Impact of the Performance-Based Financing Scheme on the Quality of Health-Care Delivery and Consumer Satisfaction in Health Districts in Cameroon

*Bodzewan Emmanuel Fonyuy, 2Pr Yongabi Kenneth Anchang

*Public Health Expert/Consultant, West Africa

Abstract

Introduction

Longstanding concerns about the cost-effectiveness of health services have raised a growing interest on financial incentive for health care-providers. Even though performance-related payment models have been implemented in developed and developing countries in various settings and forms, the scientific evidence based on the impact of these mechanisms on specific outcomes remain thin.

PBF is an operational instrument that links financing to pre-determined results with payment made upon verification that the agreed-upon results have actually been delivered. It is an intervention designed to increase the quantity and quality of health care based on the theory that providing financial incentives to health workers for meeting output targets will motivate them to produce more or better outcomes and hence improve their performance.

The general objective was to assess the impact of the Performance-Based Financing scheme on the quality of health care delivery and consumer satisfaction on the type of care provided them by care-providers in Health Districts in Cameroon.

Material and Methods

The descriptive cross sectional design was employed where-in a sample of health consumers who came for consultation in the hospital. Their opinions and practices were assessed as per the objectives of the study and findings analyzed accordingly.

Results

The quality of preventive care/services offered by the PBF scheme health facilities ranged from 45-65% and 65-85% for Vitamin A supplementation; HIV-positive pregnant women put on ARV prophylactic treatment stood at 65-85%, while 65-85% and >85% was for infants completely vaccinated. 79% were very satisfied with the quality of care rendered to them by the care-providers.

Discussion

The PBF scheme run health facilities rendered quality care to its consumers given that the incentivizing practice on care-providers relative to performance motivated them to be conscientious and assiduous in care delivery as health consumers derived enormous satisfaction from services offered them. It was observed that there was excellent reception (78%), cordiality (77%) and a hospitable environment during hospitalization (81%), appointments for check-ups (76%) as well as home visits activities (88%).

Conclusion

The results of the experience with the PBF scheme in health districts in Cameroon suggest that health system financing mechanisms for the poor is feasible under certain conditions. More importantly, it could be shown that access to health-care delivery can have a positive impact on health consumers’ welfare. The impact of PBF on the quality of care rendered to consumers could be closely tied with the extent to which the benefits package remunerated according to output.
1. Introduction

Longstanding concerns about the cost effectiveness of health services have raised a growing interest on financial incentive for health-care providers. Performance-Based Financing (PBF) is an operational instrument that links financing to predetermined results with payment made upon verification that the agreed-upon results have actually been delivered. The central idea is that a principal entity provides a reward, conditional on the recipient undertaking a set of actions to produce a desired outcome [1].

Even though performance-related payment models have been implemented in developed and developing countries in various settings and forms, the scientific evidence based on the impact of these mechanisms on specific outcomes remains thin [2].

In Africa alone, more than 35 countries, including Cameroon, are implementing or are in the process of introducing payment methods that reward performance [3]. Many impact studies, with varying degrees of rigor, have been or are being carried out in various settings on PBF and other similar financial incentives aimed at health workers motivation. Randomized studies were carried out in order to monitor health worker attendance in India and incentivized service quality by physicians in the Philippines. Results showed that in India, the monitoring system was initially extremely effective but became ineffective after 18 months due to administration laxity. In the Philippines, service quality-based incentives had significant effects [4].

Performance-based financing takes a radically different approach to the health system, giving organizational units substantial decision rights over their resources (that is autonomy). Organizational units do not rely on hierarchical relationships but on contractual or regulatory ones. Interaction through contracts requires that the steward or its proxy clearly define performance for each organizational unit. Different types of contracts are possible. For health facilities, the approach currently favored in Africa is paying for a quantity and quality mix, a fee-for-service look-alike model combined with scoring based on a quality checklist. For a restricted list of key services, each additional unit of service produced (for example one more fully immunized child) is thus rewarded. This approach also encourages the health facility to set up a bonus contract with each staff member. This contract does not try to measure individual performance (as most outputs are produced by the whole team), but takes into account individual contribution through working days, responsibilities and qualification [5].

