Devolution of the Health Sector to Communes: A Misfit in the National Health System Governance Framework and Management Shortfalls in Burkina Faso

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# Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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</thead>
<tbody>
<tr>
<td>CAMEG</td>
<td>Centrale d’Achats des Médicaments Essentiels (Center for Purchasing of Essential Medicines)</td>
</tr>
<tr>
<td>CBHI</td>
<td>community-based health insurance</td>
</tr>
<tr>
<td>CHR</td>
<td>Centre Hospitalier Régional (regional hospital)</td>
</tr>
<tr>
<td>CHU</td>
<td>Centre Hospitalier Universitaire (university hospital)</td>
</tr>
<tr>
<td>CM</td>
<td>Centre Médical (medical center)</td>
</tr>
<tr>
<td>CMA</td>
<td>Centre Médical avec Antenne Chirurgicale (medical center with surgical antenna)</td>
</tr>
<tr>
<td>CNAMU</td>
<td>Caisse Nationale d’Assurance Maladie Universelle (National Universal Health Insurance Fund)</td>
</tr>
<tr>
<td>CoGes</td>
<td>Comité de Gestion (management committee)</td>
</tr>
<tr>
<td>CSOs</td>
<td>civil society organizations</td>
</tr>
<tr>
<td>CSPS</td>
<td>Centre de Santé et de Promotion Social (Health and Social Promotion Center)</td>
</tr>
<tr>
<td>GHE</td>
<td>government health expenditure</td>
</tr>
<tr>
<td>HCC</td>
<td>health center committees</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organizations</td>
</tr>
<tr>
<td>MATD</td>
<td>Ministère de l’Administration Territoriale et de la Décentralisation (Ministry of Local Government)</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOL</td>
<td>Ministry of Labor</td>
</tr>
<tr>
<td>PFM</td>
<td>public financial management</td>
</tr>
<tr>
<td>PPS</td>
<td>purchaser-provider split</td>
</tr>
<tr>
<td>RAMU</td>
<td>Régime d’assurance Maladie Universelle (Universal Health Insurance Plan)</td>
</tr>
<tr>
<td>UHC</td>
<td>universal health coverage</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>XOF</td>
<td>West African CFA franc</td>
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</table>
INTRODUCTION

Over the past five decades, sub-national government units around the world have assumed some extent of decision-making authority (Cheema and Rondinelli 2007). This often occurs through devolution, a reform that typically involves the transfer of different government functions related to sectors, such as health, from the central government to sub-national units. Devolution often entails changes to public financial management (PFM) rules, systems, and processes. In parallel, countries have also initiated health financing reforms, such as expanding publicly managed health insurance, eliminating user fees, and introducing performance-based payments to move closer to the goal of achieving universal health coverage (UHC). While national governments exercise a high degree of control over the design of health financing reforms, their implementation in devolved contexts is heavily influenced by local politics, policies, and processes. Sub-national government units are often the main purchasers of primary health care services, exercising considerable control over the funds flowing to public facilities, including from user fees or insurance reimbursements.

Public funds lie at the heart of sustainable health financing policy for achieving UHC (Kutzin, Yip, and Cashin 2016). Globally, public financing accounted for approximately 60% of health spending in 2017 and increased faster than any other source of health expenditure over the preceding decade (World Health Organization 2019). Given public funding’s growing role, governments and development partners increasingly recognize the importance of PFM to effective, efficient, and equitable health spending (Cashin et al. 2017; Barroy et al. 2019). Therefore, devolution and related PFM reforms can affect how public funds are allocated, used, and reported in the health sector.

The World Health Organization (WHO) and ThinkWell jointly developed a series of case studies to explore the implications of devolution for health financing, with a deep dive into PFM issues. The cases shed light on how health financing functions are organized within and impacted by each country’s devolved system of government. They also explore how devolution has shaped PFM processes in the health sector, including budget development, approval, execution, and accountability.

This case study details health financing and health-related PFM processes in Burkina Faso, a country where decentralized governance was introduced 30 years ago when the country established a democratic government. Complex political factors lie behind the decision of the central government to give up powers and resources to sub-national government bodies. At the heart of this decision were ambitions to improve inclusion and participation, often in response to major events such as a political or economic crises (as in the Philippines, Indonesia, and Kenya). After decade of political instability and centralized state control (Eaton, Kaiser, and Smoke 2011), which allowed for very limited decision-making power to the sub-national level or among local leaders, the new constitution adopted in 1991 formally launched the country onto a path of inclusion and participation of the sub-national governments in decision-making.

Today, the central government and local governments share authority and responsibilities over six social sectors including health, which is the focus of this case study. Together, these levels of government finance and manage health service provisions at the sub-national level. This case study highlights the respective roles of each with a particular focus on health financing, as well as identifying opportunities to improve the balance of decision-making powers between the two levels.

1 The literature offers several typologies to distinguish between different forms of decentralization (devolution vs. deconcentration, administrative, fiscal vs. political decentralization), which are discussed in a separate methodology document.
**METHODOLOGY**

ThinkWell and WHO collected data in the selected countries that answer the following overarching questions:

– How are the three health financing functions—revenue raising, pooling, and purchasing—and related governance functions organized and affected by a devolved system of government in a country?

– What challenges related to devolved health financing exist and how do these affect progress toward UHC?

– How do PFM processes unfold across government levels, and what is the role of sub-national governments in allocating, spending, and reporting public funds for health?

– What is the role of health facilities in PFM processes?

Data for Burkina Faso were mainly collected through desk review and supplemented with expert interviews. We conducted a purposeful review of documents and data that were available online or via research libraries, including official documents from the Government of Burkina Faso; programmatic reports from local governments in Burkina Faso; and reports from international organizations, development assistance projects, and peer-reviewed literature. In addition, expert interviews were conducted to fill in information gaps from the literature review (detailed in Annex 1).

Analysis on the sub-national level will be limited to “communes” and districts. The former is to date the only type of local government that has been granted the responsibility to manage health activities. We also explored the role of districts, which can have one or more communes within them, because they play important administrative functions in the health sector—including management of the Gratuité user fee reimbursement program. In terms of health service providers, more emphasis will be placed on primary health centers as they are the only type of public health provider impacted by devolution. The findings presented in this report are not intended to comprehensively capture all sub-national practices; rather, they depict general trends in the country, as well as some of the current realities at the sub-national level.

