Mixed Provider payment methods in Burkina Faso: Mapping and preliminary results

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Who spends on health, 2014

35
Per capita

Overview of purchasers, payment methods and providers

### Purchasers
- Ministry of Health
- Ministry of Finance
- Municipalities
- NHI scheme
- NGOs
- Central Medical Store
- CBHI
- Private insurers

### Payment methods
- Global budget
- Line-item budget
- Fee-for-service
- Results-based financing
- Capitation

### Providers (public sector)
- PHC centers
- District hospitals
- Regional hospitals
- Teaching hospitals
Mixed provider payment methods in Burkina Faso

**Line-item budget**
- Vertical programs
  - At least 7 broad FHCI including FP, TB, AIDS, immunization etc. funded by various TFP & NGOs through MoH
- Assigned Funds - MoH
- Monthly Salaries - MoF

**District hospital (example of Nouna HD)**

**Fee-for-service**
- FHCI (under 5 and eligible women)
- CBHI / Mutuelles de santé / worst-off exemption

**RBF (Global budget from PADS, government bonuses & CAMEG bonuses are included here)**

**P4P**
Mixed provider payment methods in Burkina Faso

PHC center (exemple in Tougan HD)

- Vertical programs – At least 9 broad FHCI (see previous slide), including vaccination campaigns and mass treatments, funded by various TFP & NGOs
- CBHI / Mutuelles de santé
- Government bonuses
- CAMEG bonuses
- P4P
- Global budget
- Line-item budget
- Transferred credits
- Monthly Salaries
- From PADS – Flexibility for a set of operating expenditures that have been broadly agreed on
- FHCI reimbursement (for under 5 and eligible women)
- Capitation
Some examples of good alignment & misalignment / Provider perspective

- Transferred credits (line-item budget)
- Results-based financing
- Bonuses (Government)
- Bonuses (CAMEG)
- FHCI for under 5 and eligible women (Fee-for-service)
- Vertical programs (line-item budget)
- CBHI / Worst-off exemption (fee-for-service)
- Capitation

Incentive to increase activity / over prescription
- Incentive to decrease activity / sub prescription / Under or sub-provision
- Cream skimming
- Cost shifting, over-billing
- Shifting of resources / Overstock of drugs / high rate of expired drugs
- Gaming - Fraud
- Feeling of work overload
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Governance issues

- High fragmentation of the heath financing architecture – limited pooling

- A lot of pilots and initiatives at the same time – Piloting all these is very challenging – Difficult to have a clear overview of the total mix effects from a system perspective

- Large fragmentation of the monitoring / information systems

- Lack of information and clarity about criteria and procedures of resources allocation (for instance assigned and transferred credits)
Current orientations / Perspectives

Most of strategies are activity-based to address low health services utilization:

- A shift from **line-item** towards program budgeting
- Many FHCI
- Some P4P in place (e.g. government or CAMEG bonuses) or under experimentation (e.g. RBF to increase utilization and quality of care)

Near future challenges:

NHIS (fee-for-service or capitation)

RBF (case-based payment + quality of care)

FHCI for under 5 and eligible women (fee-for-service)

What alignment between them?

With other payment methods?
Which / What is the good entry point for strategic purchasing in the context of Burkina Faso?

Thank you