Performance-based financing is all about public finance and, in many countries, has become central to the public sector reform toolbox. Ministries of finance and local governments see health performance-based financing as part of a strong international movement towards more results-based and client-oriented public finance models inspired by the new public management model. Many countries have embarked on some form of budget reform, including performance-based budgeting and needs, and performance-based formulas for intergovernmental transfers. The health sector may resist these reforms or pioneer them. The Government of Rwanda, for example, has established performance contracts with departments and district councils for all sectors; the contracts link funds received to performance. The health sector is one of the drivers of the reform and contributes to shaping it.

Delivering results can also win the commitment of ministries of finance to fund the health sector. In Burundi and Rwanda, performance-based financing strengthened the position of the Ministry of Health vis-à-vis the Ministry of Finance by showing a clear link between funding and outcomes. In Rwanda, the performance-based financing budget increased from US$ 0.8 million in 2004 to US$ 8.9 million in 2007. Practical implementation of more transparent public finance management is also a key benefit of performance-based financing. Public expenditure tracking surveys often find that resources allocated for service provision never reach the frontlines. A major benefit of performance-based financing is the direct transfer of resources to frontline providers, which dramatically reduces leakages [5].

Finally, performance-based financing sheds new light on decentralization in the health sector. During the
past decades, many countries have invested in ill-conceived decentralization reforms of their health systems. In some cases, these reforms have actually led to a decline in performance. The performance-based financing experience suggests that the central level of government should keep decision rights regarding key public health priorities, firmly exercising this right through its purchasing power. At the same time, it should be ready to transfer decision rights related to the delivery of priority health interventions to health facilities. This is consistent with 30 years of policy agenda, which tried to implement primary health care through greater autonomy of health facilities (e.g. the Bamako Initiative in sub-Saharan Africa). Performance-based contracts may also help level the playing field for public, private-for-profit and not-for-profit facilities, an interesting policy option in low-income countries whose health sectors are growingly pluralistic [1].

For countries such as Burundi or Rwanda, adopting performance-based financing led to a complete reconsideration of roles and functions in the health system. Functions are grouped in coherent packages to maximize economies of scale and scope, yet with a new concern to avoid conflicts of interest. As much as possible, this approach favors a “separation of functions”. This often requires the set-up of new bodies, such as a purchasing agent to act as a third-party payer, and the active involvement of new stakeholders, such as community-based organizations to help verify activities reported by the health facilities [6].

The Rwandan experience has attracted a lot of attention. It has rapidly inspired neighboring countries like Burundi and the Democratic Republic of the Congo and has consolidated an interest in performance-based financing at regional and global level. Today, more than 20 countries are in the process of introducing or scaling up performance-based financing in Africa. Performance-based financing also fits into the Millennium Development Goals aid paradigm and global efforts for rapid progress on a few key indicators. Yet several authors have expressed concerns about this wave of enthusiasm. The assessment is however, that their critique reflects a view of performance-based financing as solely a provider payment mechanism and overlooks the potential of performance-based financing to reform health systems. These critiques can’t see the woods for the trees [7].

Basinga [2] stated that in Africa, to date, only two pilot studies of the impact of PBF on health service provision and utilization have been completed; in Rwanda and the Democratic Republic of the Congo. In Rwanda, PBF proved an efficient way to increase health service quality and utilization, resulting in improved child health outcomes. In the Democratic Republic of the Congo, Elise Huillery [1] found that financial incentives improved effort from health workers to increase targeted service provision, but demand for health services was not responsive to these incentives. Six other studies using non-credible comparison groups or comparing simple before and after situations advocate PBF as a way to increase accountability, efficiency, quality and quantity of service delivery [6].

