Rwanda Health Financing Policy

Government of Rwanda

Ministry of Health

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Table of Contents

List of Tables 3
List of Figures 3
List of Annexes 3
Foreword ..... **Error! Bookmark not defined.**
1. Introduction 7
2. Background 8
2.1. Economic and Political Context 8
2.2. Health Situation 9
2.3. Health Financing Situation 10
3. Policy Context 15
4. Guiding Principles 18
5. Goals and Objectives 18
6. Intervention Areas 19
6.1 Financial Access and Protection 19
6.2 Allocation and Use of Resources 21
6.3 Internal Resource Mobilization and Financial Sustainability 22
6.4 Effectiveness of External Assistance 23
6.5 Institutional Environment for Sustainable Financing 24
7. Institutional Arrangements for Implementation 27
7.1. Roles and Responsibilities 27
7.2. Packages of activities and health financing mechanisms 28
7.3. Partnerships 31
8. Monitoring and Evaluation 33
8.1 Mechanisms for M&E 33
8.2 Joint Sector Review 33
8.3 Key performance indicators 33
8.4 Evaluation 33
8.5 Reporting on progress 33
9. Costs and Financing 34
10. Conclusion 35
References 36
Appendices 37

List of Tables

Table 1. Levels and Sources of Health Financing, 1998-2006 11
Table 2. Selected economic and health financing indicators 11
Table 3. Growth in the number of health *mutuelles*, 2003-2007 12
Table 4. Summary of Roles and Responsibilities 28
Table 5. Purchasing Health Services through alternative financing mechanisms, by service delivery mode: 30
Table 6. Summary of roles of institutions by the three functions of health financing 32
Table 7. Health Financing Key Indicators and Targets 34
Table 8: Projected costs 35
Table 9. International comparison for selected health financing indicators, 2006 42

List of Figures

Figure 1. Rwanda Health Financing Architecture 10

List of Annexes

Annex A. Logical Framework of Health Financing Strategic Plan 37
Annex B. Selected Indicators 42
Annex C: Projection of resource requirement 43

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal Care
ART	Anti-retroviral Treatment
CAAC	PBF Unit in the MOH
CAMERWA	*Central d'Achat des Medicaments Essentiels de Rwanda*
CBHI	Community-Based Health Insurance
CHUB	Teaching Hospital University Butare
CHUK	Teaching Hospital University Kigali
CHW	Community Health Worker
CPA	Comprehensive Package of Activities
CPAF	Common Performance Assessment Framework
CSO	Civil Society Organization
CTAMS	*Mutuelle* Unit in the MOH
DDP	District Development Plan
DFID	Department for International Development (UK)
DH	District Hospital
DHS	Demographic and Health Survey
EDPRS	Economic Development and Poverty Reduction Strategy
EICV	Household Living Conditions Survey
EML	Essential Medicine List
EU	European Union
FP	Family Planning
FY	Fiscal Year
GBS	General Budget Support
GC	German Cooperation
GDP	Gross Domestic Product
GF(ATM)	Global Fund for AIDS, TB and Malaria
GOR	Government of Rwanda
GTZ	German Technical Cooperation
HC	Health Centre
HIPC	Heavily Indebted Poor Country
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSCG	Health Sector Cluster Group
HSSP	Health Sector Strategic Plan
ICT	Information and Communication Technology
IDHS	Mini Demographic and Health Survey
IEC	Information, Education and Communication
IHP	International Health Partnership
IMCI	Integrated Management of Child Illness
ITN	Insecticide-Treated Net
JAWP	Joint Annual Work Plan
KFH	King Faycal Hospital
MBB	Marginal Budgeting for Bottlenecks
MDR	Multilateral Debt Relief
M&E	Monitoring and Evaluation

MCH	Maternal and Child Health
MDG	Millennium Development Goal
MOF	Ministry of Finance and Economic Planning/*Minecofin*
MOH	Ministry of Health/*Minisanté*
MOU	Memorandum of Understanding
MLGSA	Ministry of Local Government and Social Affairs
MMI	Military Mutual Insurance
MPA	Minimum Package of Activities
MTEF	Medium Term Expenditure Framework
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NISR	National Institute for Statistics Rwanda
OOP	Out-Of-Pocket (expenses)
PBF	Performance-Based Financing
PEPFAR	The President's Program for AIDS Relief
PER	Public Expenditure Review
PETS	Public Expenditure Tracking Survey
RAMA	*Rwandaise d'Assurance Maladie*
RDSF	Rwanda Decentralization Strategic Framework
SBS	Sector Budget Support
SDC	Swiss Development Cooperation
SWAp	Sector Wide Approach
TA	Technical Assistance
THE	Total Health Expenditures
US$	United States Dollar
WB	World Bank
WHO	World Health Organisation
USAID	United States Agency for International Development

Foreword

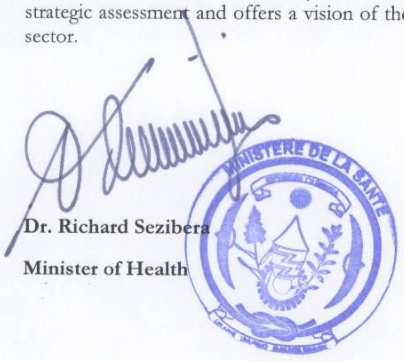
I am pleased to introduce Rwanda's Health Financing Policy. This policy presents the strategic options to ensure that the Rwandan people will have financial access to quality health services in an equitable and an efficient manner.

Over the past decade Rwanda has developed innovative health financing mechanisms. Some of the most significant have been: performance-based financing with a formal impact evaluation, community health insurance which covers 86% of the population, and empowering of health facilities to manage all financial resources in integrated planning and budgeting. These innovative financing approaches strengthen the traditional inputs-based financing in the sector. The challenge is to ensure coherence and consistency among the various initiatives. What we do over the next decade will determine whether we will be able to reap the full benefits from these early successes.

The 2005 Health Sector Policy stipulates that communities must participate in financing and management of health facilities. But, there was no policy to clarify the different but complementarily roles of the various stakeholders (communities, government etc.). Furthermore, the cost of implementation was not assessed.

Rwanda's first Health Financing Policy clearly defines the different health financing functions and related package of services. The policy provides the overarching framework to ensure coherence and complementarity between the various sources of financing and the various financing mechanisms. To this end, it will avoid duplication of resources and strengthen harmonization and alignment of health sector financial resources to specific functions and services.

The elaboration of the Health Financing Policy is an opportunity to explicitly analyze the existing situation and plan for strategies to collect resources, to pool financial and medical risks, so as to finance health services efficiently. Most importantly, the Health Financing Policy presents a strategic assessment and offers a vision of the best way to sustain the financing of Rwandan health sector.



Dr. Richard Sezibera

Minister of Health

1. Introduction

The process of developing Rwanda's first Health Financing Policy was initiated by the Government (by the Ministry of Health and Ministry of Finance and Economic Planning) and followed a process of analysis and the collation of evidence and best practice experiences, technical discussions, technical drafting, policy consultation and policy decision-making.

Several tools, studies and assessments provide the analytical underpinning for this policy. A web based database tool was created to collect best practices of health financing around the world. Several surveys and studies were conducted, for example (i) Costing of health services by Intrahealth, *Viabilite des mutuelles de sante* by CTB/BTC; (ii) Integrated households conditions survey conducted by the Ministry of Finance and Economic Planning; (iii) Impact evaluation of performance-based financing on households and facilities. Key financing analytical reports also informed the process, for example: (i)National Health Accounts 2006 (USAID/Abt Assoc.), Public Expenditure Review (World Bank), Health Financing Review of Rwanda – Options for Universal Coverage 2009 (World Health Organization), Country Status Report of Health and Poverty 2009 (World Bank).

The Ministry of Health established a Technical Working Group to develop a health financing policy and strategy. World Bank provided a technical team of economists and health system specialists to draft different chapters for review by other members of the health financing Technical Working Group. The policy options were developed and comments and feedback was solicited. This process culminated in a workshop of health financing experts to deliberate the options taking into account the analysis and international best practice. The policy dialogue continues within the government and the process will conclude in a policy decision made by the cabinet and the various government structures.

This policy document provides the analytical basis and a coherent framework for pulling together all the sources of financing and the health financing mechanisms. It furthermore proposes institutional arrangements and a results framework to monitor results and evaluate the impact of the policy. The Health Financing Policy is harmonized and fully aligned with the Vision 2020, Economic Development and Poverty Reduction Strategy (EDPRS), the Health Sector Policy and Health Sector Strategic Plan (HSSP-II) 2009-2012.

The document is structured as follows: it starts with chapters on the Background and Policy Context and the Guiding Principles that were used to inform and guide the development of the policy. This is followed by an articulation of the Goals and Objectives of the policy, and the description of the five Intervention Areas: (i) Financial Access and Protection; (ii) Allocation and Use of Resources; (iii) Internal Resource Mobilization and Financial Sustainability; (iv) Effectiveness of External Assistance and (vi) Institutional Environment for Sustainable Financing. A description of the Implementation Arrangements and Monitoring and Evaluation follows, and the document concludes with Costs and Financing needed to implement the policy.

2. Background

2.1. Economic and Political Context

Rwanda is a landlocked country with a population of 9.37 million[1] living within an area of 26,338 km^2. It is the most densely populated country in Africa with a population density of 353 inhabitants per km^2. Based on an annual population growth rate around 2.6%, it is estimated that the population will reach 16 million by 2020[2].