**COUNTRY CONTEXT**

**HISTORY, STATUS, AND STRUCTURE OF DECENTRALIZATION IN Burkina Faso**

Devolution is a governance practice that was introduced in Burkina Faso not long ago; the concept was officially embraced by the country only in 1991, three decades after independence. As opposed to some West African countries that adopted devolution early on (e.g., Nigeria and Senegal), the process of decentralization in Burkina Faso was slow to develop and inhibited by the succession of military putsches, which placed appointees—often from the army—to lead at the local level (H. M. G. Ouedraogo 2003). Since independence, gained on August 5, 1960, and until 1991, the country’s leadership swapped several times from democratic governments to military regimes (Natielse 2013). The latter lasted two decades and were marked by over-centralization (Natielse 2007). Rather than decentralization, there were deconcentration efforts largely intended to strengthen control over the population. After the new constitution was adopted in 1991, Burkina Faso has formally engaged on the path to decentralization and local governments were established.

The legal and regulatory framework for decentralization shifted over time to match the de facto organization of the central government’s technical services, but eventually settled to two levels of decentralization. The division of the country into local units has evolved since the adoption of decentralization, per governance practice in 1991 (Figure 1). The 1993 decentralization law introduced provinces and communes as the two levels of the local government in Burkina Faso (Government of
Burkina Faso 1993). Then in 1998, a decentralization implementation law (Government of Burkina Faso 1998) was adopted, adding regions as a third level of local government. However, in 2004, another law was adopted, abolishing provinces as local government units and leaving communes and regions as exclusive levels of local government in Burkina Faso. The commune is the basic unit of the local government and is divided in urban and rural communes. However, some urban communes can be classified as “communes with special status” depending on their catchment population, one that is served by a hospital or other health facility, as well as their revenue generation capabilities.

Presently in Burkina Faso, there are 302 rural communes, 49 urban communes, and two communes with special status. A “commune with special status” is an urban commune whose territorial entity comprises at least one permanent assembly of 400,000 inhabitants and carries out economic activities to generate annual budgetary resources of at least XOF 1,000,000,000 (Government of Burkina Faso 2004a). The region is a higher level of decentralization, which matches the de facto “deconcentrated” units of the state technical services, i.e. regional services. To date there are thirteen regions in Burkina Faso.

Figure 1: Selected events in the decentralization process in Burkina Faso

Source: Author based on Ki 2017

The Constitution adopted on June 2, 1991 officially shifted governance in the country from a centralized grip to local communities and people; however, it took 20 years to release decrees guiding actual transfer of responsibility and resources to local governments. From 2009 to 2014, four laws were issued for the implementation of measures that transfer authority and power from the central level to subnational levels. These laws were restricted to communes and applied to 4 areas of competence out of the 11 stated in the regulatory framework, which included health and hygiene; education and literacy; water and electricity; culture, youth, sports, and recreation. Though laws were issued for the effective transfer of competence (Table 1), to date, only communes are receiving intergovernmental funds for the devolved areas of competence. Regions funds are transferred to and managed by line ministries (Government of

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2 Four decrees were released in 2009 including Decret_2009-108-PRES-PM-MATD-MS-MEF-MFPRE portant sur le transfert des compétences et des ressources aux communes dans le domaine de la santé.
Devolution for the remaining sectors, as well as for regions—the second level of decentralization—is yet to be implemented. Starting in 2010, the central government began transferring funds to communes for health functions.

Table 1: Areas of competence devolved to local governments

<table>
<thead>
<tr>
<th>Areas of competence</th>
<th>Region</th>
<th>Municipality (commune)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and hygiene</td>
<td>Pending</td>
<td>Granted by the decree 2009-108-PRES-PM-MATD-MS-MEF-MFPRE</td>
</tr>
<tr>
<td>Social welfare and civil protection</td>
<td>Pending</td>
<td>Pending</td>
</tr>
<tr>
<td>Land administration</td>
<td>Pending</td>
<td>Pending</td>
</tr>
<tr>
<td>Education, employment, vocational training, and literacy</td>
<td>Granted by the decree 2014-923/PRES/PM/MATD/MENA/MJFPE/MESS/MEF/MFPTSS</td>
<td>Granted by the decree 2014-931/PRES/PM/MATD/MENA/MJFPE/MESS/MEF/MFPTSS</td>
</tr>
<tr>
<td>Public market, slaughterhouses (&quot;abattoirs&quot;), and expositions</td>
<td>Pending</td>
<td>Pending</td>
</tr>
<tr>
<td>Culture, sport, and leisure</td>
<td>Granted by the decree 2014-925/PRES/PM/MATD/MCT/MJFPE/MFPTSS/MICA</td>
<td>Granted by the decree 2014-939/PRES/PM/MATD/MCT/MJFPE/MFPTSS/MICA</td>
</tr>
<tr>
<td>Environment and natural resources</td>
<td>Pending</td>
<td>Pending</td>
</tr>
<tr>
<td>Water and electricity</td>
<td>Pending</td>
<td>Granted by the decree 2014-932 PRES/PM/MATD/MS/MEF/MFPTSS</td>
</tr>
<tr>
<td>Economic development and planning</td>
<td>Pending</td>
<td>Pending</td>
</tr>
<tr>
<td>Land registration</td>
<td>Pending</td>
<td>Pending</td>
</tr>
<tr>
<td>Funeral homes/parlors</td>
<td>Not applicable</td>
<td>Pending</td>
</tr>
</tbody>
</table>

Source: Author, based on data from Government of Burkina Faso

Abbreviations: PRES = Présidence; PM = Premier Ministère; MATD = Ministère de l’Administration Territoriale et de la Décentralisation; MS = Ministère de la Santé; MEF = Ministère de l’Economie et des Finances; MFPRE = Ministère de la Fonction Publique et de la Réforme de l’Etat; MENA = Ministère de l’Education National de l’Alphabétisation et de la Promotion des Langue National; MJFPE = Ministère de la Jeunesse, de la Formation Professionnelle et de l’Emploi; MESS = Ministère des Enseignements Secondaire et Supérieur; MFPTSS = Ministère de la Fonction Publique du Travail et de la Protection Sociale; MICA = Ministère de l’Industrie, du Commerce et de l’Artisanat ; MCT = Ministère de la Culture et du Tourisme

Political, administrative, and fiscal authorities between central and local governments are clearly defined in the legal and regulatory framework for decentralization in Burkina Faso. Articles 79 and 105 of the decentralization law define the political functions over which local governments have authority (Government of Burkina Faso 2004a); 10 for regions and 11 for communes as depicted in Table 1. These political functions have primarily local benefits and therefore are expected to be delivered by local governments (Shah 1994). At the local level, through a participative planning process led by the mayor of the commune or president of the region, local governments develop a five-year strategic plan in which they
lay out their development goals for devolved political functions. Nevertheless, central government ministries have a policy role of setting standards, providing guidance to local governments, and monitoring how well local governments are delivering.

