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Improving quality through performance-based financing in district hospitals in Rwanda between 2006 and 2010: A 5-year experience

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Abstract

Introduction: Since 2000 performance-based financing (PBF) made its way to sub-Saharan health systems in an attempt to improve service delivery. In Rwanda initial experiences in 2001 and 2002 led to a scaling up of the initiative to all health centres (HC) and district hospitals (DH). In 2008 PBF became national strategy.

Methods: PBF was introduced in Rwanda in 2006 at the DH level. Evaluation on their service delivery was carried out quarterly in the following areas: hospital management, support to the health centres and clinical activities. We studied four DHs.

Results: After 5 years, an improvement in the quantity of clinical activities was observed, as well as quality in hospital management, in HC support and in clinical activities.

Conclusion: PBF proves to be a promising approach in strengthening and maintaining quality service delivery in the sub-Saharan district hospitals.

Keywords

Performance-based financing, Rwanda, district hospital, quality improvement, health centre support, hospital management, clinical activities, peer-evaluation, self-assessment

Introduction

Poor service delivery has long been a major concern in the health sector. In 1995, resolution AFR/RC45/R3 of the WHO Regional Committee for Africa introduced a multitude of initiatives to improve the quality of care. This resolution urged member states: (1) to establish a national quality assurance programme; (2) to introduce in the training programmes of all health workers competencies required to deliver quality care; and (3) to give 'incentives' at all levels for the development of programs to improve the quality of care.[1]

Rwanda responded to this resolution by institutionalising Quality Assurance (QA) in all health structures in the country. In addition, in 1997, Belgian Cooperation installed a system to motivate staff by allocating fixed premiums to health staff in its intervention zones. Unfortunately, this system did not improve the staff motivation or the quality of services, because all benefited of an equal and fixed premium regardless of performance. In 2001 and 2002 PBF at Butare and Cyangugu HC, with flexible premiums linked to performance, led to an increased volume of activities as well as to an improvement in the quality of services delivered.[2,3]

Owing to positive results seen in these pilot experiments, the Ministry of Health (MoH) decided gradually to introduce PBF in HC in 2005 and in DH in 2006. In 2008, the Government of Rwanda (GoR) adopted PBF as a national strategy to improve the quality of care and decided to open a specific budget line for PBF within the government budget. When in February 2008 GoR signed with the World Bank its fourth Poverty

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