Loevinsohn and Harding [7] reviewed ten studies on the effect of contracting with non-state entities, including Non-governmental Organizations (NGOs), as a way to improve health-care delivery, and concluded that contracting for the delivery of primary care can be very effective and that improvements can be rapid.

Public expenditure on health, both domestic and official development assistance has increased over the past few years in most low-income contribute results have been slow [3]. As the public health system remains the backbone of national health policy and the main beneficiary of international aid, it is most likely to be part of the problem. In too many countries, the public health system does not meet user needs and demands [4]. It is inefficient due to resource leakage and worker absenteeism. Equity, in terms of utilization and contribution, is unsatisfactory and public spending often benefits richer groups disproportionately [8].

Ministries of health and their international advocates often cite insufficient funding as the underlying cause of low performance. Others argue that it also stems from a lack of accountability within public health systems. Although many observers and users are likely to share this view, few proposals for reform have been put forward. Their opinion is that performance-based financing, as it is being developed in several sub-Saharan African countries, is a strategy that could help address the structural problems plaguing health systems. In most low-income countries, some kind of National Health Service remains the backbone of the health system (at least in theory). These public systems rely on the central government and the ministry of health, in particular, to fulfill nearly all functions of the health system including: resource collection, pooling of funds, purchasing, regulation, provision, employment, drug supply, ownership of infrastructure and equipment, monitoring and evaluation. Decisions related to these functions, including those related to health-care provision,

SF Nurs Health J
ISSN:XXXX-XXXX SFNHJ , an open access journal page 3 of 17
are usually highly centralized. It is the central level of government, for example, that decides the required mix of staff for a health centre, allocates personnel and pays salaries [9].

In fact, with a few exceptions such as immunization, most key indicators of maternal and child health and nutrition have stagnated or worsened since 1990. The mortality rate in under-five-year-olds rose in Cameroon in the 1990s and has stagnated in the 2000s. Maternal mortality has remained high and even worsened since 1998 [10]. Analysis of the health system of Cameroon indicates that linking performance to results could indeed make a difference. The PBF program in Cameroon also includes enhanced supervision as well as financial and hiring autonomy on PBF subsidies. It is clear that in Cameroon, sub-optimal allocation of resources and resource use inefficiencies are key underlying determinants of the limited improvements achieved in the health sector. An important part of the problem is that the operational level receives a small fraction of the health budget while the lion’s share of resources is allocated for administrative purposes [10-12]. Inefficiencies are also created by the inadequate alignment between the burden of disease in Cameroon and health expenditures. Governance problems are at the root of the second key constraint to district health system functioning in Cameroon [7]. Furthermore, non-transparent human resource management practices combined with low salary levels drive health workers to abuse public funds by charging informal payments or over-billing patients for services and, ultimately, deter use by the poor. Finally, cost recovery mechanisms are extensively used in Cameroon, and are the greatest source of revenue for health facilities [6].

1.2 Research Question
What is the impact of the Performance Based Financing scheme on the quality of health care delivery and consumer satisfaction on the care provided by care-providers to the beneficiary population in Health Districts in Cameroon?

1.3 Study Objectives
1.3.1 General Objective
To assess the impact of the Performance Based Financing scheme on the quality of health care delivery and consumer satisfaction on the type of care provided by care-providers to the beneficiary population in the Health Districts in Cameroon.

1.3.2 Specific Objectives : The study was guided by the following specific objectives and include to:

- Assess the quality of care provided by care-providers to health consumers within the PBF scheme.
- Ascertain consumer service utilization and appraisal from health facilities benefiting from the PBF scheme;
- Assess consumer satisfaction to the care rendered them by care-providers.
- Assess the degree of job satisfaction by care-providers serving within the PBF scheme.

2.0 Methodology
2.1 Study Design
The descriptive cross sectional design was used for the study where a sample of health consumers was chosen from the community members who were hospitalized or came for consultation in the District hospitals at the time the study was carried out. Their opinions and practices were assessed as per the objectives of the study and findings analyzed accordingly.