Implementation of national health policies at sub-national levels is monitored and steered by the central government, through regional health offices and district health offices that form the “deconcentrated” government system. The district health office oversees the bottom layer of the health system. The District Health Team provides technical assistance to and is the administrative authority over the District Hospital, known as Centre Médical avec Antenne Chirurgicale (CMA) and Centre Médical (CM)\(^3\); primary health centers, known as Centre de Santé et de Promotion Social (CSPS); and health center committees (HCC), known as Comité de Gestion (CoGes). The district team is responsible for technical guidance and the proper functioning of the health facilities in the district. Their mandate includes planning, budgeting, supervision, training, management, and health information.

**HEALTH SYSTEM STRUCTURE**

The public health system in Burkina Faso has a pyramid structure composed of four layers (Figure 2). The first, bottom level consists of the primary health centers known as CSPSs. CSPSs are at the commune level and are assumed to be the point of entry to the health system. At the intermediate level, CMs and CMAs take referrals from the CSPS and are located at the district level. These are followed by regional hospitals, known as Centre Hospitalier Régional (CHR), located at the regional level. On top of the health pyramid is the university hospital (CHU in French), which provides specialized care. Alongside this public health sector, there are two coexisting sectors that provide health care services, namely the private sector and the traditional sector (Traoré 2016).

Central government and communes have distinct responsibilities in the health sector, except for health financing at the primary health care level, where there is an overlap. Policy, planning, and coordination of the health sector is exclusively the responsibility of the central government. The Ministry of Health (MOH) develops a long-term strategic plan, a 10-year plan known as Plan National de Development Sanitaire, to which all government tiers should align when developing annual activity plans. The MOH oversees service provision at teaching, tertiary, regional and district hospitals, as well as primary health centers. The MOH is also responsible for revenue mobilization and purchasing for these levels. Local governments responsibilities on the other hand are limited to revenue mobilization and purchasing for the primary health centers.

The MOH (through the district health office) and communes have mandate over primary health centers. While the MOH is the only entity that has mandate of the top three layers of the public health care pyramid, health centers have dual reporting structure. Each primary health center reports to both the health district office and the commune. All primary centers in a commune share a single corresponding health district. However, a health district can have health facilities from more than one commune in its catchment area.

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\(^3\) CM is at an intermediate level between CMA and Centre de Santé et de Promotion Social (CSPS).
**Figure 2: Burkina Faso health care provision pyramid**

<table>
<thead>
<tr>
<th>ADMINISTRATIVE</th>
<th>LEVELS</th>
<th>HEALTH SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office of the Minister</td>
<td>CENTRAL/ Tertiary level</td>
<td>CHU, private providers</td>
</tr>
<tr>
<td>Permanente Secretariat</td>
<td>INTERMEDIATE/ Secondary level</td>
<td>CHR-CHRU and private providers</td>
</tr>
<tr>
<td>Head office departments</td>
<td>Basic/ Primary level</td>
<td>CMA/HD, private providers</td>
</tr>
<tr>
<td>Regional Health Office</td>
<td></td>
<td>CM</td>
</tr>
<tr>
<td>District Health Office</td>
<td></td>
<td>CSPS</td>
</tr>
</tbody>
</table>

Source: Burkina Faso Health system development plan 2021-2030

Abbreviations: CHU = Centre Hospitalier Universitaire; CHR = Center Hospitalier Régional; CHRU = Centre Hospitalier Régional Universitaire; CMA = Centre Médical avec Antenne Chirurgicale; CM = Centre Médical; CSPS = Centre de Santé et de Promotion Social

**HEALTH FINANCING LANDSCAPE IN THE CONTEXT OF DEVOLUTION**

While the health financing ecosystem in Burkina Faso is characterized by various financing schemes, the government accounts for the largest portion of health spending. According to the latest National Health Accounts (NHA) data, 60% of total health expenditure in Burkina Faso is controlled by the government, which includes donor funds flowing through government (Ministry of Health 2017). Household out-of-pocket expenditure accounts for 32% of health spending, while private employer schemes, insurance, and non-profit institutions account for 1.4%, 3.6%, and 2.6% of spending respectively.

Government spending for health is organized into both input- and output-based financing schemes (Table 2). The bulk of the government’s budgetary spending on health at both the national and commune levels is structured as input-based financing for public health facilities that provide health services to all residents in the country, with cost sharing from the population for some services. Public finances for health are also flowing into schemes that target specific groups or geographical areas, such as the Gratuité program—which is funded by the government budget and allows all pregnant and lactating women, as well as children under five, to access services free of charge—with the MOH reimbursing facilities for the user fees forgone. The results-based financing (RBF) scheme, funded by the World Bank and implemented by the MOH, channels funds to 15 districts out of 55 for services provided to pregnant and lactating women, as well as children under five. The 15 health districts are classified as the poorest in the country.
Table 2: Funding stream for primary health center activities

<table>
<thead>
<tr>
<th>Activity category</th>
<th>Fund flow</th>
</tr>
</thead>
</table>
| Health facilities’ general activities | — Central government pays for health workers directly  
— Central government transfer to the district health office account, which purchases goods and services on behalf of the health center  
— Intergovernmental transfers for health; communes purchase goods and services on behalf of the health center  
— User fees are kept in a private bank account; the HCC oversees the execution of those funds and the health facility procures goods and services—if applicable—by itself |
| Health facilities activities falling under a specific program (e.g., malaria; HIV) | — Drugs and commodities are centrally purchased and sent to the district level for dispatch to health centers |
| Gratuité | — Funds for pharmaceuticals are transferred to Centrale d’Achats des Médicaments Essentiels (CAMEG); health facilities collect pharmaceuticals from the local level  
— Funds for operations are transferred by the MOH to the district health office, which in turn transfers funds to health facility accounts |

Source: Author based on information from the literature and experts

Over the past 10 years, only 3% of government health expenditure on average was controlled by communes (Figure 3). As we discuss below, communes rely extensively on transfers from the national government and cover only a portion of the costs of health care delivery through public facilities. Public health expenditure for the sub-national level is still highly centralized. The MOH continues to pay for some big ticket items, including health worker salaries, and the Ministry of Finance (MOF) makes direct transfers of Gratuité funds to health facilities. Whilst hospitals receive funds in their treasury accounts, Gratuité funds for primary health centers transit through district treasury accounts. District treasury accounts only facilitate the transfers of funds. Commodities for vertical programs are also procured at the central level.
**Figure 3: Government health expenditure (GHE) through the MOH and communes, per capita**