Rwanda has achieved sustained GDP growth over the last 7 years. Per capita GDP (current prices) grew from US$ 235 to US$ 492 between 2002 and 2008. Despite this progress, this level of per capita GDP places Rwanda in the poorest category of countries in Sub-Saharan Africa. In 2006, 80% of the population was reliant on agriculture for family income.[3] In 2008 agriculture contributed 31% to the economy, while services contributed 47.7%, and industry contributed 15.6%[4]. Poverty is widespread as it affects 57% of the population[5].

The Rwandan government is committed to sound financial management and transparency in all sectors. The fiscal performance has improved over the last five years, with revenue collection growing to around 13% of GDP in 2006[6]. The domestic fiscal deficit has widened from around 2% of GDP in 2001 to 6% in 2006. Priority expenditure, which allocates resources to pro-poor needs, has increased over the past five years. Rwanda has also benefited from both the Heavily Indebted Poor Country (HIPC) and Multilateral Debt Relief (MDR) initiatives resulting in a sustainable debt position.

Decentralization reforms have increased the roles of local governments, the districts, in service delivery in the health sector. The central government agencies' roles and responsibilities are mainly in policy formulation, regulation and support to local governments through capacity building, financing and monitoring and evaluation. The province is responsible for coordinating district development planning with national policies and programs, supervising implementation of the national policy in the Districts within the province, coordinating governance issues in the province, as well as monitoring and evaluation. Districts are charged with local economic development and planning and coordinating the delivery of public services. Fiscal decentralization, an essential component of Rwanda's decentralization reforms, has created new fiscal relations including block grants to districts through the Local Authority Budget Support Fund, earmarked transfers to districts for health services, and other transfers to districts. Decentralization reforms have been deepened in the health sector in 2006 and have resulted in large autonomy in budgeting and financial management of health facilities.

[1] MINALOC, 2008 NID
[2] The population is estimated to be 9.3 million end 2007 (based on projections of Census 2002).
[3] EICV2 2005-2006
[4] MINECOFIN GDP estimates, February 2008
[5] NISR; EICV2, 2005-2006
[6] World Bank and Ministry of Health, 2009. Rwanda : A Country Status Report on Poverty and Health. September 2009 (forthcoming).

2.2. Health Situation

Rwanda has made good progress towards meeting the health related Millennium Development Goals (MDGs). Under-five mortality rates have declined from 152 to 103 per 1,000 in less than 10 years[7]. These impressive achievements are due to an increase in the coverage of essential child health interventions including immunization, use of insecticide treated bed-nets (ITNs), and the management of neonatal and childhood illnesses). Positive trends in maternal health are also observed during the last decades. The rate of deliveries assisted by skilled staff has increased from 39% in 2005, to 52% in 2007; the percentage of women between 15 and 49 years of age using modern contraceptive methods impressively increased from 10% to 27%. Child malnutrition, however, remains a challenge in the country as 24% of children under 5 are underweight.

The principal causes of outpatient visits are pulmonary infections, malaria and diseases related to poor hygiene, which can largely be prevented through improved hygiene and behavior change. The main causes of mortality in the adult population are HIV/AIDS and related opportunisstic infections and severe malaria. Although the HIV prevalence rate remains at of 3% in 2005, major progress has been made in the prevention and management of HIV. Among children under five years of age, malaria pulmonary infections, diarrhea, malnutrition and prematurity, also linked to malaria, are the leading causes of mortality. Malaria morbidity in children has reduced significantly from 37.31 in 2005 to 15.01 in 2008[8].

If these trends are maintained, Rwanda will meet the child mortality MDG by 2015[9]. This will require sustained efforts for: scaling-up successful community-based nutrition interventions and improving neonatal management. In order to reach the maternal health related MDG, Rwanda needs to invest important efforts to sustain the increasing trends in the coverage of family planning and professional assistance at delivery and to improve the quality of reproductive health services. Rwanda needs also to strengthen preventive measures in order to reduce significantly the prevalence of HIV/AIDS and its burden on households, the health system and the economy. Finally, towards the elimination of malaria as a public health problem, the prevention and control of malaria should focus increased attention on the poorest segments of the population and in rural areas, the extension of coverage of community-based interventions.

Rwanda needs also to address major health systems bottlenecks which are constraining the extension of the coverage of essential health interventions. Major progress has been made to improve the availability, distribution and motivation of qualified health personnel; however, there are remaining challenges in the human resources for health area including the lack of midwives, in particular in rural areas, the shortage of medical specialists in hospitals, nutrition professionals, etc. In addition, while geographical access to health facilities has been improved, unmet need remains considerable: the MOH norm is that the population should have access to a health facility within one hour (walking); however, approximately 40% of patients still have to travel more than 1 hour or more than 5 km to reach the closest health facility. Finally, Rwanda has made progress in strengthening the legal framework, strategic management and regulatory capacities of the pharmaceutical sector, as well as the procurement and distribution systems of drugs and medical supplies in the health sector, through the expansion of the role of CAMERWA in the procurement and distribution of drugs and

[7] DHS 2005, IDHS 2008.

[8] DHS 2005, IDHS 2008.

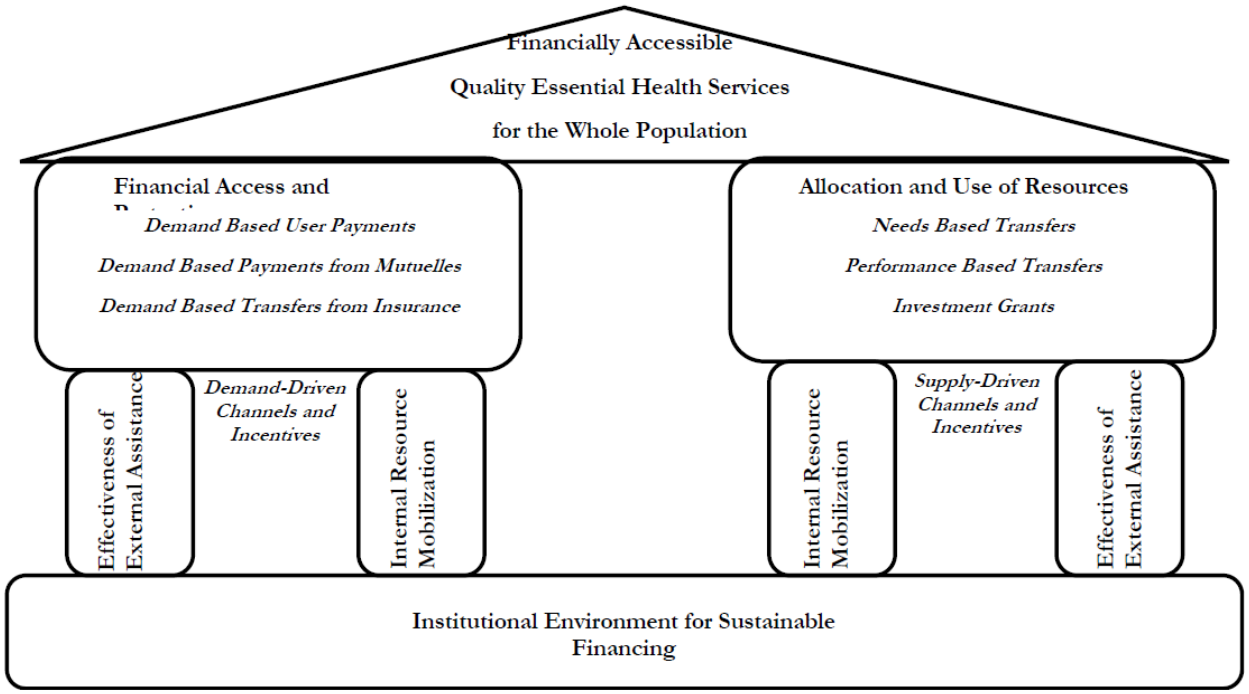
[9] World Bank and Ministry of Health, 2009. Rwanda : A Country Status Report on Poverty and Health. September 2009 (forthcoming).

medical supplies. The progress in the management of procurement and distribution of material resources at the national level, however, has not been fully matched at the intermediate and peripheral levels.

2.3. Health Financing Situation

Over the last few years, Rwanda has developed a comprehensive financing framework for health building on global health care financing best practices. This financing framework has built two main channels for financing, one from the supply side – transfers from the treasury to districts and health facilities- and one from the demand side – the insurance system, as illustrated in Figure 1. These two channels were designed as part of a remarkable post genocide effort at institution building including: (i) the implementation of fiscal decentralization with increased transfers from the central government to local governments and peripheral health facilities on the basis of needs and performance and (ii) the construction of a health insurance system including three levels of risk pooling and cross-subsidies from richer to poorer group. Challenges and policy issues related to the demand-side and the supply-side of the emerging health financing framework are discussed after a summary of the levels and sources of health financing in the country.

Figure 1. Rwanda Health Financing Architecture



Levels and sources of funding (Revenue collection)

Total health expenditure (THE)[10] in Rwanda has increased substantially in recent years[11]. Following the decline in THE per capita from US$18 in 1998 to US$12 in 2002, THE per capita has increased

[10] Total health expenditure includes domestic resources from the government, external resources from donors and private expenditure from private sources (households and other private).
[11] NHA 2006.

to US$17 in 2003 (Table 1). Between 2003 and 2006, nominal health expenditure per capita doubled from US$ 17 per capita to US$ 34[12]. In 2006, total health expenditure reached 10.7 percent of GDP (compared to 6.6 percent in 2003) (Table 2). In constant prices, financing nearly doubled from US$ 14 to US$ 26 per capita over the three years: this increase, however, must be put in perspective as an important share of these expenditures is earmarked to the fight against HIV/AIDS. In 2006, government expenditures reached US$ 6.3 per capita (19% of THE), donor participation reached US$ 17.7 per capita (53% of THE) and private expenditures US$ 9.4 per capita (28% of THE) (Table 1).

