%, 55.%. 90%, 68% and presently at 88% in January 2020
- Community Survey score of client satisfaction by an NGO in 2019 December at 95%
- Weekly surveys on patient satisfaction increasing better.
- Business plan – every quarter for hospital management committee to review and approve.
- January 2018 could increase staff strength from 250 to present 488 of which 220 are Nurses and midwives; only a third are Public servants.
- A public hospital, receives 80.000patients per year, BOR-84%, ALS-5.2days and 400bed capacity , second referral level serving 19 districts of the NWR
- Problem- Crisis area, slow payment of incentives especially quality bonuses which has never been paid

- Benefits- Renovations of units, equipment, manpower increase, reinforcement of governance structures- PF task force, hospital management committee and others ; quality performance as seen above.

Recommendations : PBF improvements

- Effective integration of PBF budget lines in government budget and improved finance procedures- work on the financial and legal documents that facilitate the payment of PBF subsidies
- Offer performance bonuses to main players or decision makers (Ministries of Health and finance) through performance contracts to obtain a competitive remuneration adequate to only defend the public interest.
- Compulsory large-scale health insurance schemes are theoretically a good solution, and this risk sharing schemes have been proven to be effective most countries

Recommendations cont.

- Health insurance systems should be designed in away to enable public money pays the premiums for the poor, it is better to apply instead the PBF equity instruments of targeting the poor to obtain free or subsidized health care. The PBF equity systems have become well-tested and they better assure efficiency, sustainability, robust verification and the quality and accreditation of the health services.

Recommendations

- Emergencies Approach- in social crisis situations;

❑Health facilities that face emergencies should be allowed to continue operating autonomously through the PBF best practices instead of replacing their authority by outside NGO emergency organizations-is more cost-effective, more sustainable and strengthens the health system rather than weakening it.

❑It requires an enabling environment of regular payments and allowing managers to have access to their bank accounts so that they can replace without any delay lost medicines or to conduct repairs of any damages inflicted by the crisis.

Recommendations

- The managers with support of their health committees should have the authority to recruit staff willing and able to work in the “hot zones” and to buy their inputs (medicine, consumables, equipment etc.) from accredited wholesale distributors, which also operate in competition.
- CDV agencies to apply, flexible strategies activities by using local transport instead of project vehicles, make appointments in safer areas to verify the registers and make well-informed use of the investment’s units or quality improvement bonuses. District validation committees should have the autonomy to declare a health facility catchment area an emergency zone so that the ceiling for targeted free health care can be increased

Recommendations cont.

- For sustainability, health facilities should not become totally dependent on external (PBF) funding but be allowed to review with their community how much patients can continue to pay under the given circumstances – a percentage of output should be saved as expected in the index or financial analysis tool to assure future sustainability about 10% of total production.
- Timeliness of payment of subsidies- quantitative indicators in performance subsidizes and qualitative indicators in the form of quality or equity bonuses as due.

Benefits of PBF- Among the many renovations

Equipment

The Incinerator and Fence

The Nursery Renovation

THANKS FOR LISTENING

SUGGESTIONS AND QUESTIONS ARE WELCOMED

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