<table>
<thead>
<tr>
<th>Year</th>
<th>GHE through MOH</th>
<th>GHE through communes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>5,717</td>
<td>89</td>
</tr>
<tr>
<td>2012</td>
<td>7,433</td>
<td>179</td>
</tr>
<tr>
<td>2013</td>
<td>6,169</td>
<td>346</td>
</tr>
<tr>
<td>2014</td>
<td>6,254</td>
<td>306</td>
</tr>
<tr>
<td>2015</td>
<td>5,474</td>
<td>243</td>
</tr>
<tr>
<td>2016</td>
<td>9,476</td>
<td>237</td>
</tr>
<tr>
<td>2017</td>
<td>10,937</td>
<td>269</td>
</tr>
<tr>
<td>2018</td>
<td>12,864</td>
<td>322</td>
</tr>
<tr>
<td>2019</td>
<td>10,137</td>
<td>301</td>
</tr>
<tr>
<td>2020</td>
<td>10,902</td>
<td>292</td>
</tr>
</tbody>
</table>

*Source: Author’s estimates, based on Ministry of Health 2017 NHA data and Ministry of Local Government report*

**REVENUE RAISING**

While communes fund their operations—both recurrent and capital spending—from both central government transfers and local resources, they are highly reliant on the former. In 2018, central government transfers represented over 43% of communes’ revenue and were meant to cater to communes operating costs, as well as devolved responsibilities. These are earmarked grants that can only be used for the specific sectors and specified activities. Communes’ own resources (Figure 4), on the other hand, can be allocated to any project or activity. Local source revenues are insufficient and, in most cases, not enough to cover the local government’s operating costs (Mahieu and Yilmaz 2010).

**Figure 4: Communes’ sources of revenue, 2018**

*Source: Data shared by MATD 2018*
Revenue Collection
In Burkina Faso, fiscal decentralization is well implemented and there is a clear division of authority on revenue raising. Taxes raised at the local level are exclusive to the local governments. Furthermore, local governments can introduce new taxes. However, this should be in alignment with the legal framework for taxation. Local authorities also have the ability to determine rates for specific taxes (Government of Burkina Faso 2004a).

Revenue collected through both the national and sub-national taxation system is not meant to be assigned to a specific sector or activity. Tax revenues are gathered in a consolidated fund and then allocated to specific sectors or activities, following the national or the sub-national budget allocation process. Revenue received from foreign sources on the other hand are earmarked either for the health sector in general or to specific health program.

User fees are collected and managed by health. CoGes can collect and keep these user fees in the health facility’s own bank account and then use it for renewal of the drug stock and other running costs. Although revenue generated by health centers are kept and used by health centers, health facility managers are required by law to report their annual revenue and expenditures to the commune (Government of Burkina Faso 2004b) and must be earmarked for health service provision. However, these figures are not included in the commune’s budget, but instead, these are treated as supplementary budgetary funds.

Intergovernmental Transfers
Intergovernmental transfers for the health sector have registered a general increase over time (Figure 5). These transfers for the health sector were introduced in 2010. While they have risen and fallen over the past 10 years, they have stabilized around XOF 6.3 billion (approximately US$11.5 million) from 2018-2020, up from XOF 892 million (approximately US$1.7 million) in 2010.

Figure 5: Intergovernmental transfers for health, 2010-2020

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount in million XOF</th>
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<tbody>
<tr>
<td>2010</td>
<td>2,017</td>
</tr>
<tr>
<td>2011</td>
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</tr>
<tr>
<td>2012</td>
<td>2,017</td>
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<td>2017</td>
<td>2,017</td>
</tr>
<tr>
<td>2018</td>
<td>2,017</td>
</tr>
<tr>
<td>2019</td>
<td>2,017</td>
</tr>
<tr>
<td>2020</td>
<td>2,017</td>
</tr>
</tbody>
</table>

Source: Shared by MATD 2021
The central government uses a combination of approaches to allocate recurrent and investment budgets to communes. Budget allocation for recurrent expenditures of the health sector are based on both the number of health facilities in the commune, as well as on the commune’s geographical classification (rural versus urban). A predefined amount of XOF 1.24 million (approximately US$2,200) is allocated per health center in rural communes, compared to XOF 1.29 million for those in urban communes (approximately US$2,400). Funding for capital expenditure in the health sector does not follow a set formula but is instead at the discretion of the central government, based on the availability of funds. This unconditional resource allocation in the context of acute budget constraint has resulted in most communes going several years without receiving an investment budget for health from the central government.

Intergovernmental transfers are made exclusively to communes with no conditional ties. Though meant for primary health centers, central government funds for health are transferred to the commune. No co-financing conditional ties, a percentage minimum of resource or matching fund requirements, are tied to budget allocation for communes. Nevertheless, some communes anecdotally allocate their own resources to health spending. However, it is difficult to estimate communes’ spending for health from their own resources, as they use an income and expenditure report template that presents expenses by cost category only, and the classification does not specify sectors and purpose. As shown in Table 3, pharmaceuticals bought for health centers and those for commune staff are captured in the same line. Likewise, fuel for the health center ambulance and fuel for the commune’s non-health facilities related activities are also captured on one line.

Table 3: Example of communes’ recurrent expenditure layout

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Article</th>
<th>Paragraph</th>
<th>Description</th>
<th>Budget</th>
<th>Disbursement</th>
<th>Disbursement rate (%)</th>
<th>Expenses yet to be approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>600</td>
<td></td>
<td>Pharmaceuticals</td>
<td>xxxx</td>
<td>xxxx</td>
<td>xxxx%</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>601</td>
<td></td>
<td>Food</td>
<td>xxxx</td>
<td>xxxx</td>
<td>xxxx%</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>602</td>
<td></td>
<td>Clothing</td>
<td>xxxx</td>
<td>xxxx</td>
<td>xxxx%</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>603</td>
<td></td>
<td>Fuel, lubricant, &amp; combustibles</td>
<td>xxxx</td>
<td>xxxx</td>
<td>xxxx%</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>6030</td>
<td></td>
<td>Fuel</td>
<td>xxxx</td>
<td>xxxx</td>
<td>xxxx%</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>6031</td>
<td></td>
<td>Lubricants</td>
<td>xxxx</td>
<td>xxxx</td>
<td>xxxx%</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>6032</td>
<td></td>
<td>Combustibles</td>
<td>xxxx</td>
<td>xxxx</td>
<td>xxxx%</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>604</td>
<td></td>
<td>Detergent</td>
<td>xxxx</td>
<td>xxxx</td>
<td>xxxx%</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>606</td>
<td></td>
<td>Stationaries</td>
<td>xxxx</td>
<td>xxxx</td>
<td>xxxx%</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>607</td>
<td></td>
<td>Road furniture</td>
<td>xxxx</td>
<td>xxxx</td>
<td>xxxx%</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>608</td>
<td></td>
<td>Office supplies</td>
<td>xxxx</td>
<td>xxxx</td>
<td>xxxx%</td>
<td>x</td>
</tr>
</tbody>
</table>

Source: Ministry of Finance 2012
Intergovernmental transfers for health are geographically earmarked but some communes come together to share their resources to achieve greater equity in distribution following stipulated rules. Reallocation of funds across sub-national entities are allowed under Article 130 of the Local Government Act (Government of Burkina Faso 2004a). Under this article, communes that belong to the same region can “merge” and form a group of communes called Communauté de communes. Responsibilities are therefore shared within this new geographic boundary. As a result, the “basket” of funds transferred by the central government is shared among the concerned communes based on their specific needs. Nevertheless, the central government transfers for health remain earmarked by budget items. The group can reallocate the funds for a particular budget item, as long as the total spending by the group for that budget item does not exceed the central government’s allocation.

