Performance-Based Financing Experiences in Rwanda

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Content

- Background of PBF in Rwanda
- Challenges facing the Rwanda health system in 2005
- How the Project addressed the issues
- Project key achievements
- Results
- Lessons learned
Background of Performance-based financing in Rwanda

- Jan 03: CYANGUGU PBF Pilot
- Jun 02: Start BUTARE PBF Pilot
- Dec 04: Mutual Policy
- Feb 05: New Health Policy
- May 05: Health Strategy 2005-2009
- Jun 05: VILLE DE KIGALI PBF Pilot
- Jul 06: DH PBF Model
- Feb 06: HC PBF Model & Start PHASE-1
- Jan 06: Roll-out of CBHI
- Apr 08: Start PHASE-2

- Jun-02 - Feb-06: PBF Pilot schemes
- Mar 06 - Jul 06: Period of Transition from PBF pilot to new DH model
- Feb 06 - Nov 07: Period of Transition from PBF pilot to new HC Model
Performance Problems/Underlying Causes

- In 2002, 2 NGOs introduced PBF pilots schemes in the former Cyangugu and Butare provinces
- Why PBF?
  - Low quality of health care & services
  - Diminishing coverage: low Utilization of Health Services
  - Financial barriers to access health services/demand side problems
- The approach proved successful to the extent that the MOH decided to include it in its 2005 Health Policy
- In 2005, the Belgian Technical Cooperation (BTC) started a third PBF pilot
Overview of the three Rwandan Pilot PBF models

<table>
<thead>
<tr>
<th>Model</th>
<th>No of Clinics under contract</th>
<th>No of Hospitals under contract</th>
<th>DHT's under contract</th>
<th>Project Budget per capita per year $</th>
<th>PBF Budget reaching clinics per capita per yr $</th>
<th>Average Health Worker Income $/month</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;BTC&quot; model</td>
<td>75</td>
<td>4</td>
<td>6</td>
<td>$1.57 (2005)</td>
<td>$0.08 (ii) (2005)</td>
<td>Base salary + $18 (2005)</td>
</tr>
</tbody>
</table>

PBF pilots covered 137 Health Centres (about 40% of total) and 11 District Hospitals (about 30%) by end 2005
In 2005, MOH introduced 3 major strategies to improve health services:

- Community-Based Health Insurance
- Performance-Based Financing
- Continuous Quality Assurance
Challenges facing the Rwanda health system in 2005

- Decision to extend the PBF strategy throughout the entire country
  - Develop a common model/administrative approach
  - Introduce institutional structures
  - Develop tools
- Many resources required for the PBF scale-up
  - Time; Material; Human
- Introduce PBF for HIV services whilst protecting the quality of general health services
- Community Based Health Insurance roll-out
- Administrative reforms
What the HIV/PBF project contributed to the national roll-out of PBF

- Providing technical support to implementation of PBF
- Building on the pilots models to develop a new PBF models and tools
- Building partnership and relationship with MOH and partners
  - CAAC- PBF Technical Working Group
  - Functional Extended Team approach: bridging the gap between policy and implementation (over 40 technical assistants from USG CAs, bilateral agencies, donors and MOH)
- Development of capacity building strategy

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Key project achievements

- The project reached nationwide coverage in 30 districts in April 2007
- Support national implementation of PBF
  - Coordinated design of new national PBF models (HC, DH, community and central MOH departments).
  - Set up institutional structures
  - Defined performance indicators and their values
  - Developed evaluation tools
  - Contracted with sites for HIV services and PCA
  - Built Capacity to manage PBF activities at all levels
- Provided TA to USG partners to implement PBF in their facilities
The new National PBF models

- A new national PBF model for health centers
- A new national PBF model for district hospitals
- Community PBF
- Model for Central MOH (being developed)
Coordinated design of PBF model

- Design models and institutional set up of the national PBF model:
  - TA to the PBF steering committee in managing PBF at district level
  - Practical trainings related to the quantity and quality control functions were done.
  - Develop the peer review mechanism for DH

- Central level PBF:
  - Creation of the evaluation checklist
  - Carry out evaluation
Performance indicators defined

• Health Center:
  - Performance Earnings = (Σ Services * Unit fees) * % Quality
  - 14 PHC indicators + 10 HIV indicators; unit fees $0.18-$8.90, measured monthly
  - 111 composite indicators (1058 data elements) across 14 services/departments, measured quarterly
  - Internal market: introducing market forces in public health services

• Hospital PBF model:
  - Balanced score card approach: (2009) 59 composite indicators, over 350 data elements
  - Annual global prospective budgets between $59K- $315K
  - Transparent peer-evaluation mechanism
Monitoring and Evaluation Mechanism