Table 1. Levels and Sources of Health Financing, 1998-2006

	1998	2000	2002	2003	2006
Levels of Total Health Expenditures (THE)					
THE per capita (US$ 2006)	10.4	9.5	9.9	16.9	33.9
THE as % of nominal GDP	5	4	4	9	11
Financing sources distribution as a % of THE					
Public[a]	10	18	25	32	19
Private	40	30	42	25	28
Donors	50	52	33	42	53

Source: NHA 2006
Notes. a. Public including loans and grants.

Table 2. Selected economic and health financing indicators

	2002	**2003**	**2004**	**2005**	**2006**	**2007**
Health Budget as share of GDP (%)	2.1	1.4	1.6	2.2	3.4	3.0
Health Budget as share of National Budget (Recurrent) (%)	4.5	6.4	5.6	6.0	6.4	6.1
Health Budget as share of National Budget (Development) (%)	10.2	4.8	8.0	12.6	24.0	15.0
Health Budget as share National Budget (Total) (%)	6.9	5.9	6.3	8.2	12.6	9.1

Source: 2008 Public Expenditure Review.

Despite sustained efforts over the past years, increasing the level of public domestic spending on health remains a major challenge. The increase in domestic revenue and in aid flows together with the major reduction in debt services led to a significant increase of total public expenditure in recent years. Compared to neighboring countries, however, public domestic spending on health is still limited in Rwanda: it amounts to US$ 6.3 per capita in 2006 compared to US$ 23 in Zambia, US$ 14 in Kenya or US$ 12 in Mozambique (see Table 9 and Annex B). The share of the public budget allocated to the health sector (including that for other ministries than the MOH) has reached 11.4% in 2007, still below the 15% Abuja agreement[13].

The high dependence of the Rwandan health sector on external assistance raises concern about the financial sustainability of health improvements in the country. The share of domestic resources to public health expenditure has decreased while external health resources increased. Donors' share of THE have increased to over 53 percent in 2006 compared to 42 percent in 2003. Rwanda is among

[12] The level of THE per capita is close to international estimates on the per capita resources needed in order to deliver good quality basic health services, but the distribution of expenditure is not the same as the allocation that the Commission had proposed. *Organisation Mondiale de la Santé*, 2001. *Macroéconomie et Santé : Investir dans la Santé pour le Développement Economique. Rapport de la Commission Macroéconomie et Santé. Genève.*

[13] Ministry of Health, 2009. Health Sector Strategic Plan: July 2009 –June 2012. Ministry of Health, 2008. Rwanda Public Expenditure Review for the Health Sector: 2006-2007 Data and Trends from 2002-2007. April.

the countries of the region (with Madagascar and Mozambique) that have the largest share of external resources flowing to the health sector, exceeding 50 percent of THE (see Table 9 and Annex B). Rwanda ranks among the countries with the highest per capita external assistance on health.

Although prepayment mechanisms have been extended with the scale-up of mutual health insurance schemes, out-of-pocket expenditures are still the main mechanism of private expenditure in the health sector. Private health spending is composed mainly by household expenditures in the health sector: the share of private spending in THE increased to 28 percent in 2006 compared to 25 percent in 2003. Private expenditures amounted to US$ 9.4 per capita in 2006 out of which US$ 7.5 constituted private household out-of-pocket expenditures.

Demand-side financing channels and risk and revenue pooling

As a consequence of growing public spending from internal and external resources discussed above, risk pooling has been improved in the health sector. However, most of the external assistance is still used for vertical programmes instead of targeting the entire health system. In addition, huge amounts provided by NGOs and some development partners are often not accounted for in the budget. However, the sector is moving towards a Sector Wide Approach (SWAp) to enhance coordination and efficiency and reduce duplication; such developments could facilitate the establishment of pooled funding mechanisms of internal and external public spending.

Table 3. Growth in the number of health *mutuelles*, 2003-2007

	2003	2004	2005	2006 (b)	2007
Number of health centers	347	353	366	382	403
Number of health mutuelle sections	88	226	354	392	403
Number of district health mutuelles	(a)	30	30	30	30
Target population	7,934,929	8,157,555	8,376,993	8,607,399	8,779,577
Number of health mutuelle beneficiaries	555,445	2,202,539	3,685,876	6,283,401	6,496,887
Membership rate (%) in health mutuelles	7	27	44	73	74
Reference date	End of December	End of December	End of December	End of November	End of August

Notes:
a. Before the district health mutuelles were set up, health mutuelle federations had existed in health districts since 1999 and later in administrative districts.
b. For 2006, the table shows more health mutuelle sections than health centers. The reason for this is that the health centers counted in the table are the health centers that have health information system codes from the Ministry of Health. This means that for 2006 there are ten health centers that were operational but did not yet have a code.

Health insurance coverage has been expanded for people employed in the formal sector, as well as informal and rural sectors of the economy since 2000. A medical insurance regime has been established since 2001 for public servants and their dependants: *Rwandaise d'Assurance Maladie* (RAMA). The military and their dependants are covered through a health insurance regime managed within the Ministry of Defense: Military Medical Insurance (MMI). Risk pooling from private sources has been greatly improved as a result of the extension of community-based health insurance (CBHI) schemes, established by the law N° 62/2007 of 30 December 2007, allowing the majority of the population access to healthcare services and drugs after paying their annual contribution of RWF 1000 to the scheme; 85% of the population is now covered by CBHI (Table 3)[14]. Although enrollment in CBHI schemes has increased enormously over the last few years, not everybody has

[14] CTAMS, August 2008.

joined the CBHI and the low budget level does not allow the MOH to subsidize all those who cannot afford to pay the CBHI contribution themselves, leaving a substantial number of poor people without access to health services. The budget of the pooling risk fund is insufficient and at district level most pools are unable to pay hospitals timely for costs incurred.

The extension of risk pooling arrangements over the past five years has contributed to the structuring of the demand-side of the Rwanda health financing framework. On the demand side, health services are financed now through three main channels. First, *demand based user payments*: direct user payments represent 28% of total expenditures. Most of the funds (63%) finance private pharmacists and shops as well as traditional healers and private clinics; only about US$ 24 per capita goes to public primary facilities and public hospitals. Second, *demand based payments from formal insurance including RAMA:* payments are made by the insurance system for the formal sector including the civil service. Third, *demand Based payments from mutuelles:* payments are made directly by *mutuelles* to facilities on the basis of fee for service. *Mutuelles* have an office in each health center. *Mutuelles* are funded based on a combination of diverse sources: in 2006 70% of the premiums were contributed by households, 8% by employer, 9% by donors and 13% by government. Three levels of risk pools are in place: *Umurenge* (subdistrict) pool covering about 15,000 people, *Akarere* (district) "District Risk Sharing pool" covering about 300,000 inhabitants and the "National Risk sharing Pool". *Mutuelles* currently contribute about US$ 3.6 per capita to the funding of services

Rwanda can improve on this emerging demand side of its health finance framework by addressing major ongoing challenges and issues of the risk pooling arrangements. Rwanda has built a remarkable system of risk sharing through fund pooling. Yet, the financing of these pools still relies mainly on the contributions of households who are relatively poor and cross-subsidization from richer groups (inside Rwanda and from external aid) needs to be improved: current contribution policies under the mutual health system are based on a flat rate for all income groups. Based on NHA 2006 health expenditures estimates, out-of-pocket expenditures is still high. Although internal sources of funding have been identified, the national and district risk pools are under-funded as a result of weak contribution of potential sources and weak administrative capacity for resource mobilization. In many *mutuelle* schemes, financial sustainable has been threatened by over-prescriptions which have raise concern about the appropriateness of provider payment modalities. The financial sustainability of *mutuelles* is also threatened by the rigidity of contribution levels which have not changed since 2005. Another critical issue is the governance of the pools which needs to be strengthened in order to improve oversight on the use of the funds. Management capacities at the sector, district and national levels need to be strengthened in order to improve the institutional sustainability of the mutual health insurance system.

Supply-side financing channels and purchasing

There is now a growing number of health financing agents which are responsible for the allocation of health resources in the Rwandan health sector. The Government, mainly through the MOH and districts, is managing slightly over one-quarter of total health expenditure, while development partners and households are the two main other managers of health resources: since 2006, *mutuelles* are evolving as a major manager of health resources. Variable priorities in health spending of the MOH and development partners and variable mechanisms used for allocating resources to health care providers are contributing to the structuring and major issues of the supply side of the health financing framework.

The allocation of health spending varies across activities and different levels of the health service delivery system. First, HIV/AIDS resources represent almost one quarter of THE (24%), while malaria gets 14 percent of THE, and reproductive health only 6 percent. The shares of malaria and reproductive health in THE have decreased since 2003, while the share of HIV/AIDS financing has increased. This is mainly due to the striking amount of resources earmarked by some donors (Global Funds, PEPFAR) to HIV/AIDS activities.