2.2 Target Population
Health consumers seeking health-care and health-care providers delivering services were randomly sampled and recruited for the study using precise eligibility criteria.

2.3 Sample Size and Sampling Procedure
2.3(a) The sample size was calculated using the following formula:

\[ N = \frac{(t)^2 \times p(1-p)}{(e)^2} \]

Where,
- N= the required sample size
- t = confidence interval of 95% (type value 1.96)
- p = the percentage of patients using the health facilities at 50% / Care-providers providing care at 50%.
- e = random error of 5% (type value of 0.05)
- N= 384 health consumers and care-providers.
(b) **Sampling Procedure:** 300 health consumers (42 per health district) drawn from the health areas in the seven PBF scheme Health Districts using the systematic random sampling method; this was done a week following hospitalization or after their discharge from the hospital as well as after consultations (out-patients); conversely, 84 health-care providers (12 per hospital) from the seven District hospitals had their practices and opinions elicited using the inclusion criteria mentioned above.

2.4 **Data Collection Instrument**

A structured questionnaire was used for the collection of primary data from respondents. The questionnaire was structured to tie with the specific objectives of the study.

2.5 **Data Collection Procedure**

Primary data was collected with the use of the research questionnaires; it was self-administered by the co-researchers as to health consumers who were literate; health consumers who were semi-literate had the co-researchers (who hail from these communities) read out the questions and transcribed the responses verbatim into the questionnaires.

2.6 **Method of Data Analysis**

Primary data collected from health consumers was managed through a number of systematic steps, complementary to each other in other to derive substantial data for onward merging before exporting from Epi-Info 7 to Excel for graphical designs and analyses. Results were presented as statistical tables and charts; all data were discussed at 0.05 significant level.

3.0 **Presentation of Findings**

3.1 **Socio-Demographic Data**

3.1.1: **Age Frequency Distribution of Health Consumers**

**Figure 1:** Age Frequency Distribution of Health Consumers Involved in the Study in The two Regions

![Age frequency distribution of Health Consumers for the two regions](image)

In figure 4.7, 75 health consumers were within the age range 35-39 years, 73 within the age range 40-44 years and 48 within the age range 30-34 and 45-49 years respectively.
3.1.2: Occupation Distribution of Health Consumers

**Figure 2:** Distribution of Health Consumers According to Occupation Involved in the Study

Within the sphere of occupational distribution, 28% of the health consumers were semi-skilled workers, 20% were skilled workers, and 22% were unskilled while 15% were unemployed.

3.1.3: Grade/Profession Distribution of Care Providers

**Figure 3:** Grade/Profession Distribution of Care Providers Involved in the Study

On the aspect of grades/professions of Care-providers recruited for the study, 26% of them were Nursing Assistants, 25% were Registered Nurses, and 16% were Nursing Superintendents while 15% were medical officers.

3.2.4: Distribution of Care-Providers in Health Districts Benefiting from the PBF Scheme

**Figure 4:** Distribution of Care-Providers in Health Facilities Benefiting from PBF Schemes in the Two Regions

For the seven health districts benefiting from the PBF scheme randomly selected for the study; the Limbe Health District had the 97 care providers sampled for the study; the Nkambe, Tiko and Buea Health districts with 88, 87 and 86 care-providers respectively.
3.1.5: Distribution of Respondents According to Marital Status

The marital status of both health consumers and care-providers involved in the study revealed that 46% of them contracted monogamous marriage; 34% of them were single; 6% of them contracted polygamous marriage; 6% were widows and 6% were divorced.