While the bulk of the intergovernmental funds are disbursed, there are continuous delays in disbursement, which hinders the effectiveness of central government financing. The average disbursement rate of funds from the central government and donors channeled through the MOF for the period 2014-2018 is estimated at 98%. However, except for the year 2020 when funds were disbursed in the first quarter, as stipulated by the law, communes generally receive funds from the central government in the second quarter of the year. This delay in disbursement hinders the ability of communes to continue smooth operations.

Budget Development and Negotiation
At both national and sub-national level, budgeting is the annual “embodiment” of a long-term development vision balanced with economic realities. At the national level, there in a five year planning document known as Plan National de Développement Economique et Social. The government sets long term objectives and coordinates actions to achieve expected results. This plan is done in a participative approach involving line ministries (e.g., the MOH). In the same vein, sectoral long-term strategic planning takes place. For instance, the MOH develops a 10 year plan know as Plan National de Development Santé, reviewed every five years. The plan includes an operational schedule that specifies activities to be carried out each year. The Plan National de Development Santé is the guiding document for central government health interventions. A three year financial programming framework, which is revised each year, known as Cadre Budgétaire a Moyen Terme is developed by the MOF and used to determine the government revenue and expenditure for the following year, i.e. the annual budget.

Communes, like the national government, transcribe their long-term vision in a five-year planning document known as Plan quinquennial. This plan includes an operational schedule that specifies activities to be carried out each year. It includes a section for health, which is developed in collaboration with the nurse in-charge from primary health centers within communes; nongovernmental organizations (NGOs) in the health sector and civil society organizations (CSOs). It is the guiding document for commune budgeting for health using its own resources.

Budget formulation is a nine month process based on a bottom-up approach in which beneficiary entities must defend their proposal and get approval from the highest authority at their governance level (Figure 6). Burkina Faso’s fiscal year follows the annual calendar, January to December, and the budget development process starts in March-April with the budget preparation circular (Collaborative Africa Budget Reform Initiative 2008), an instruction document for line ministries, agencies, and local government to develop their budget and allocation breakdowns by program. Budget proposals are then crafted in line with annual activities and objectives, as per respective strategic documents. Within communes, hearings are held before the MOF for the central government or the local council. The budget is then revised to incorporate all feedback.
For the central government, a finance bill is prepared by the MOF and submitted to Parliament. Feedback from budget hearings and debate at the legislature will be incorporated and reflected in the Finance Act, which details budget approvals by the legislature. The budget is then approved by the president for execution. Concerning communes, the local council’s approved budget is then submitted to a regional technical committee, formed of regional representatives of five directorates from the MOF. Once the budget is approved by this committee, it is then submitted to both the regional governor and the parent ministries at the central level, including the MOF and MATD for approval prior to implementation (Centre D’information, De Formation Et D’études Sur Le Budget 2019).

Figure 6: Selected key events in Burkina Faso’s budget formulation process

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y-1</td>
<td>Preparation and dissemination of budget preparation call</td>
</tr>
<tr>
<td>Y-3</td>
<td>Line ministries budget proposal preparation</td>
</tr>
<tr>
<td>Y-2</td>
<td>Technical budget hearings</td>
</tr>
<tr>
<td>Y-1</td>
<td>Update of the macro-fiscal framework; budget preparation and finalization</td>
</tr>
<tr>
<td>Y-1</td>
<td>Preparation and transmission of finance bill to parliament</td>
</tr>
<tr>
<td>Y-0</td>
<td>Parliament review and vote on the Finance Act to parliament</td>
</tr>
<tr>
<td>Y-0</td>
<td>Presidential assent of the budget</td>
</tr>
</tbody>
</table>

Source: Author

Spending priorities for the health sector are evaluated by the legislator, or its equivalent at the sub-national level. The central government health budget is scrutinized and debated at the national legislature. Regarding communes, only capital investment is scrutinized and debated, as the operations budget for health is a fixed amount derived from intergovernmental transfers. All capital investments in the communes budget must be in line with the five year development plan. This is checked by the local council comprised of elected members, equivalent to the legislature at the national level. Furthermore, community members and CSOs can also attend the budget hearings, ask questions, and challenge the investment budget.

POOLING

Risk pooling in Burkina Faso is characterized by the coexistence of multiple mandatory and voluntary schemes, as well as non-pooled out-of-pocket spending that accounts for a third of health spending. At present, the MOH pools funds from domestic and foreign sources into the health budget and allocates them to service providers, in principle providing all people access to health services. In 2015, Burkina Faso committed to setting up a national health insurance fund known as Régime d’assurance Maladie Universelle (RAMU), aiming to combine a compulsory health insurance scheme for workers in the formal sector with a voluntary health insurance scheme that will gradually become compulsory for actors in the informal sector and the agricultural sector (Constitution of Burkina Faso 2016). It is not expected that RAMU will assume all MOH pooling functions or that of communes, even if some programs like Gratuité may shift to the RAMU. The MOH and communes will continue to pool funds to pay for some of the costs of service delivery and RAMU will coexist alongside it, paying providers for some of the costs.

The intergovernmental transfer for implementation of the national health insurance scheme seems improbable. During the pilot phase of RAMU in four regions—Boucle du Mouhoun, Hauts-Bassins, Nord, and Center—the permanent secretariat of the National Council for Social Protection, a body housed in the prime ministry, had identified 67,000 indigents for whom a RAMU premium must be paid by the central
government to community-based health insurance (CBHI) through communes. However, in 2020, the central government started a RAMU pilot exercise and paid a CBHI premium for indigents through the the Caisse Nationale d'Assurance Maladie Universelle (CNAMU), Burkina Faso’s national health insurance agency, instead of communes. This pilot is financed with a repurposed CNAMU 2019 operating budget. While the CNAMU is yet to document the indigents program, there are concerns about the government’s financial ability to sustain health coverage for the indigents in the long-term. Budget constraint seems to be the major hindrance to the implementation of the RAMU (Kagambega 2020).