As regards to health functions, spending on pharmaceuticals and nondurables has been multiplied by five between 2003 and 2006: this increase was supported mainly by households. Curative outpatient spending, which came at the third position after prevention spending and health administration spending in 2003, was multiplied by 3 between 2003 and 2006, and has gained the first position in health spending ; curative inpatient spending nearly doubled in the same time period. Prevention and public health program spending nearly doubled between 2003 and 2006. Health administration spending experienced the lowest growth during the three year period. A relative large share of government spending (1/3) is absorbed by health administration in 2006. Donors are the largest contributors to prevention and public health programs (83%). They also spend a significant share of their contribution to the sector on curative care and health administration. Households' expenditures, however, are essentially focused on curative care and drugs.

Second, health facilities receive public funds through MOH programs, district transfers, and internally generated revenues. The general trend of expenditures in real values at health centers, district hospitals and referral hospitals reveals a significant increasing rate, as expected with the growing budget for the health sector; this suggest that resources are being utilized at the ultimate level of service delivery, the health facilities. Over the period 2002-2007, however, expenditures have increased almost at the same pace at the three levels or care, suggesting that there was no priority given to the lower levels of care although most of the health services needed by the population are delivered at the health centre level. However, internally generated revenues have increased by 660% at health centers between 2002 and 2007; by 305% at district hospitals; and by 194% at referral hospitals during the same period. While health centers were capturing 44.6% of internally generated revenues by health facilities in 2002, their share has increased to 65.3% by 2007[15].

These supply-side patterns of resource allocation are being transformed by health financing reform initiatives implemented in the past five years which have resulted in five main transfer mechanisms. First, *needs based* transfer, in the form of a monthly block grant provided by the Government to health centers and hospitals, the amount of which is calculated on the basis of a formula that includes population and poverty levels as a weighing factor; this transfer amounts to US$ 1.36 per capita for health centers and US$0.24 per capita for hospitals in 2008. US$ 0.9 per capita was also transferred to tertiary care hospitals (CHUK, CHUB and KFH). Second, *performance based transfer (PBF),* in the form of a quarterly block grant transferred by the government directly to facilities – health centers and hospitals- and to districts for community health. In 2007 the funds transferred amounted to US$ 1.6 per capita, of which US$ 0.88 per capita was for health centers US$ 0.58 per capita for hospitals and US$ 0.27 per capita for community health respectively. Third, *history based transfer,* in the form of a subsidy from the government to facilities to maintain their assets. This amounted to US$ 0.3 per capita in 2008.

[15] Ministry of Health, 2009. Health Sector Strategic Plan: July 2009 –June 2012. Ministry of Health, 2008. Rwanda Public Expenditure Review for the Health Sector: 2006-2007 Data and Trends from 2002-2007. April.

The fourth mechanism is based on *investments grants* using the subsidy of the government for construction and equipment as per the national plan. Finally, the *fragmented donors' transfers* from various donor agencies to specific facilities constitute a fifth supply-side mechanism with variable bases. Criteria for funding under this fifth mechanism are not always known: most of the transfers are made in kind (commodities, training, TA); some financial transfers are made although usually not aligned with the four main public finance channels (1-4 above); the amounts transferred are largely unknown but can be estimated at US$ 3 in 2006 using some proxies from different costing tools and reports.

There are efficiency and equity problems and policy issues which remain in the supply side of the emerging health financing framework. A key issue is the equity of the needs based transfers. Currently this transfer (newly established in 2008) is calculated on the basis of the number of personnel employed weighted by population and poverty level. The transfer should progressively give more weight to the needs based criteria and less to the historical criteria. More importantly there is currently a major problem of efficiency and equity linked to the modes of transfers of donors' funds. Currently the subsidy from donors appears inefficient with large amounts going to overheads and a lack of clarity on the criteria for allocation to districts and facilities. In addition, high impact interventions which are main contributors for reaching the child and maternal health MDGs have not been adequately funded compared to HIV/AIDS related interventions. Finally a key issue is the governance of the facilities particularly hospitals. Currently the hospitals boards are not fully functional and there is limited oversight on the use of the public subsidy.

3. Policy Context

Directions for the Health Financing Policy are based on key international and national policies and goals which are detailed in the following sections.

Millennium Development Goals

The GOR has committed itself to achieving the MDGs by 2015. Four MDGs are related to health:

- Goal 1: Eradicate extreme poverty and hunger (malnutrition)
- Goal 4: Reduce child mortality
- Goal 5: Improve maternal health
- Goal 6: Combat AIDS, malaria and other diseases

The Health Financing Policy goal and objectives are oriented towards speeding up the achievement of health-related MDGs in equitable, efficient and sustainable way. By putting an emphasis on the protection of household income against the impoverishing effects of illness and catastrophic illness related expenditure, the Health Financing Policy will also strengthen the health sector's contribution to reaching MDG 1.

Africa Health Strategy 2007 – 2015

The Health Financing Policy is also guided by the Africa Health Strategy 2007-2015, which provides strategic direction to Africa's efforts in creating better health for all along with an overarching framework to enable coherence within and between countries, civil society and the international community. The Strategy emphasizes the need to strengthen health systems, providing the poor with services and thereby contributing to equity. It also encourages sector-wide approaches to guarantee alignment of donor funding with nationally determined plans and priorities.

Abuja Declaration, Accra Accord and the Paris Declaration

Rwanda has signed up to the Abuja Declaration committing 15% of government spending in the health sector. Furthermore, donor commitment to the Paris Declaration for aid harmonization (2005) and Accra Accord for aid effectiveness (2008) are contribution to improved donor co-ordination: the Health Financing Policy builds from these external frameworks and internal achievements to strengthen the effectiveness of external assistance in the health sector.

Vision 2020

Developed in 2000, Vision 2020 elaborates a national long-term vision in terms of goals and objectives to be achieved by the year 2020. By that year Rwanda should: be a middle-income country; have halved the percentage of people living in poverty; raised life expectancy to 55 years; and have reduced its aid dependency. It expects to reach these goals by means of seven strategies/pillars, which include decreasing population growth, increasing access to education and improving the health of the people. This document serves as the basis for the elaboration of national and sector plans in the medium term. Vision 2020 acknowledges the importance of education and health in ensuring an efficient and productive workforce. It also identifies demographic pressure as a major cause of the depletion of natural resources and subsequently, poverty and hunger. To reverse this trend and improve the health status of the population, health policies should target the poorest and seek to improve access, quality, and cost of health care.

EDPRS 2008-2012

The EDPRS provides a medium-term framework for achieving the goals set out in Vision 2020 and provides the national priorities within which the sector strategic plans should be developed. It describes the status quo, targets for 2012, and what Rwanda is going to do to meet these targets. It contains three Flagship Programmes:

1. Sustainable growth for jobs and exports
2. Vision 2020 *Umurenge* – poverty reduction in rural areas
3. Governance.

For health, the EDPRS aims to maximize preventive health measures and build the capacity for high quality and accessible health care services for the entire population in order to reduce malnutrition, infant and child mortality, and fertility, as well as to control communicable diseases. On the basis of the EDPRS a Common Performance Assessment Framework (CPAF) was made to monitor progress in the context of general budget support.

Good Governance and Decentralisation Policy

The decentralization process was launched in 2000, and entered its second phase in 2005, with an administrative reorganization aimed at reducing the number of provinces from 15 to four (in addition to Kigali) and reducing the number of districts from 106 to 30. Below the district level there are 416 sectors (*imirenge*), 2,150 cells (*akagari*) and almost 14,826 villages (*imidugudu*). The policy states that the minimum requirements are: at least one hospital for each district; at least one health centre (HC) per sector; and at least one health post (HP) for each cell. Additionally, a network of male and female community health workers is proposed below sector level.

The Rwanda Decentralization Strategic Framework (RDSF) has been developed to guide the implementation of the Government of Rwanda's policy of decentralization as set out in the 2000 Policy Paper. The RDSF serves as the overall framework of reference for current and future interventions towards decentralization in Rwanda. It goes beyond sectoral policy in that

decentralization is a transversal process that imposes itself as the principal focus of governance reform, the designated motor for the coherency of governance and, finally, as an important vehicle for collaboration between the Government and its national and international development partners. This strategy is additionally meant to secure Vision 2020, the Millennium Development Goals and the Economic Development and Poverty Reduction Strategy in Rwanda as it is reinforcing the link between good governance and the attainment of broad reaching development objectives.

Social Security Policy 2009

The Social Security Policy of 2009 (SSP 2009) defines the vision of Rwanda as regards health insurance as "to achieve the goal of health for all through universal health insurance". The SSP 2009 recommends: to establish a plan to achieve universal coverage and to integrate the pensioners within the "RAMA scheme" which will be incorporated within RSSB; to clarify and enforce Labor Code provisions relating to compulsory affiliation of all employees and the employers' obligation to provide medical care to employees; to address price, service availability, and quality of service differentials between private sector medical insurance and mutual medical insurances; to identify financial resources to subsidize insurance premiums for those unable to make full payment; to the extent financially feasible expand coverage to HIV Aids; to consider permitting limited access to critical medical services available in neighboring countries, to the extent fiscally feasible.

Health Policy 2004

In 2004 the MOH revised its health policy, based on Vision 2020, the PRSP (2002) and the Good Governance and Decentralization policy. The Policy's seven objectives that guide interventions in the health sector are:

1. to improve the availability of human resources;
2. to improve the availability of quality drugs, vaccines and consumables;
3. to expand geographical accessibility to health services;
4. to improve the financial accessibility to health services;
5. to improve the quality and demand for services in the control of disease;
6. to strengthen national referral hospitals and research and treatment;
7. to reinforce institutional capacity.