3.2: Assessment of The Quality of Care Provided by Health Care Providers to Consumers

3.2.1: Staff Distribution per Service in The Health Facilities

Care-Providers were recruited for the study from diverse units/departments in the seven Health facilities benefiting from the PBF Scheme; 81.20% were from the Out-Patient Departments; 48.12% from the Medical Wards; 46.11% from the Surgical Wards; 44.11% from the Maternity and 41.10% from the Theatre Departments.
3.2.2: Quality of Curative Care/ Services Rendered to Consumers

Figure 7: Quality of Curative Care/ Services Provided by Health care Providers in PBF Health Facilities in %

The quality of curative care, referrals and counter referrals offered by the PBF health facilities were varied; with 45-65%, 65-85% and >85% of curative care rendered to health consumers in the Out-patient Departments being 37% and 54%, for minor surgical cases being 37% and 58%, and 25-45% for referral and counter-referral cases being 28% and 48%; 20%, 26%, and 47% respectively.

3.2.3: Quality of Preventive Care/ Services Rendered to Consumers

Figure 8: Quality of Preventive Care/ Services Provided by Health care Providers in PBF Health Facilities in %

The quality of preventive care/services offered by the PBF scheme health facilities ranged from 45-65% and 65-85% for Vitamin A supplementation being 31% and 60%; HIV positive pregnant women put on ARV prophylactic treatment being 34% and 56% , VAT-2 or VAT-3 or VAT-4 or VAT-5 against the tetanus in pregnant women 89%; 65-85% and >85% for children completely vaccinated with all the antigens in the EPI program 48% and 52%; and 29% and 38% respectively for home visits.
3.2.4: Quality of Reproductive Services Rendered to Consumers

Figure 9: Quality of Reproductive Services Provided by Health care Providers in PBF Health Facilities in %

![Quality of Reproductive Services Provided by PBF Health Facilities in %](image)

The quality of reproductive health Care / Services offered by health facilities across the activity areas were varied: 45-65% , 65-85% being 34% and 58%%, for ANC-1 or ANC-2 or ANC-3 or ANC-4 services carried out before delivery, Family Planning (New or Old Acceptants of Oral pills or injections); while 65-85% and >85% being 82% for Post-abortive Curettage (Spontaneous or Induced) and Normal Assisted Deliveries being 52%

3.3: Consumer Service Utilization and Appraisal From Health Facilities Benefiting From The Pbf Scheme

3.3.1: Accessibility Approach Employed to Attend to The Poor/Vulnerable /Hard to Reach Population

Figure 10: Accessibility Approach Employed to Attend to the Poor/Vulnerable /Hard to Reach Population

![Accessibility Approach Employed to Attend to the Poor/Vulnerable/Hard to Reach Population](image)

With in the PBF scheme, the approach used to attend to the poor, the vulnerable and the hard-to-reach population were assessed: 36.8% of care-providers said by creating mobile teams to attend to them; 32.1% said by setting a % discount for treatment and drugs; 16.4% said by keeping social mobilizers in close contact with them while 11.9% said by free-of-charge consultation and treatment
3.3.2: Impact of Bottom-Up Approach in The Accessibility and Quality of Healthcare Delivery

The bottom-up approach enhanced community health financing according to 57.3% of them; 18.4% said it increased revenue turnout and 17.4% said it encouraged health facility utilization.

3.3.3: Degree of Staff/Patient Relationship in Health Facility After Introduction of The PBF Scheme

The degree staff/patient relationships in the five health facilities after the introduction of the MHO scheme were: 49.5% had excellent reception from the care-providers, 32.5% had excellent quality of care rendered with enormous patient satisfaction and 13.8% were very cordial and friendly.
3.4: Assessment of Consumers’ Satisfaction to The Care Provided By Care Providers

3.4.1: Respondents and Family Members Care Seeking Practice

<table>
<thead>
<tr>
<th>Frequency at which respondents and family members sought healthcare in health facilities</th>
<th>Knowledge if Health Facility benefits from the PBF scheme/</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td></td>
</tr>
<tr>
<td>Twice in six months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% At which respondent and family</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>% of Total</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Twice a month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% At which respondent and family</td>
<td>47</td>
<td>47</td>
</tr>
<tr>
<td>% of Total</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Once a month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% At which respondent and family</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>% of Total</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total</td>
<td>61</td>
<td>61</td>
</tr>
</tbody>
</table>