**There are two types of voluntary schemes in Burkina Faso today, CBHI and private insurance, which are essentially population-segmented schemes based on socioeconomic criteria.** Households from the formal sector generally use private insurance companies; beneficiaries of private insurance companies were estimated to represent 0.1% of the population in 2005 and are generally from the private formal sector (World Bank 2012). The current coverage may be lower as the National Statistics Bureau has reported a steep decline in working population within the private formal sector, from 2.6% in 2005 to 0.8% in 2018 (Institut National de la Statistique et de la Démographie 2019). The informal and agricultural sectors, on the other hand, use CBHI schemes. The 2014 inventory shows the existence of 188 operational nonprofit health insurance schemes covering 256,015 beneficiaries, from which 56% are from CBHI. This represents 0.9% of the population (Ministry of Labor [MOL] 2014, as cited in Kagambega 2020).

**Burkina Faso has a range of CBHI schemes covering selected health services.** The premium charged by CBHI schemes in Burkina Faso is around XOF 750 (US$1.50) for adults and XOF 250 (US$0.50) for children. Insured persons can access health care, free of charge at point of use, such as consultation, medication, laboratory tests, or x-rays at their reference health facility, which is usually the insured individual’s closest health facility. Health insurance also covers surgery and in-patient treatment for up to 15 days at the hospital, but only if insured patients have been referred to the hospital from their local health facility. AIDS treatment, dental care, circumcision, or ophthalmology are not covered by the CBHI (Schoeps et al. 2015).

**The population coverage of CBHI remains low and is not present in all communes.** An estimated 0.9% of the population was enrolled in CBHI in 2014 (MOL 2014, as cited in Kagambega, 2020). The current CBHI national coverage may be lower, as the MOL has reported a 35% drop in the number of operational CBHI from 2011 to 2016 (Government of Burkina Faso 2016b), due in part to financial barriers that prevent people from affording the premium (Parmar et al. 2014). The introduction of fees exemption for services provided to children under five years old and pregnant women, under the Gratuité program, could have also led to this decline; it is anecdotally reported that most families were joining CBHI to provide health coverage to children and pregnant women. Though the central government is planning to build on CBHI schemes to roll out its national health insurance scheme to the informal and agricultural sector, no funding mechanism is in place in the interim to ensure that the poor are enrolled into CBHI. In its 2016 review, the MOL reported that CBHI schemes were presented in 76 communes out of the 353 in the country (Government of Burkina Faso 2016b), representing a 22% national coverage. Communes also do not invest their local resources to provide risk adjustment subsidies to CBHI. There are anecdotal reports of isolated action by “wealthy” communes regarding payment of premiums for school-enrolled children, which cannot qualify as a risk adjustment mechanism. Because of their small size, CBHI pools can be financially precarious, raising efficiency and capacity concerns (Mathauer, Saksena, and Kutzin 2019).

**PURCHASING**

**Purchasing Roles and Responsibilities**
Expenditure authority and responsibility for tertiary and secondary health care providers is essentially steered by the central government, whilst primary health purchasing is shared between the central government and communes. The MOH is the main purchaser of tertiary and secondary care in the public
sector, which is largely done by paying for inputs, including human resources for health. On the other hand, central government, communes, and HCCs share purchasing responsibilities for primary health centers through a complex set of arrangements. Drugs and other commodities for vertical programs are procured by the central level in order to achieve economies of scale. The central government also pays for drugs and commodities for services covered under the Gratuité program. Health facilities use revenue from user fees to access all other drugs and commodities from the district medical store. Capital investment, remuneration of clinical health workers, as well as payments under Gratuité program are also handled by the central level. Communes purchase office supplies for primary health centers; pay utility bills; and pay ancillary staff (e.g., ambulance driver and security guards) and community health workers. They also purchase some drugs and health commodities, but this is at a small scale. In certain circumstances, communes also finance capital investments. HCCs oversee the expenditure of revenue collected and retained by health facilities.

While communes are autonomous in purchasing, HCCs are steered by districts, which are the central government’s administrative units at the local level (as part of Burkina Faso’s system for deconcentration). Communes have a high level of autonomy vis-a-vis the national government on what to purchase. They develop their own budget and make their purchasing decisions based on a needs assessment conducted. In some instances, they can align their purchasing decisions to the national health strategic plan recommendations, such as supporting behavioral change communication for a specific program or disease. In such instances, they contract community health workers to conduct sensitization. In contrast, HCCs must produce an operation plan to be approved by the district health office. All purchases must be authorized by the head nurse as the local representative of the district health office.

Only communes and HCCs can carryover funds that they oversee for future purchases. Communes and HCCs can use surplus funds or keep reserves for use at any given time. Communes can therefore decide to use a portion of the central government transfer to health matters without incurring any penalty. This level of discretion can encourage delays in the procurement process, which hinders the availability of inputs required for quality service provision at the facility level. The district health office, on the other hand, loses all unspent funds allocated to primary health centers at the end of the fiscal year.

Provider Payment and Contracting

As dictated by the central government, input-based budgeting is the sole payment mechanism used by communes for primary health care providers. Payment methods by communes are guided by the Local Government Procurement and Financial Management Act, issued by the MOF and the MATD at the national level (Government of Burkina Faso 2019). Budget funding is the sole payment mechanism that communes can use. Furthermore, funds are not transferred to health centers’ bank accounts to cater for line items supported by the communes. Instead, communes procure goods and services on behalf of health centers and provide them as in-kind transfers to the facility.

Communes’ purchasing authority is limited to operating costs and ancillary health workers; while they may purchase drugs and other health commodities, they can only do so from the CM store. Though the Devolution Act of 2009 gives the responsibility of drugs purchasing to local governments, in practice the funds that are transferred from the central level to local governments are generally intended to cater for running costs, as well as for the refurbishment of health facilities. As shown in Table 3 public funding for drugs and other health commodities for primary health care are still handled by the national level. However, when funds allow and needs arise, communes can use their own resources to procure medicines for health centers (Government of Burkina Faso 2016). The general principle is that medicines for public health facilities must be through the Centrale d’Achats des Médicaments Essentiels (CAMEG) irrespective of the purchaser, including communes and HCCs. CAMEG supplies 67 district dispatching depots which
consolidate and distribute orders for health facilities. However, in the event of a stockout, upon approval from the district medical director, purchasers can procure medicines with private suppliers.