Health Sector Strategic Plan 2009-2012

Programme areas of the HSSP-II have been categorized along two axes to reflect the revised focus of the health sector: client-centred service delivery and support services. Client-centred service delivery contains all objectives and outputs directly related to improving the health of the people. This axis includes four main components or programmes: (i) all services related to family planning, maternal and child health, reproductive health and nutrition; (ii) all services related to infectious diseases (including preparedness for epidemic disasters); (iii) all services related to non-communicable diseases, disabilities and injuries; (iv) all efforts to promote primary prevention of disease by influencing people's lifestyles.

The system-focused components contain objectives and outputs that provide an enabling environment for service delivery to be optimally effective and efficient. These components all relate to health system strengthening. This axis includes 8 components: Planning and M&E, Health Financing, Human Resources for Health (including basic and in-service Training), Infrastructure, Equipment and Transport, Commodities Supply and Logistics (including Pharmaceuticals), Quality Assurance, Research, Governance.

HSSP-II builds on its predecessor, including the scaling up of initiatives developed during the lifetime of HSSP-I. It also contains new initiatives, which include:

- the *performance-based financing scheme (PBF),* developed to reward health facilities and staff for good performance (increased utilization and quality of services), emphasizing output financing mechanisms rather than input financing, will be further expanded
- the *community-based health insurance (CBHI)* scheme will be scaled up even further to ideally ensure coverage for everyone, while looking for more sophisticated and diverse mechanisms to subsidize the premiums for the poor
- *community health* interventions, a way of bringing services closer to the people and increasing coverage with basic curative and preventive care, will be further strengthened.
- *Development of the SWAp*
- *Decentralization process* that is underway.

4. Guiding Principles

The Ministry of Health is guided by a number of principles in the development and implementation of the Health Financing Policy:

- Equity, risk-sharing, and solidarity are the guiding principles that support efforts in resource mobilization and risk pooling and promoting access to quality services in the health sector. Building on these principles, we ensure that the costs of illness of the sick are also shared by the healthy, and the costs of illness of the poorest are also shared by the wealthy among Rwandans.
- Efficiency, evidence-based decision making and result-based financing and management, transparency and accountability are the guiding principles of efforts to improve the allocation and use of health resources and to strengthen contractual arrangements between major actors of the health sector.
- Ownership, empowerment and participation, and partnerships are the guiding principles upon which efforts to ensure the financial and institutional sustainability of the health financing framework will be built.

These guiding principles are broadly specified to provide a framework for subsequent and complementary elaboration of the Health Financing Policy into strategies, programs, rules and regulations, guidelines and procedures, and implementation arrangements. All sectoral policies and strategies with implications on the financing of the health sector will be assessed to ensure their consistency with these principles.

5. Goals and Objectives

5.1. Goal of the Health Financing Policy

The goal of the Health Financing Policy is to ensure that quality essential health services and particularly MDG-related interventions are financially accessible to the whole population in an equitable, efficient and sustainable manner under a result-based financing framework.

5.2. Objectives of the Health Financing Policy

To reach this goal, the Health Financing Policy will be focused to reach the following objectives:

- To strengthen risk pooling for improved financial access and household income protection of Rwandan families;
- To improve efficiency in the allocation and use of health resources and coverage of high impact interventions;
- To increase internal resource mobilization for sustainable funding of the health sector;
- To improve the effectiveness of external assistance in the health sector; and
- To strengthen the institutional environment for sustainable financing of the health sector.

Interventions to reach these objectives are focused on strengthening the Rwanda health financing framework as outlined in Figure 1. The demand side channels of the health financing frameworks are aligned to interventions to strengthen risk pooling for improved financial access and household income protection. The supply side channels of the health financing frameworks are strengthened through interventions to improve efficiency in the allocation and use of resources and the coverage of high impact interventions. These two pillars of the health financing framework are strengthened by policy initiatives to increase internal resource mobilization, to improve the effectiveness of external assistance, and to strengthen the institutional environment for sustainable financing of the health sector.

6. Intervention Areas

6.1 Financial Access and Protection

Rwanda has built a remarkable system of risk sharing based on a national network of local mutual health insurance schemes supported by subsidies from internal and external sources. As suggested above, the equity, the financial and institutional sustainability of the mutual health insurance system are major challenges that still need to be addressed. Out-of-pocket expenditures are still high although health insurance coverage has been expanded. Some groups of the Rwandan population do not have the capacity to pay their contributions to the CBHI. In addition, the current flat membership fee with regressive burden on the households' budget is too high to enable poor households to join the CBHI. Revenue collection is still very weak at the National Risk Pooling Fund and the District Risk Pooling Fund levels: although internal sources of funding have been identified, the national and district risk pools are under-funded as a result of weak contribution of potential sources and weak administrative capacity for resource mobilization. In many *mutuelle* schemes, financial sustainable has been threatened by over- prescriptions which have raise concern about the appropriateness of provider payment modalities. The financial sustainability of *mutuelles* is also threatened by the rigidity of contribution levels which have not changed since 2005. The risk pooling mechanisms are highly fragmented with effective risk pooling occurring only at "*mutuelles* de section" level. There is no specific legal and regulatory framework for private health insurance which is operated as a normal non-life business.

As a priority intervention, Rwanda will build on guiding principles of equity, risk sharing and solidarity of the current Health Financing Policy to consolidate the financial and institutional sustainability of its mutual health insurance system and social health insurance systems. Based on

these principles, the Government and stakeholders will invest major efforts to maintain high enrolment in *mutuelles* among populations employed in the rural and informal sectors. The Government will ensure that health insurance schemes are targeted at financing curative services in order to increase financial access and to protect households from the impoverishing effect of illness The Government will strengthen subsidy schemes for providing health insurance coverage to the poor. It will reduce copayments for the poor and vulnerable groups who benefit from health insurance coverage. The Government will strengthen risk-pooling mechanisms at the sector and district levels. It will increase the financial sustainability of the national risk-pooling mechanism and government budget allocation to the national and district pooling mechanisms. The Government will ensure that appropriate payment modalities are implemented for improved risk-sharing under contractual arrangements between health insurance organizations and health care providers. The legal framework will be strengthened to increase private and social health insurance schemes contributions to the national and district pooling mechanisms. Mandatory health insurance for employees of formal sector enterprises will be reinforced.

As a result of the elaboration and implementation of these policy measures, the "Demand Based User Payments" channel is expected to represent a decreasing share of total health expenditures; it will however remain an important source of funding for tertiary care as well as non essential care. The "*Demand Based Payments from Mutuelles"* channel is expected to expand by several folds to increasingly cover the basic package of curative services at health center and hospital level. Additional financing will flow to the *mutuelles* system in order to : (i) increase the subsidy to the enrollment of the poor , subsidizing the premium targeting the 37% poorest segment of the population; (ii) fund the reduction of co-payments for critical groups and critical health interventions, e.g. progressive elimination of co-payments for children less than 5 in poor rural health centers. Finally, the "*Demand Based Payments from Insurance"* channel is expected to represent an increasing share of total health expenditures following economic growth and expansion of the formal sector. It is expected that as it grows this channel will increasingly cross-subsidize the national mutual health insurance system.

Objective: Risk pooling for improved financial access and household income protection of Rwandan families in the health sector strengthened

Strategic Interventions:

- Ensure financial access and equity for the population to health services
- Strengthen risk-pooling mechanisms of the mutual health insurance system
- Extend appropriate payment modalities for improved risk-sharing under contractual arrangements between health insurance organizations and health care providers

Indicators:

- % of the population enrolled in health insurance schemes
- % the poorest 20% households who benefited from health insurance coverage through targeted subsidies
- RwF X billions of Government resources allocated to risk pooling mechanisms
- % of private and social health insurance schemes revenues transferred to the national risk pooling mechanism
- Pooling risk reimburses 100% of eligible hospital bills on a timely basis
- % *mutuelles* which reimburse partner health centers and district hospitals on a timely basis
- Availability of regularly revised tariffs for reimbursing health care providers reflecting the cost of services

6.2 Allocation and Use of Resources

Efficiency and equity problems remain on the supply side of the emerging Rwanda health financing framework. As stated above, the equity of the needs based transfers needs to be improved: the transfer should progressively give more weight to the needs based criteria (population, poverty and disease burden) and less to the historical criteria. High impact interventions which are main contributors for reaching the child and maternal health MDGs have not been adequately funded compared to HIV/AIDS related interventions. More importantly there is currently a major problem of efficiency and equity linked to the modes of transfers of donors' funds. Currently the subsidy from donors appears inefficient with large amounts going to overheads and a lack of clarity on the criteria for allocation to districts and facilities. Finally a key issue is the governance of the facilities particularly hospitals: the hospitals boards are not fully functional and there is limited oversight on the use of the public subsidy.

To address these problems and progress towards the EDPRS and HSSP health objectives, the Government of Rwanda will build on the efficiency, evidence-based decision making, priority on high impact intervention, and result-based financing and management principles, in order to improve efficiency in the allocation and use of health resources. Based on these principles, the Government will ensure that public health functions are adequately funded (health promotion, health information, disease surveillance, etc.). The Government will increase resources allocated to high impact interventions and encourage providers to reduce or removal user-fees for targeted high impact interventions. It will strengthen funding of home and community-based interventions. The Government will increase the level of resources for extending geographical access in underserved and poorest areas. It will strengthen financing mechanisms to support improved quality of care, including increased resource allocations for peripheral health facilities in order to improve the quantity and quality of human resources for health, the availability of medical and non-medical commodities, quality assurance, supervision, accreditation, and certification. The Government will institutionalize investment and maintenance grants for district hospitals and health centers. Finally,

the Government will increase the level of resources allocated through performance-based mechanisms at the district hospital, health center and community levels.