3.4.2: Perceived Satisfaction of Health Care For Specific Services Used and Why Respondents Felt Satisfied or Not Satisfied (Ns- Not Satisfied; F-Fair; S-Satisfied; Vs-Very Satisfied; E-Excellent)

Figure 13: Perceived Satisfaction of Health care Services Rendered by Health Facilities with PBF Scheme (OPD & MCH services)

Out of the 156 consultations in the Out-Patient Departments in the PBF scheme Health Facilities 79% were very satisfied while 11% were satisfied with the services rendered to them by the care-providers; as concerns the laboratory services out of the 177 services sought by health consumers, 38% were very satisfied, 52% found the services satisfactory; for the 177 mothers seeking immunization services, 79% of them found the services very satisfactory; for Antenatal Consultation by pregnant women, of the 176 cases seeking care, 80% found the services very satisfactory; for Maternity Services, 73% of the users found the services very satisfactory.
Figure 14: Perceived Satisfaction of Health care Services Rendered by Health Facilities with PBF Scheme (Clinical services)

PLWHA consultations, 52% were very satisfied while 40% were satisfied with the services rendered. For family planning services, 62% of the recipients were very satisfied while 32% were satisfied with the services rendered. For minor surgery services, 54% found the services very satisfactory, 39% satisfactory with them. For the fight against HIV/AIDS, 55% were very satisfied with the services while 39% were satisfied with them; for hygiene, environment and sterilization practices, 55% found the services very satisfactory, 38% satisfactory.

Figure 15: Perceived Satisfaction of Health care Services Rendered by Health Facilities with PBF Scheme (TB, Drug mgt, home visits and staff reception)
3.5: Degree of Job Satisfaction by Care-Providers Serving Within The PBF Scheme

3.5.1: Perceived satisfaction by Health consumers of Health Care offered them

Out of the 156 consultations in the Out-Patient Departments in the PBF scheme Health Facilities, 79% of the patients were very satisfied while 11% were satisfied with the services rendered to them by the care-providers; as concerns the laboratory services out of the 177 services sought by health consumers, 38% were very satisfied, 52% found the services satisfactory; for the 177 mothers seeking immunization services, 79% of them found the services very satisfactory; for Antenatal Consultation by pregnant women, of the 176 cases seeking care, 80% found the services very satisfactory; for Maternity Services, 73% of the users found the services very satisfactory.

4.1: Discussion of Results

4.1.1: Occupation Distribution of Respondents

Within the sphere of consumers’ occupation, 28% of the health consumers were semi-skilled workers, 20% were skilled workers, 22% were unskilled while 15% were unemployed. The impact of the PBF might be felt among these people since most of them carry out mostly hand to mouth system of farming whilst a majority of the population. This is in line with a study carried out in Rwanda where a majority of the study population was made up of low income earners [13-15].

4.1.2: Quality of Care / Services Rendered to Consumers by Care-Providers in PBF Health Facilities

The PBF scheme was geared at rewarding service output or performance by incentivizing the care providers accordingly. The quality of preventive care/services offered by the PBF scheme health facilities ranged from 45-65% and 65-85% for Vitamin A supplementation in the various hospitals; the quality of service offered HIV-positive pregnant women put on ARV prophylactic treatment stood at 65-85%, while 65-85% and >85% was for infants (0-11months) completely vaccinated with all the antigens in the EPI program whereas the service quality was >85% for home visits carried out by community health workers. The fact that the service quality was within a higher range shows that the incentives provided the health-care providers played a plausible impact on the quality of care and dedication to service rendered to health consumers. Thus PBF schemes can potentially increase utilization of priority services, enhanced equity, improved quality, and increased efficiency [3]. PBF can address household behaviors, or the ‘demand side’, by stimulating households to take health related actions such as immunizing children and giving birth with the assistance of a skilled attendant.
Similarly, the quality of curative care, referrals and counter referrals offered by the PBF health facilities from the study were varied; 65-85% and >85% of curative care rendered to health consumers in the Out-patient Departments, and 25-45% for referral and counter-referral cases.