**Public facilities in Burkina Faso collect user fees, which they retain and spend to cover some of their costs.** These funds are held in private bank accounts. The HCC oversees the use of these funds, which facilities typically spend on pharmaceuticals (75%), salaries (10%), other operating cost (15%) and capital investment (3%) (Olivier, Traoré, and Cros. 2016). From the perspective of a public sector health facility, there are multiple purchasers with varying degrees of separation. Purchaser-provider split (PPS) is a service delivery approach wherein third party payers are kept organizationally separate from service providers. There is a clear PPS in the devolved system between communes and the health facilities they purchase from. In contrast, there is limited PPS between the MOH and its local district offices on the one hand and health facilities on the other. Moreover, within primary health centers, the HCC is part of the health facility management and also acts as a purchaser of services provided by the health center. There are also instances where the HCC acts as the management committee of the local CBHI.

**Benefits Package Design**

In Burkina Faso’s health system, the national level determines the minimum health benefit package to be provided at each level of the public health service’s organizational structure. A health benefits package, a set of services that can be feasibly financed and provided in a country, are the services made available to the population depending on the funds available (Glassman et al. 2016). In Burkina Faso, the central government is the main funding source for the health system, therefore the health benefits package reflects the set of services required to achieve UHC that national public funding can afford. The MOH defines two types of health benefit packages at the primary health care level: basic and supplementary. Health facilities have the discretion to provide supplementary services if their budget permits.

**Budget Execution**

There is centralization of financial management processes; therefore, spending of public funds in Burkina Faso must be approved by the national level irrespective of the beneficiary government (national or sub-national). Once the central government budget is approved by parliament, ministries, sub-national levels, hospitals, and health districts, the budget is uploaded in the electronic PFM system for execution. Quarterly disbursement is done to their respective sub-paymaster account by the national treasury. The same applies to a commune’s budget. Expenditure at both levels is initiated by beneficiary entities, but approval and actual payment is steered by the national MOF.

**Health facilities have limited control over budget allocated to them.** As primary health centers do not have a sub-paymaster account for public funding allocated to them, it is spent on their behalf by communes and the district health office. As shown in Table 3, financial and in kind-transfers are mainly processed through either the district health office, except for operational costs funded under the Gratuité program. These funds are transferred to primary health centers’ own private bank accounts for recurrent expenditure (Barroy 2021).

**There is flexibility for budget amended during the year, but it must be approved by the legislator or its equivalent at the sub-national level.** The central government’s budget reallocation or supplement budgets known as *Loi de Finance rectificative* is allowed during the year, which can only be initiated by the MOF and must be approved by parliament. Lower levels of government, including the MOH, regional health offices, district health offices, and health centers could not amend the budget. Regarding communes, there is flexibility for supplementary budgets, which can only be initiated by the local council and must be approved
by the regional technical committee, followed by approval from the governor as well as the MOF and MATD.

**REPORTING, OVERSIGHT, AND ACCOUNTABILITY**

There is a unique PFM system for central and local governments, which is mainly managed by the central level. The MOF and the national treasury have considerable authority over line ministries, state agencies and local government’s financial management by virtue of their control over budgeting and budget execution. Communes’ cash collection and disbursement operations are verified, authorized, and monitored by the MOF through sub-national administrative units, irrespective of the source of funds.

The MOF plays a pivotal role in tracking public expenditures at both the national and sub-national level. The integrated Public Financial Management System for tracking spending is known as circuit informatisé de la dépense, which is used to report on and monitor central, regional, and district levels as well as a commune’s budget execution, including its health budget. Every step in the budget execution (i.e., the initiation of purchase orders and the release of funds) are captured in that tool, which allow the MOF to generate figures and monitor budget execution rates for both the national and the sub-national levels.

The use of two different budget classifications tracking actual health spending at the sub-national level difficult. Whilst the central government use a program-based budgeting in which funding allocated to the health sector can easily be identified (Barroy, Andre, and Nitiema 2018), communes do not use an input-based budgeting, which does not allow tracking of spending for health (World Bank 2016). Health expenditures incurred by communes are instead reported as “public expenses for decentralization” in the the MATD budget. As a result, public health expenditure is partially reported, presenting only the national health expenditure or budget as tracked by MOF and the MOH. The MATD monitors health expenditure from intergovernmental transfers, though this information is not presented in the central government’s budget execution reports.

**DISCUSSION**

This case study has revealed the following trends related to health financing in Burkina Faso following devolution:

1. **Devolution has not yet led to a significant increase in public spending for health.** While the government’s per capita spending on health through the MOH has registered a general increase over the past 10 years, per capita health expenditure through local governments, including communes, has remained constant, hovering around XOF 300 (US$0.6) per capita during the same period. The intergovernmental transfer for health tends to be inconsequential, with very little effect on increasing per capita spending. Furthermore, communes do not allocate much of their own resources to health. As there is no co-financing conditionality on central governmental transfers, communes may choose, as appropriate, not to give priority to the health sector during the allocation of their scarce resources.

2. **The current funding arrangement does not enable devolution to improve service delivery in primary health facilities.** The amount allocated to drugs in the budget transferred to communes, as well as their role in health workers recruitment and pharmaceuticals procurement, is nominal. Therefore, the probability of devolution impacting local needs seems improbable.

3. **Weak technical capacity of communes to undertake priority setting as well as planning for the health sector would not allow them to properly handle budget formulation for the health sector**
at the sub-national level. Technical capacity building seems not to have been taken into account during political dialogue on devolution in the health sector. Fearing communes’ lack of technical capacity on health matters, coupled by the absence of a common reporting and accountability mechanism between communes and the MOH, this has resulted in the latter still holding onto prerogatives that have been transferred to communes as per the Devolution Act of 2009. Human resources, drugs, and other health commodities will continue to be managed by the central government.

4. Though the matters of social welfare and health are devolved to the sub-national level, communes in Burkina Faso have not set up financial protection programs for their constituents. CBHI are introduced at the sub-national level with the support of donors or NGOs. The central levels encourage implementation of CBHI in all communes, however, there is no legal instruments in place to impulse risk adjustment mechanisms by communes to ensure implementation of CBHI and, most importantly, higher households’ enrollment. In addition to the lack of legal instruments or frameworks, funding such mechanisms may also be critical. Resource mobilization is a big issue for local governments in Burkina Faso (Government of Burkina Faso 2020) thus, the probability of them investing their own resources in risk pooling seems very low. Intergovernmental transfer appears to be a suitable alternative.

5. Communes’ role in pooling might be limited—for now—to a deconcentrated role, essentially an administrative function. Communes are already issuing indigents cards, which could serve as a base to update the list of eligible people to the central government premium subsidy program for indigents. Furthermore, as demonstrated during the period 2014-2019 under the World Bank Reproductive Health project, communes can be very instrumental in facilitating creation of CBHI. Under that project, 100 communes have successfully supported the introduction of CBHI, thereby providing workspace or land for construction of CBHI offices, supporting community sensitization, and mobilization.