Through these policy measures, the Government will strengthen supply-based channels and incentives of the health financing framework under the context of decentralization. The "Needs base transfers" channel to districts and facilities will be expanded on the basis of a clear formula based on population, poverty, and disease burden to ensure equity of access to infrastructure, human resources and essential commodities: this should lead to poor rural Umurenge and Districts to progressively receive a larger level of public subsidy than richer more urban districts. The "Performance Based transfers (PBF)" channel to districts and facilities will be expanded to increase the level of coverage of MDGs related high impact interventions: PBF will be targeted at the purchasing of public goods and preventive services including community-based interventions, essential reproductive and child health services at primary and secondary health services, as well as quality of services at the primary, secondary and tertiary levels. The "Investment grants" channel will be further institutionalized and consolidated with the current history based transfers for maintenance of investment. Donors funding, when targeted to the supply side, will as much as possible be streamlined into one of the three channels of funding above : at the time of signing the financing agreement donors will indicate which channel of funding they will be supporting.

Objective: Efficiency in the allocation and use of health resources and coverage of high impact interventions improved

Strategic Interventions:

- Allocate health sector budget according to priority areas based on needs
- Increase resources allocated through performance-based financing mechanisms to deliver quality health services at the community, health centre and district hospital levels
- Increase the level of resources for extending geographical access in underserved and poorest areas

Indicators:

- RwFrancs per capita allocated to community health workers through performance-based financing mechanisms
- RwFrancs per capita allocated to health centre and district hospital levels through performance-based financing mechanisms
- % of needs base transfers to districts and facilities expanded on the basis of a formula based on population, poverty and disease burden
- Resource allocation formula based on population, poverty and disease burden developed by 2012

6.3 Internal Resource Mobilization and Financial Sustainability

One of the greatest challenges of the health sector in Rwanda is related to the financial sustainability of health services in the country. Out of a level of total health expenditure per capita of US$ 34 in 2006, US$ 17.7 per capita were from external sources, US$ 9.4 per capita from internal private sources, and US$ 6.3 per capita from government sources. In addition to efforts to improve the efficiency of health spending in the country, Rwanda needs to strengthen internal resource

mobilization in order to start to pave the way for improving the financial sustainability of health services and to reduce aid dependency in the health sector.

To address the sustainability of health services, the Government of Rwanda will build on the equity, risk-sharing, solidarity, transparency and accountability, and ownership principles, in order to increase internal resource mobilization. Interventions in this area will support the consolidation of the demand-based channels and the supply-based channels of the Rwandan health financing framework. Based on these principles, the Government will increase government allocation to health to reach the Abuja target. The Government will improve resource mobilization in the health sector based on ability to pay. As the culture of prepaying for health services is being consolidated based on the national scale-up of community-based health insurance, the Government will improve the progressivity of contributions into the mutual health insurance system. It will promote the recycling of out-of-pocket spending through increased prepayments into community-based health insurance schemes. The Government will strengthen community financing mechanisms in the health sector. It will strengthen private sector employers' contribution to the financing of health coverage of their employees. Private and social health insurance schemes contributions to the national and district pooling mechanisms of the mutual health insurance system will be strengthened.

Through these policy measures, the Government is expecting to increase the share of internal sources in the funding of the demand-based channels of the health financing framework. In addition, an increasing share of funding of supply-based channels will be based on internal public sources, including the performance-based transfers' channel. It is not expected that internal sources could totally be substituted to external sources of funding of health services in the foreseeable future; however, the Government will assume greater fiscal responsibility of key channels of the Rwanda health financing framework in the coming years.

Objective: Internal resource mobilization for sustainable funding of the health sector improved

Strategic Interventions:

- Improve internal public spending in the health sector
- Improve mobilization of private (households and enterprises) resources in the health sector through prepayment mechanisms

Indicators:

- Per capita total health expenditures (US$)
- Share (%) of health in the government expenditures
- Share (%) of internal public spending in total health expenditures
- Share (%) of internally generated revenues in recurrent budget of health centers and district hospitals
- Per capita contributions (RwFrancs) into the health insurance system by quintile
- Share (%) of private spending in total health expenditures

6.4 Effectiveness of External Assistance

External assistance has contributed significantly to rebuilding the health sector and health improvements which have been observed in Rwanda over the past decade, but Rwanda could gain more from current levels of external assistance in the health sector. External assistance has contributed to resource allocation distortions in the health sector as a few vertical programs continue to command disproportionate shares of health resources while maternal and child health

interventions, including community-based health and nutrition interventions, remain poorly funded. As stated above, there is a major problem of efficiency and equity related to the modes of transfers of donors' fund: subsidies from donors appear inefficient as large amounts of funding are absorbed by overheads; in addition, there is a lack of clarity on the criteria for allocation of donors' funding to districts and health facilities.

The Government of Rwanda will build on the efficiency, result-based financing and management, transparency and accountability, ownership and partnership principles, in order to improve the effectiveness of external assistance in the health sector. The health sector is moving towards a Sector Wide Approach (SWAp) to enhance coordination and efficiency and reduce duplication. All major development partners have signed the Memorandum of Understanding. Additionally three main development partners have signed an agreement with the MOH to provide sector budget support (SBS): the Belgian Government, German Cooperation (GC) and the UK Department for International Development (DFID). A Pooled Fund for Technical Assistance has also been agreed upon and the same 3 development partners as well as the Swiss Development Cooperation (SDC) made financial commitments to make the fund operational.

The Government will enlarge and strengthen these cooperative agreements in the near future. The Government will engage efforts to align the use of external resources to health sector priorities by aligning external funding mechanisms to the main channels of the Rwanda health financing framework: needs based transfers, performance-based transfers, and investment grants' channels in the supply side; subsidy for the poor and reduction of copayments in the demand side. The Government will promote the harmonization of disbursement procedures and mechanisms. It will promote the increase of the share of external assistance channeled through budgetary and sector support mechanisms and the share of external assistance channeled through long-term financial commitments. The Government will apply Paris Declaration principles for aid effectiveness through contractual arrangements such as a "Compact" under the International Partnership for Health. The Government will strengthen M&E system for improved mobilization and use of external resources. It will elaborate systematically exit strategies for priority health interventions and programs with sizable external support.

Objective: Effectiveness of external assistance in the health sector improved

Strategic Interventions:

- Improve alignment and harmonization of aid
- Align the use of external resources to health sector priorities

Indicators:

- Share (%) of external assistance in total health expenditures
- % of external assistance to health channeled through budget and sector support mechanisms
- % of external assistance allocated through the Government performance-based financing mechanisms
- % of external assistance allocated to the provision of health insurance coverage to the poor and vulnerable groups

6.5 Institutional Environment for Sustainable Financing

The pace of health financing reforms in Rwanda, not only the number of reforms implemented in such a short period of time but also the depth of the health financing reforms, is quite unique in the developing word. Rwanda was able to succeed with the implementation of these reforms based on

strong leadership and regulatory framework at multiple levels and the ability of government to adapt strategies, in light of the changing macro- and health sector environment. Fiscal decentralization has created new health financing agents which hold significant financial resources and are involved in the allocation of resources in the health sector at the local level: the districts.

In addition, the scale-up of health insurance have resulted in numerous health insurance organizations which manage important financial resources of the health sector: district *mutuelles* and sections of *mutuelles*. Extension of health insurance coverage is accompanied by new challenges associated with opportunistic behaviors of actors including: overuse, over-prescription and over-charging of acts by providers; the moral hazard caused by over-prescription and over-invoicing; the misappropriation of funds by sections. These challenges are exacerbated by little managerial capacities and lack of autonomy at district and section levels.

Health facility autonomy has increased the needs of improved management capacities at the local level. New performance-based financing mechanisms are associated with increased needs of management capacities at health facilities as well as at MOH and district health administration structures. The health sector has moved from a centralized command-and-control bureaucracy to a health sector where most transactions are based on contractual arrangements between autonomous actors. All these new health financing initiatives are translated into new demands on limited management capacities at the local level require and a changing role and adaptation of the Ministry of Health.

The Government of Rwanda will build on the result-based financing and management, transparency and accountability, ownership and participation, and partnership principles, in order to strengthen the institutional environment for sustainable financing of the health sector. The Government will support health promotion activities in order to empower citizens and families for improved health decision-making, spending and participation in the health sector. The Government will take stock on the achievements and will reinforce broad public education, sensitization and development of interconnections with other community based programs such as Ubudehe and Umuganda. The Government will ensure that all health insurance institutions (private, public, or community based) are managed professionally, in respect with all governance and financial standards, especially standards related to ensuring solvency and sustainability. It will strengthen M&E and information systems and other technical support systems of mutual health insurance schemes. It will strengthen the legal framework of mutual health insurance schemes, including the legal framework for transfer mechanisms between health insurance regimes covering the richest and mutual health insurance schemes covering the poor. The Government will strengthen financial management and procurement capacities of health care provider organizations (CHWs, Health Centers, District Hospitals, and National Hospitals). It will strengthen external auditing mechanisms of autonomous health insurance organizations and health care provider organizations.