In like manner, the reproductive health care/services offered across the activity areas were varied: 45-65% , 65-85% for ANC-1, ANC-2, ANC-3 and ANC-4 services carried out before delivery, 45-65% for Family Planning (New or Old Acceptants of Oral pills or injections); while 65-85% and >85% being 82% for Post-abortive Curettage (Spontaneous or Induced) and Normal Assisted Deliveries; showing a marked improvement from the output quality prior to the inception of the scheme. The PBF scheme health facilities rendered quality care to its consumers given that the incentivizing practice on care-providers relative to performance motivated them to be conscientious and assiduous in care delivery. According to the WHO [3, 16], the Pilot PBF projects were successful in improving productivity and ensuring the quality of services. PBF is considered to have been particularly effective in purchasing preventive health-care outputs which have a strong public good character. However, demand-side incentives should be able to match the financial incentives of PBF. Thus, by providing financial incentives to achieve results, PBF seeks to change behaviors of health system actors and reward actions that lead to results.

4.1.3: Degree of Job Satisfaction by Care-providers

A majority of respondents (45%) run two shifts while 35% run one shift and according to the level of work load attributed to them, 45% of staff said they were overworked, 50% said they were moderately worked. The researchers equally observed that staff received satisfactory incentives from the hospitals aside their salary. This was also observed from a study in Rwanda that PBF led to an increase personnel incentive which provided them with that spirit of improved efficiency as well as greater accountability [17-21].

4.2.1: Assessment of Services Satisfaction by Consumers in PBF Scheme Health Facilities

Of the 156 respondents whose data on Out-Patient Department consultations were collected in the PBF scheme health facilities, 79% were very satisfied while 11% were satisfied with the services rendered to them by the care-providers. As concerns the laboratory services, out of the 177 services sought by health consumers, 38% were very satisfied, 52% found the services satisfactory; for the 177 mothers seeking immunization services, 79% of them found the services very satisfactory; for Antenatal Consultation by pregnant women, of the 176 cases seeking care, 80% found the services very satisfactory; for Maternity Services, 73% of the users found the services very satisfactory. This implies that the incentivizing practice on the staff boost their service output with the quality of care rendered, satisfactory with a positive appraisal from the health consumers.

Conversely, PLWHA consultations, 52% were very satisfied while 40% were satisfied with the services rendered. For family planning services, 62% of the recipients were very satisfied while 32% were satisfied with the services rendered. For the fight against HIV/AIDS, 55% were very satisfied with the services while 39% were satisfied with them; for hygiene, environment and sterilization practices, 55% found the services very satisfactory and 38% found them satisfactory. Service satisfaction for the vulnerable population was within satisfactory range as per health consumer assessments.

Health consumers derived enormous satisfaction from services offered by PBF scheme health facilities with good reception (78%), cordiality (77%) and a hospitable environment during hospitalization (81%), appointments for check-ups (76%) as well as home visits activities (88%). The above results revealed that the pilot introduction of PBF scheme in some Health Districts in Cameroon could yield substantial outcome in terms of performance output by care-providers. The inefficiencies and economies of scale have been the reasons for the introduction and promotion of PBF in Rwanda thus the above findings could be extrapolated in other Health Districts in the country. The introduction of the PBF approach in Rwanda changed the way health providers were remunerated. This suggests that an increase in investment and recurrent expenditure for human resources may still be necessary. PBF does not directly respond to the issues of shortage and mal-distribution of health workers; these require additional tools such as local recruitment of workers and retention of posts by facilities, which have been adopted by the government [3].

The attitudes of health providers at reception on occasions when health consumers visited the health facility to seek for health care; 21% found them excellent, while 72% found them very satisfactory. Of the 156 respondents, 69.23% of them were very satisfied while 25% were
satisfied with the services rendered by the PBF scheme health facilities.