6. There is a partial devolution of purchasing functions to communes, which may hinder significant benefits from decentralization. While financial resources for operations and investment are transferred and managed by communes, human resources for health are still managed by the central government. When a civil servant is needed at the sub-national level, communes express their need to the district medical officer, who will forward the request to the high commissioner of the province and the MATD. A civil servant commission meeting, under the leadership of the high commissioner, gathers all district medical officers and mayors to dispatch the pool of health workers allocated to the province by the central government and the governor of the region. Civil servant allocation is based on a commune’s needs and is mostly based on what is made available by the central government. Hiring, firing, and salary payment are controlled by the central government. The salary of the loaned employee (e.g., a nurse) is paid directly by the central government, while allowances are co-paid by the communes and the central government. Generally, civil servant allowances are higher at the sub-national level compared to the national level. The central government pays any loaned employee allowances used while working for the central government, and the communes will bridge the gap with its own resources.

7. It is desirable to avoid different levels of decentralization across the major inputs (i.e., salaries, operating costs, and capital expenditure) required for the delivery of a specific service. This means that if a function is decentralized, then so too should the salary, operating, and capital budgets associated with that function. If this is not done, then it is unlikely that there will be
significant benefits from decentralization, since communes will not be able to adjust the input mix to respond to local circumstances and preferences (Hart and Wellham 2016).

8. **There was an intent to devolve salary payment.** In 2011, the MOF tried to involve communes in salary payment, but the initiative was blocked but the civil servants union, which was skeptical about the ability of communes to pay salaries to “loaned employees” on a timely basis. The MOF and the MATD are working together to transfer this responsibility to communes by 2022, with the central government giving allowances to civil servants working at the commune level. Communes will top up their budgets with their own resources and make a single payment to loaned employees.

9. **Due to their limited contribution to the funding pool, it is unlikely that communes will modify the benefit package beyond what the central level can afford.** Most primary health facilities at the sub-national level struggle to provide the basic health package, due to lack of adequate human resources and equipment (WHO Regional Office for Africa 2017). Since communes do not contribute to the funding pool for health services, it is therefore unlikely that they will support primary health facilities with adequate human resources and equipment, plus expand the benefit package beyond what is defined by the national level. Furthermore, revenue generated by individual health facility through out-of-pocket or CBHI is not sufficient to hire clinical staff, purchase equipment, and subsequently offer a full basic package to the population. The probability for communes to expand or modify the health benefit package seems very low.

10. **The limited capacity of communes to undertake financial programming in effect means that devolution has merely shifted the centralized budget formulation to another level.** The regional representatives of the MOF (deconcentration) estimate expected revenue and decide budget envelope allocation to various programmes. Furthermore, a commune’s final budget must be approved by the national level (through the region offices of the MOF) by execution. A commune’s role in budget formulation is thus limited to identification of interventions that can fit into the central government investment budget.

11. **The transfer of functions, including those for health, happened before the roles of the national MOH and communes had been agreed on.** As a result, the MOH continues budgeting for primary health care providers, as it was prior to devolution. A primary health center’s budget is prepared by the HCC under the supervision of the head nurse, using standardized action plan and budget templates provided by the district health office. Action plans and budget proposals are reviewed by the district team, especially the planning officer, during the district support supervision visit. The final documents are submitted to the district health office for incorporation into the action plan and budget, along with district hospital and the district office activities and needs. A health facility’s budget is defended by the district health office during budget hearings held at the regional level.

12. **A fragmented budget execution and reporting system may lead to inefficiencies.** Before devolution, all health expenses for the sub-national providers from government grants were processed through the MOH sub-paymaster account by the national treasury, as there was only one funding stream. With the introduction of devolution in the health sector, payment to sub-national providers is split—though not equally—between MOH and communes. At the sub-national level, there is a fragmented budget execution process with two different entities engaging spending, sometimes for the same goods and beneficiaries. This hinders the economy of scale and causes delays in delivering goods to recipient health facilities. Furthermore, the coexistence of two
reporting systems working in silos does not provide a clear and accurate picture of public health spending for better resource allocation. A consolidated budget execution report for the health sector is yet to be institutionalized. Data on budget execution at the two levels, national and local, are produced by public entities but have not yet been consolidated into a single report.

**13. Earmarked funds for health expenditure at the local level has led to inefficiencies in the system.** Communes’ internal bureaucracy delays the delivery of goods bought by the communes. Furthermore, budget rigidity limits communes’ ability to address the real needs of the health facilities. For instance, if XOF 300,000 (US$600) is allocated to the office supply, the health center will receive goods for this amount, even though their needs in terms of office supply is XOF 50,000 (US$100) and XOF 250,000 (US$500) for medicines. Communes are not allowed to reallocate central level funds.

**CONCLUSION**

More than a decade of statutory delegation of powers from the central government to communes as it pertains to health in Burkina Faso has not yielded a significant increase in public spending for health, nor shifted key health financing functions to communes. Though it is advisable to accelerate effective devolution in Burkina Faso, the transfer of purchasing functions—especially payroll management—might not be suitable to the context and therefore could remain centrally managed. Non-wage expenditures and other health financing functions could be fully transfer to communes, however perquisites—such as alignment of budgeting frameworks, improved accountability at the commune level, and local resource mobilization—should be in place to avoid losing the sub-national level progress toward UHC. Devolution can be improved in Burkina Faso and may require a phased approach, starting at the commune level by adopting a program-based budget.
REFERENCES


### ANNEX 1: LIST OF INTERVIEWED INDIVIDUALS

This annex contains a list of individuals interviewed by the author between July and October 2020. For each interview, a semi-structured questionnaire was prepared based on the subject’s expertise and information gaps following the desk review.

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Interview date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guézouma Traoré</td>
<td>Commune of Kangala</td>
<td>October 2020</td>
</tr>
<tr>
<td>Alassane Traoré</td>
<td>Commune of Samorogouan</td>
<td>October 2020</td>
</tr>
<tr>
<td>Madou Coulibaly</td>
<td>Commune of Kagnan</td>
<td>October 2020</td>
</tr>
<tr>
<td>Herman Sirima</td>
<td>Arrondissement 7 Commune of Bobo</td>
<td>October 2020</td>
</tr>
<tr>
<td>Dr. Lamine Ouedraogo</td>
<td>Ministry of Health</td>
<td>October 2020</td>
</tr>
<tr>
<td>Ramde Sokoba</td>
<td>Ministry of Local Government</td>
<td>July 2020</td>
</tr>
<tr>
<td>Adama Traoré</td>
<td>ThinkWell</td>
<td>July 2020</td>
</tr>
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