QUALITY OF HEALTH CARE

CASE STUDY: Performance-based Contracting for Health Services in RWANDA

Since 1994, the Government of Rwanda has taken great steps towards improving the national health care system. However, infant and child mortality rates remain high, with 10% of children not surviving to their first birthday, 20% of children not surviving past their fifth birthday and 43% are stunted. Treatable infectious diseases, such as malaria, are the leading causes for infant and child mortality. In addition, maternal mortality in Rwanda is one of the highest in the world, with nearly 1 out of 6 deaths of women between the ages of 15 and 49 resulting from maternal causes. Finally, the delivery of HIV/AIDS treatment is a contributing factor to the overworked health care work force, with an infection rate over 3 percent. Improvement and expansion in the delivery of health care services is a key factor in addressing these issues.

One promising method for addressing the issues of health care worker supply and health care worker motivation is performance based contracting (PBC). PBC mechanisms are typically two-part payments, where a fixed amount is paid to providers plus an additional payment that is based on some performance or outcome indicator related to specific service utilizations. By conditioning part of the payment on utilization, there is a financial incentive to avert health care provider absenteeism and increase service quality to attract more patients. While the direct impact is intended to target worker motivation, the incentives-based scheme may also indirectly affect worker recruitment and retention. However, PBC may provide an incentive to decrease quality in excess demand situations. In this case, the PBC needs to also condition on quality indicators or at least verify a minimum level of quality.

In 2005, the Ministry of Health of Rwanda and the World Bank initiated an impact evaluation of the national performance-based contracting scheme for general health and HIV/AIDS services in Rwanda. A key element of the study is involves observing changes in the quality of health care as a result of the incentives-based payment scheme. For this reason, the data collection includes facility level questionnaires, provider vignettes and patient exit interviews.

Quality of Care Survey Instruments
- Provider Motivation/Behavior
- Vignettes
  - Prenatal Care, Child curative, Adult curative, VCT, PMTCT and AIDS detection case studies
- Exit Interviews
  - Prenatal Care, Child curative, Adult curative, VCT and PMTCT patients
- Facility Direct Observation
- Facility Supervisor

Findings
Initial results from the baseline health facility survey of 168 facilities across 17 districts in Rwanda provide an overview of the resources and services available at the health facility level, as well as raise several issues regarding the delivery of health care services. First, while health facilities report user fees and prescriptions as their major sources of income, these are two concerns raised in patient interviews. 25% of patients were not satisfied with the cost of medications, while 16% were not satisfied with the user fees.

1 Data from “Rwanda Demographic and Health Survey 2000 Key Findings” (RDHS-II 2000)
Regarding the quality of health care, initial analysis shows a severe gap between provider competence and effort as measured in prenatal, adult and child health care visits. The data suggests that as provider competence increases, we see little effect on provider effort. This could be due to such issues as lack of motivation and overcrowding at the health center level. Additional analysis is required in order to determine causes for this large gap between provider competence and effort.

Notes on the Survey

There were many lessons learned during the first phase of the impact evaluation. The baseline health facility and provider data collection for the general health services component took place from December 2005 – January 2006. During this time, several lessons were learned which were applied to the HIV/AIDS component of the impact evaluation.

1) Our team had a predetermined number of vignette topics: prenatal care, adult and child curative, as well as voluntary counseling and testing (VCT). Once in the field, however, the team realized that not all services were conducted everyday. In particular, VCT and prenatal care services were only conducted 2-3 days a week. For this reason, the survey teams visited several facilities on off-days, and were unable to find patients for the prenatal care or VCT exit interviews. This adversely affected the sample size of patients, particularly for VCT services, and restricted our analysis to only prenatal care, adult and child curative care services. We highly recommend researchers determine which services they intend to study, and schedule field work based on the availability of these services at the facilities in their sample.

2) Our team also experienced difficulty with coding questionnaires in order to properly match the providers interviewed for vignettes with the doctors who treated patients interviewed in the exit interviews. In the instance where multiple doctors provide the same service, the research team must be careful to ensure the exit interviews are administered to patients of the same provider interviewed in the vignette. For example, if doctors A and B provide prenatal care, and only doctor B responds to the prenatal vignette, then only patients of doctor B can respond to the prenatal care exit interview. This can be mitigated by assigning provider codes during the vignettes, and ensuring the provider code is included on the patient exit interview.

3) Particular attention must be paid during training and pre-testing enumerators in order to ensure they fully understand how to administer the vignettes without prompting providers for the correct response.

Description of Researchers

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