- Six levels of control have been introduced
- Set up of validation and accountability functions
  - Harmonize quantity verification tool with regular control and
  - Quality evaluation checklist
- Two national protocols for counter verification of reported services in PBF were tested and adopted as national standard.
  - Applied 4 times through a contracted third party (HDP)
  - Quality counter verification by the Extended Team
Performance Contracts (with business plan) have been developed and signed:

- MSH signed 88 sub contracts with HF to purchase HIV services.
- Contracts with 9 DH (for PCA)
- HIV/PBF project assisted MOH to contract 416 HC for PHC and 39 DH
- and 30 contracts with steering committees
- Creation of a web-application to manage contracts, indicators and amendments and payments
Coordination with partners

- Close collaboration with USG collaborating agencies on PBF for HIV/AIDS services has been initiated
  - PBF Extended Team approach was launched
  - Close information sharing and explanation of the technical developments surrounding PBF
  - Training technical assistants through Extended Team
    - PBF BDD data entry and Pivot table
    - On PBF model
    - Financial risk forecasting and electronic contract management
Results

1. Increase in the Volume of Services

2. Increase of the Quality of Services

3. Provider Enthusiasm and Motivation
## Increase in Volume of Services (after 39 months)

<table>
<thead>
<tr>
<th>PBF Indicator</th>
<th>January 2006 average/month/health center (258 health centers on average)</th>
<th>March 2009 average/month/health center (297 health centers on average)</th>
<th>Percentage increase (linear/log R²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional Deliveries</td>
<td>21</td>
<td>39.7</td>
<td>89% (log 0.77)</td>
</tr>
<tr>
<td>New Curative Consultations</td>
<td>985</td>
<td>1835</td>
<td>86.3% (log 0.28)</td>
</tr>
<tr>
<td>ANC new cases</td>
<td>100.8</td>
<td>76.2</td>
<td>-24% (log 0.05)</td>
</tr>
<tr>
<td>Family Planning new users</td>
<td>15.5</td>
<td>58.6</td>
<td>278% (linear 0.79)</td>
</tr>
<tr>
<td>Family Planning users at the end of the month</td>
<td>175.2</td>
<td>1005.6</td>
<td>473.9% (linear 0.98)</td>
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</tbody>
</table>
Results for Institutional Deliveries

Institutional deliveries

R² = 0.7699

Average number per month

200601 200602 200603 200604 200605 200606 200607 200608 200609 200610 200611 200612 200701 200702 200703 200704 200705 200706 200707 200708 200709 200710 200711 200712 200801 200802 200803 200804 200805 200806 200807 200808 200809 200810 200811 200812 200901 200902 200903

Total

Linear (Total)
## Increase in Volume of Services

<table>
<thead>
<tr>
<th>PBF Indicator</th>
<th>October 2006 average/month/health center (6 health centers)</th>
<th>December 2009 Average/month/health center (6 health centers)</th>
<th>Percentage increase (linear R2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VCT clients tested</td>
<td>158</td>
<td>372</td>
<td>135% (0.45)</td>
</tr>
<tr>
<td>PMTCT children born to HIV+ mothers seen for CTX treatment</td>
<td>7</td>
<td>29 (Dec 09)</td>
<td>325% (0.75)</td>
</tr>
<tr>
<td>IO number of HIV+ clients treated with CTX</td>
<td>55</td>
<td>134</td>
<td>143% (0.82)</td>
</tr>
</tbody>
</table>
Increase in the Quality of Services in Health Centers (1)
Increase in the Quality of Services in Health Centers (2)

Quality trends in Health Centers services - B

- Gestion Financière
- Gestion Médicaments Essentiels
- Laboratoire
- Lutte contre le VIH
- Surveillance de la croissance et Réhabilitation Nutritionnelle
- Tuberculose
- Vaccination
Provider Enthusiasm and Motivation

- Health workers appreciate the additional bonuses
- Most providers recognize clear advantages in the better services they provide, and take clear pride and ownership of these activities
- Additional money for the health facility, thus more locally made decisions possible, (with increased autonomy and decentralized salary budgets)
- Retention of health workers has improved
Lessons learned

- PBF can lead to:
  - A Significant Increase in Service Production and Quality of Services in a Relatively short period of time
  - A Significant Increase in Health Workers Salaries and Motivation

- Identification and involvement of all key stakeholders is essential for success in the design and implementation of PBF

- Clearly defined and agreed upon measurable goals must be linked to routine and transparent reporting with an effective system for validating data

- It is possible to strengthen public health services in poor countries by introducing market forces through Performance-Based Financing (accelerating achievement of MDGs)
Partners

The Government of Rwanda,
USAID
MSH
Cordaid
Healthnet TPG
Intrahealth
Health Development and Performance (HDP)
IDEAS
Belgian Technical Cooperation
World Bank