4.2.2: Approaches Employed to Resolve Identified Patient Problems

Various approaches were employed by care-providers in seeking for solutions to patients’ problems; 43.3% of them said they carried out joint decision-making with the concerned patients; 29.6% said they carried out concertation with other colleagues to arrive at a compromise while 22.5% said they present the problem to hierarchy for a finite decision to be taken. The bottom-up approach enhanced community health financing (57.3%); increased revenue turnout (18.4%) and encouraged health facility utilization (17.4%).

Within the PBF scheme, the approach used to attend to the poor, the vulnerable and the hard-to-reach population was: creating mobile teams to attend to them (36.8%); setting a % discount for treatment and drugs (32.1%); keeping social mobilizers in close contact with them (16.4%) and free-of-charge consultation and treatment (11.9%).

As staff in PBF health facilities are motivated according to results; incentives for their motivation were calculated according to longevity in service (87.2%), according to professional grades (25.2%) and according to performance/output (18.4%).

Conversely, the improvements in management of staff and scaling-up of services seem more suitable solutions to overcome the present situation in Cameroon rather than trying to reduce demand.

From the study, relative to suggestions by interviewed care providers, the introduction of the PBF approach was not merely a change in the way some health indicators were remunerated. The approach was based on a clarification of the responsibilities and roles of the various parties involved in the supervision, monitoring and provision of health services.

This was achieved through the introduction of contracting-in and the strengthening of monitoring structures for the performance of contracts. Substantial resources were mobilized to strengthen almost all components of the health system - including information collection and management, supervision, planning and management, monitoring, and so on. In other words, PBF’s financial incentives are unlikely to have triggered the current achievements on their own, even based on output. The vast majority of the responses identify financial incentives as key in triggering the motivation of health workers, but those incentives are neither the most important nor sufficient to achieve substantial improvements in service delivery or a change in health workers’ behaviour.

This is in line with the study carried out in Rwanda and democratic republic of Congo where PBF has led to increase in health service quality by increasing the number of qualified staff resulting to improved child health outcome [1]. As such PBF can play a role in increasing the productivity of health workers and have positive effects on health service utilization. The Rwandan experience has attracted a lot of attention [22-25].

As health facilities are remunerated according to their outputs, they have strong incentives to satisfy users. Granted more autonomy in exchange for greater accountability for results, health facilities can tailor initiatives to the populations they serve. In addition, health workers view health information systems differently under the PBF scheme: properly completing and filing health information forms is a “must”, as the data provide the basis for part of their remuneration [26].

5.2: Conclusion

From the result obtained from the study, it could be concluded that increase financing of health system will lead to increased productivity, both in quantity and quality. The results of experience with the PBF scheme in health districts in Cameroon suggest that health system financing mechanisms for the poor is feasible under certain conditions. More importantly, it could be shown that access to health-care delivery can have a positive impact on health consumers’ welfare.

The impact of PBF on the quality of care rendered to consumers could be closely tied with the extent to which the benefits package remunerated according to output. This PBF initiative can equally contribute in the human resource development, amelioration of the health coverage and the reduction of transmissible diseases related morbidity and mortality. Finally, policy-makers, donors, and other relevant stakeholders should consider how such healthcare financing mechanisms can be extrapolated into the broader discussion around universal health coverage.

The potential comprehensiveness of healthcare financing mechanisms should encourage policy-makers to address health services in an integrated, interconnected fashion rather than through the lens of disease-specific continuum. The policy debate around universal health coverage has relevance for the health of populations, just
as these findings from population health assessment have relevance for the broader discussion around health care financing and universal health coverage.

Further investigation should be devoted to the extent to which healthcare mechanisms, or its lack, affects people’s labor productivity and willingness to undertake risky, but potentially profitable investments.

Reference

Citation: Bodzewan Emmanuel Fonyuy (2017) Impact of the Performance-Based Financing Scheme on the Quality of Health-Care Delivery and Consumer Satisfaction in Health Districts in Cameroon. SF Nurs Health J 2:1.