It will strengthen the regulatory framework of price setting of pharmaceutical products and services of health care provider organizations. The Government will develop a comprehensive nomenclature (list of reimbursable drugs and acts, tariffs, codes) to facilitate transactions between health care provider organizations and health insurance organizations. The Government will improve M&E and information systems and other technical support systems of the PBF mechanisms. It will improve the administrative capacities and efficiency of the PBF mechanisms.

The Government will strengthen district capacities in the management of health resources. It will extend the use of Marginal Budgeting for Bottleneck (MBB) tools for improved decision-making in the health sector at the district level. It will strengthen the linkages between health priorities, the mid-term expenditure framework (MTEF), and budget allocations in the MOH. Finally, it will improve the financial information base to support decision-making, resource allocation and budgeting (NHA, PER, PETS, MBB) in the health sector.

Objective: Institutional environment for sustainable financing of the health sector strengthened

Strategic Interventions:

- Empower citizens and families for improved participation in the health sector
- Improve financial and administrative management capacities of autonomous health service provider organizations
- Improve public sector management capacities in the health sector

Indicators:

- % clients who are satisfied with health services;
- % of *mutuelles* with computerized financial and administrative management systems;
- % of health facilities with computerized financial and administrative management systems;
- Public expenditure review produced every 2 year
- Public expenditure tracking survey (PETS), National Health Accounts (NHA) and Benefit Incidence Analysis (BIA) organized every two years;

7. Institutional Arrangements for Implementation

The implementation of the Health Financing Policy is based on a Health Financing Strategic Plan and the associated Medium-term Expenditure Framework. Every year, operational action plans are elaborated at all levels of the health system in order to coordinate activities of all actors and to reach the objectives of the Health Financing Policy. The implementation arrangement outlines the: (i) roles and responsibilities the implementation of the Health Financing Policy relative to the organization of the health system; (ii) the packages of activities defined for different levels of the health care delivery system; and (iii) how financing mechanisms are combined to purchase services at different levels; and (iv) partnership arrangements supporting the financing of health services in the country.

7.1. Roles and Responsibilities

The health system is organized in three levels: central, intermediary and peripheral. The central level includes the central Directorates and Programmes of the Ministry of Health. The central level elaborates policies and strategies, ensure monitoring and evaluation, and regulation in the health sector. It organises and coordinates the intermediary and peripheral levels of the health system, and provides them with administrative, technical and logistical support. A Health Financing Directorate has been set up at the MOH to support the elaboration of the Health Financing Policy. This Directorate is composed of a team of experts as follows: policy and planning experts, health economists, coordinator of development partners, human resources and institutional development experts, monitoring and evaluation experts, health insurance experts and performance based financing experts.

The central level also directly oversees the national referral hospitals. There are three national referral hospitals including Butare hospital and Kigali hospital (CHK) which together make up the University Hospital (CHU) and Ndera mental health hospital. The King Fayçal hospital is a private non-profit hospital receiving a large subsidy from the Government of Rwanda with the aim to provide a higher level of technical expertise than that available in the national referral hospitals.

The Districts are responsible for implementation of health financing policies, the coordination of activities, and the provision of technical, administrative and logistical support. Districts ensure that there is an equitable distribution and an efficient utilisation of resources at the local level. To support the roles of Districts in the implementation of health policies, a unit responsible of health and social affairs advises the District Mayor and other Executives on matters relating to health.

The District Government oversees a network of autonomous facilities (district hospital and health centres) that are either public autonomous, government assisted not-for-profit (mostly faith based), or private, and the network of autonomous *mutuelles* within the districts. Contract arrangements are developed between Districts and health care providers in line with the accountability and results-based management principles of the Health Financing Policy. Districts and its subdivision oversee sensitization and enrolment of the population in *mutuelles*, the identification of indigents, and the proper functioning of *mutuelles* management bodies. Districts ensure that formal contractual relations are established between health facilities and *mutuelles*. At all levels of the District governments (Akarege, Umurenge, Akagare, Umudugudu), decisions are made collectively through various committees, which serve as vehicles of community participation in local government. Communities also participate in the management of the facilities through health committees at health centre level

(in place), and participation in hospital boards (still to be further developed), and management committees of *mutuelles*.

Table 4. Summary of Roles and Responsibilities

Health Financing Directorate	**-** support the elaboration of the Health Financing Policy - composed of a team of experts as follows: policy and planning experts, health economists, coordinator of development partners, human resources and institutional development experts, monitoring and evaluation experts, health insurance experts and performance based financing experts
Districts	- implementation of health financing policies - coordination of activities - provision of technical, administrative and logistical support - ensure equitable distribution and an efficient utilisation of resources at the local level
District Government	- oversees a network of autonomous facilities (district hospital and health centres) and the network of autonomous *mutuelles* within the districts - engages in contract arrangements between Districts and health care providers - together its subdivision, District oversees sensitization and enrolment of the population in *mutuelles*, the identification of indigents, and the proper functioning of *mutuelles* management bodies - ensure that formal contractual relations are established between health facilities and *mutuelles* - Unit responsible of health and social affairs advises the District Mayor and other Executives supports the roles of Districts in the implementation of health policies, on matters relating to health.
Sub-district level and Community level	- At all levels of the District governments (Akarege, Umurenge, Akagare, Umudugudu), decisions are made collectively through various committees, which serve as vehicles of community participation in local government. - Communities also participate in the management of the facilities through health committees at health centre level (in place), and participation in hospital boards (still to be further developed), and management committees of *mutuelles*.

7.2. Packages of activities and health financing mechanisms

One of the pillar of health financing in Rwanda is the focus on efficiency which will be enhanced through a focus on the delivery of high impact interventions which will enable reaching MDG targets, increasing access to quality services and as well as protecting households from the impoverishing effect of illness.

As there are multiple sources of financing, clear allocation of areas of financing according to the specificity and added value of each one is critical. This complementarity is imperative to avoid duplication and inefficiencies. Different packages of activities have been defined according to each of the levels of the health system in order to (i) provide equitable and quality care across the country, (ii) ensure that there are procedural standards for operation and management, (iii) allow for better planning and management of resources, and (iv) provide the basis for establishing and evaluating the quality of health services.

The table below summarizes how major health financing mechanisms which have developed in the health sector during the past decade are strategically combined to meet the needs and demands for health services in the country. First, the needs based transfers will focus on ensuring access to all to quality health services. Their key role is to ensure equity of access to infrastructure, human resources and essential commodities. This transfer will be allocated on the basis of an equity formula taking into account various measures of needs (e.g., population, poverty, burden of diseases etc.). There will be two forms of needs based transfers: for recurrent cost and for investment.

Second, PBF will be targeted at the purchasing of public goods and preventive services including community-based interventions, essential reproductive and child health services at primary and secondary health services, as well as quality of services at the primary, secondary and tertiary levels as outlined in the table above in order to improve the coverage of MDGs related high impact interventions.

Third, Demand-side Performance-based financing (vouchers and in kind conditional cash transfers) will focus on increasing use of essential high impact interventions by the poor. Demand PBF will focus on high impact interventions for MDG 1, 4, 5 and 6.

Fourth, some earmarked transfers will be maintained. These earmarked transfers will be used to ringfence and control very high cost inputs (VHC) for which a separate source of funding needs to be secured in light of the high fiscal liability. This will be the case of HAART for example but could also include new vaccines and other new products

Finally, health insurance on the other hand will be targeted at financing curative services, both outpatient and inpatient with the aim of increasing financial access and protect households from the impoverishing effect of illness. Government subsidy will focus on ensuring enrollment of the poor in insurance and guarantee their financial access to benefits.

Table 5. Purchasing Health Services through alternative financing mechanisms, by service delivery mode:

	Purchasing Health Services Through Alternative Financing Mechanisms by Service Delivery Mode: Guiding Principles and Orientations				
Health Service Delivery Modes	**Financing Mechanisms**				
	Demand-based mechanisms		***Supply-based mechanisms***		
	Health insurance	**Demand Side Performance based financing (vouchers)**	**Performance based financing**	**Needs Based Transfers**	**Earmark funds**
Objective	**Ensure financial access and protection of income**	**Ensure utilization of high impact services by the poor**	**Ensure delivery of high impact interventions and quality care**	**Ensure equity of supply (infrastructure, human resources and commodities)**	**Ensure ring- fencing of very high cost (VHC) inputs**
Focus	**Curative care**	**High Impact Interventions for the poor**	**Preventive care and High Impact Interventions**	**Equity of access**	**Very High Cost Interventions**
Home-based and Community health services (CHW's)			IMCI (family planning , ITNs, treatment of diarrhea, pneumonia, and malaria, nutrition, reference of pregnant women for delivery in health facility.	Recurrent: Products and drugs.	
Primary health services (Health center)	Outpatients and 72 hours observation curative care, birth deliveries, basic emergency obstetrical and neonatal care.	Antenatal and postnatal care, family planning, birth deliveries, basic emergency obstetrical and neonatal care	Prevention of mother to child transmission of HIV, immunization, antenatal and postnatal care, family planning, birth deliveries, well baby clinic Quality of services	Investment Recurrent: Human Resources Vaccines, Contraceptives, Epidemic products and drugs.	HIV/AIDS (Antiretroviral drugs for HAART , laboratory reagents and services), contraceptives, vaccines,
Secondary health services (District hospital)	Referred outpatient's curative care, in patient's curative care, complementary emergency obstetrical and neonatal care.		Quality of services	Recurrent: Human Resources Contraceptives, Epidemic products and drugs.	HIV/ AIDS (Antiretroviral drugs for HAART, laboratory reagents and services), contraceptives.
Tertiary health services (National referral hospital)	Referred outpatient's curative care, in patient's curative care and emergency obstetrical and neonatal care		*Quality of services*	Recurrent: Human Resources Contraceptives, Epidemic products and drugs.	HIV/AIDS (Antiretroviral drugs for HAART, laboratory reagents and services), contraceptives.

