

Performance Based Contracting in low-income countries: The Performance Initiative in Butare, Rwanda

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Content

- Initial situation in Gakoma and Kabutare districts.
- The intervention.
- The results.
- The main lessons.
- Challenges.

Initial situation

- Availability of key inputs: buildings, equipment, drugs and human resources.
- Traditional strategies in place (Minimal Package of Activities).
- Heterogeneity in performance (coverage).
- Opportunities for referring cases.
- User fees as the major source of income. A barrier?

Gakoma and Kabutare districts

	Gakoma	Kabutare
Population	79,744	304,372
Health centres	4	15
Before	No bonus	Fixed bonus

The strategy (MoH – HNI)

- (1) Input-based \Rightarrow Output-based payment.
- (2) Staff as residual claimants.
- (3) More decision rights to the HC team.
- Contract between the health centre and a Steering Committee.

Output-based payment

- Remunerate the health facility for each unit of output that has been delivered. Ex: US\$ 1 per child fully immunised.
- Advantages of payment per unit:
 - Fair to Health Centres covering large population and to those performing well already.
 - No threshold effect.
 - // User fees.
 - Unitary output is good proxy of effort.
 - Predictability for the HC.

The contracts



Key results

Method

- Data from the Health Information System (2001-2003).
- Data in Gakoma and Kabutare have been monitored by the project.
- Comparison with other rural health centres in the country (in blue).

District without bonus before (Gakoma)

	2001	2002	2003	2003/2001
Population	77.557	79.744	81.993	+6%
Consultations (New Cases)	36.374	50.490	45.310	+25%
NC/inhabitant/year	0,47 (0,23)	0,63	0,55 (0,29)	+18% (+25%)
Deliveries at the Health Centre	463	1.042	1.034	+123% (+38%)
Deliveries referred by the Health Centre	29	75	64	+121%
Assisted deliveries / Expected deliveries	14%	31%	30%	+111%
New subscriber to Family Planning	22	150	171	+677%
Coverage rate for TT 2-5	47% (45%)	74%	70% (55%)	+47% (+30%)
Coverage for DTP3	60% (77%)	88%	87% (81%)	+44% (+11%)
Coverage for Measles immunisation	59% (70%)	63%	92% (77%)	+56% (+16%)

District with fixed bonus before (Kabutare)

	2001	2002	2003	2003/2001
Population	276.487	284.284	292.301	+6%
Consultations (New Cases)	106.998	174.952	192.594	+80%
NC/inhabitant/year	0,39 (0,23)	0,62	0,66 (0,29)	+70% (+25%)
Deliveries at the Health Centre	925	1.816	2.234	+142% (+38%)
Deliveries referred by the Health Centre	142	463	618	+335%
Assisted deliveries / Expected deliveries	9%	18%	22%	+153%
New subscriber to Family Planning	399	625	869	+118%
Coverage rate for TT 2-5	34% (45%)	52%	46% (55%)	+35% (+30%)
Coverage for DTP3	68% (77%)	75%	77% (81%)	+14% (+11%)
Coverage rate for Measles immunisation	65% (70%)	56%	80% (77%)	+23% (+16%)

Nature of the improvement

- Improvement has been general in the 19 HCs.
- Typology of change:
 - Health centres which were biased towards curative care have expanded their preventive packages.
 - Health centres without maternity have opened one.
 - Health centres neglecting quality of service have changed their behaviours.
- Homogenisation of performance + general increase \Rightarrow the poor performers are catching up.

Costing

- Cost of the Performance Initiative: US\$ 0.24 per capita per year (62% for incentives to the health centres, 27% for incentives to district and province managers, 11% for the transaction costs).
- As the NGO was already paying fixed bonuses in Kabutare district in 2001 (around US\$ 59,000 a year), one can consider that the incremental improvements there have cost around US\$ 0.035 per capita per year.
- Bonuses financed by the Performance Initiative contributed up to 39% of the staff income in the health centres of Kabutare District.

Key lessons

The failure of current institutional arrangements in the public sector

- There are problems of accountability in the pyramidal public health systems.
- The monopolies offer rents to the health care providers.
- Hierarchies fail in enforcing the input-based contracts \Rightarrow performance is low.
- Other remuneration contracts should be considered for the health centres.

There are arguments for Output-based contracts

- There are already some of these contracts: the user fees for curative care. Introducing fees for other outputs may correct the existing bias towards curative care.
- Some preventive outputs are easy to monitor.
 \Rightarrow New role for the community organisations?
- Alternatives are either poorly enforced (input based contract) or not feasible today (capitation contract + competition).

Limits

- Some dimensions of the remunerated outputs can be less easy to monitor (e.g. quality of care).
- Some preventive outputs are much more difficult to contract. E.g. nutritional rehabilitation.
- The contract should not undermine other accountability mechanisms, including ethics and professional behaviour \Rightarrow accompanying measures?

Challenges for scaling up

- It is a real reform for the health system. New roles for the Ministry of Health, health district authorities, international actors and the local communities. New agencies, capacities, financial flows and accountability procedures have to be established.
- New philosophy that may hurt some practices. Some resistance is possible. Stakeholders matter!