7.3. *Partnerships*

Sector-wide approach. Building on the national poverty reduction strategy, actions in the health sector will have more of a sustainable impact if they are integrated and fundamentally incorporated into the national development programmes. Intersectoral consultation and collaboration with ministerial partners is essential in the implementation of major health strategies. The creation of an institutional framework is necessary in order to allow intersectoral collaboration at the various levels of the health system. The central and District levels can, depending on the need, put in place a framework for collaboration adapted along the line of the norms of the Ministry of Health, such as the Health Care Financing Working Group.

Multilateral, bilateral and non-governmental cooperation is founded on the basis of mutual agreement between the Government and the donor country or organisation. Mechanisms for the joint management and evaluation of resources to support the functioning of health services are to be strengthened. The mechanisms for national and international coordination, as initiated by the Ministry of Health and certain partners, are to be put in place under the umbrella of a sector-wide approach. This cooperation will be strengthened by the signing of a Compact between the Government of Rwanda and the international community under the International Partnership for Health (IHP+).

Rwanda Health Insurance Council. Rwanda has managed to scale-up to coverage of health insurance over 85% of the population through health *mutuelles* and a state-community partnership in a short time period. *Mutuelles* combined with RAMA and MMI cover over 90% of the population in Rwanda. The insurance arrangement will be consolidated while preserving the strengths of the current system, particularly its state-community partnership nature and the decentralized arrangement and ownership of the *mutuelle* schemes by the population. In that perspective, a "Rwanda Health Insurance Council (RHIC)" will be established to strengthen regulation, oversight of health insurance schemes, and ensure sustainability of the different schemes. The RHIC will be constituted by members from MOF, MLGSA, MOH, *Mutuelles* representatives, CSO representatives, MMI, RAMA, private health insurance companies, health providers and citizen's representatives. RHIC will not be a fund holder. An executive office is set-up to provide technical and managerial support and carry-out the decisions of the RHIC.

Office of the RHIC. The office of the RHIC will be composed of a team of experts who will be responsible for informing health insurance policy and cross-subsidization policies among health insurance regimes. It will maintain a database of health insurance organizations in the country. It will be responsible for conducting studies to generate evidence and inform the functioning of health insurance schemes. These studies will include risk analyses and actuarial analyses to support the periodic revision of contribution and premium policies and safeguard measures, cost and benefit analysis, client satisfaction assessment, and utilization analysis. It will provide technical assistance and support services to the various insurance regimes existing in the country.

Table 6. Summary of roles of institutions by the three functions of health financing

	Functions	Institution	Remarks
Revenue Collection	Setting and collecting taxes (e.g. establishing a new tax to fund health insurance)	MINECOFIN	
	Setting premium rates	MOH, RAMA, MMI	
	Collecting premium contributions	Mutuelles, RAMA, MMI	
	Setting membership rules and registering (enrolling) members (beneficiaries)	MOH, RAMA, MMI	
	Marketing to new members in the case of voluntary enrollment	Mutuelles, RAMA, MMI	
Pooling	**Pooling funds**	**Mutuelles, RAMA, MMI**	
	Pooling or risk equalization among insurance funds	District Association of Mutuelles for district pool MoH (National Risk Equalization fund). MINECOFIN	The National Risk Equalization fund will serve pooling and risk equalization role for first referral and second referral packages of care.
	Setting membership rules and registering (enrolling) members(beneficiaries)	MOH, Mutuelles, RAMA, MMI	
	Fund financial management (investments ensuring reserve requirements, cash flow management)	Mutuelles, RAMA, MMI	
Purchasing	**Setting a basic benefits package**	**MOH, RAMA, MMI**	
	Delivery of benefits package	Providers: public, parastatal, FBO/NGO, and private-for –profit	
	Setting the provider payment mechanism and rates	MOH, RAMA, MMI	
	Setting eligibility and qualification standards for providers to participate	MOH, RAMA, MMI	
	Enforcing/implementing eligibility and qualification standards for providers to participate (utilization and quality management)	MOH	
	Claim processing (reviewing and paying bills from providers and beneficiaries)	Mutuelles, RAMA, MMI	

8. Monitoring and Evaluation

8.1 Mechanisms for M&E

The key indicators defined in Table 7 are the most important indicators for measuring the health financing performance in the next 10 years (2010-2020). They are derived from and are informed by the country's long term vision and strategic direction (Vision 2020, MDGs and the EDPRS). They are among the most important indicators specified within the logical framework of the health financing strategy (see Annex A), which aim to measure progress towards the attainment of the desired health financing objectives and outputs. The main sources of data for monitoring, review and evaluation of the sector are: the HMIS, household surveys such as DHS, EICV, studies such as NHA, PETS and Health PER.

8.2 Joint Sector Review

Health financing performance will be monitored through the Health Sector Performance Review to be carried out annually, led by the Ministry of Health, as part of the Joint Health Sector Review. The meeting will be attended by both internal and external stakeholders in the sector, and will use the annual and periodic performance indicators. The main purpose of the joint sector review is to take stock of progress made in the sector, identify challenges and the reasons for them. The results obtained from the review would then be used to inform future strategies and plans.

8.3 Key performance indicators

Table 7 gives an overview of health financing related indicators and targets for 2012, 2015, and 2020. Baseline data are taken from the latest information available: the I-DHS and DHS 2005, EICV II, NHA 2006 and data compiled by specific programmes or the HMIS system.

8.4 Evaluation

An external evaluation of the health financing strategy is planned every three years. A first external is planned for 2012, in time for the results to feed into the planning process for the next EDPRS and HSSP-III. The health financing strategy will be adapted and aligned with the next EDPRS and HSSP-III policy orientations. A second external evaluation will be carried-out in 2015.

8.5 Reporting on progress

Monitoring of the health financing strategy is integrated in the monitoring of HSSP II. Each year after the Joint Annual Review a report will be produced with findings and recommendations, which will be widely distributed to all partners and stakeholders, on the national and district levels. Likewise any external reviews or evaluations will be disseminated. The M&E unit in the MOH will monitor the implementation of recommendations resulting from the annual reviews and external evaluations.

Table 7. Health Financing Key Indicators and Targets

Indicator	2005/6/7 Baseline	2012 Target	2015 Target	2020 Target
Level of utilization of modern curative care among the poorest 40% of the population				
Out-of-pocket health expenditures (US$) per capita	US$ 7.5[3]	US$ 5.0	US$ 5.0	US$ 5.0
Incidence of catastrophic health expenditures (% of households which have experienced catastrophic health expenditures during the year)	2.9%[1]	1%	1%	0.5%
% of the population enrolled in health insurance schemes	81%	92%	95%	100%
% the poorest 20% households who benefited from health insurance coverage through targeted subsidies				
Per capita total health expenditures (US$)	33.9[2]			
Share (%) of health in the government expenditures	11.4%[2]			
Share (%) of external assistance in total health expenditures	53[2]			
% of external assistance to health channeled through budget and sector support mechanisms				

Sources of baseline estimates:
a. MOH and WHO, 2009. Health Financing System Review of Rwanda. April.
b. MOH, 2008. Public Expenditure Review for the Health Sector. April
c. MOH, 2008. NHA 2006.

9. Costs and Financing

Cost and Funding Gap

Estimating the cost of delivering future services encompasses a certain level of uncertainty as overall cost of provision of services depends on both clients and providers' behaviours which themselves are affected by policy options, and derived incentives. A health strategy with a strong focus on families and community based interventions with a strong prevention component is cheaper than a strategy that focuses on high technology. It is therefore not always accurate to infer future costs from current ones. In the case of Rwanda, one additional and major source of uncertainty is the fact that all information available dates back to 2005-2006 when both service provision and coverage with health insurance were at a much lower level than today. Between 2005 where the last survey was conducted and 2009, enrolment in health insurance has dramatically expanded from about 40% to more than 90%. This extremely dynamic situation and unique achievement of Rwanda to be the only developing country having reached more than 90% universal coverage makes projections more perilous than in any other context.

However, the cost of implementing the HSSP II strategy of Rwanda has been estimated at US$47 per capita using ingredients and marginal budgeting for bottlenecks (MBB) methods by different teams. Showing that this was a very robust cost estimate. This cost projection is shared as follows: 36% for human resources for health, 25% for drugs and other commodities, 22% for infrastructures and equipment, 9% for health insurance and performance based financing and 8% for administration (see Table 8 and Annex C).

Table 8: Projected costs in millions of US$

Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Total Costs	**476**	**516**	**542**	**569**	**597**	**627**	**659**	**691**	**726**	**762**	**6,165**
Human Resources	171	186	195	205	215	226	237	249	261	274	2,219
Drugs and Commodities	119	129	135	142	149	157	165	173	182	191	1,542
Infrastructure and Equipment	105	114	119	125	131	138	145	152	160	168	1,357
Health Insurance and PBF	43	46	49	51	54	56	59	62	65	69	554
Administration	38	41	43	46	48	50	53	55	58	61	493
Total Costs	**476**	**516**	**541**	**569**	**597**	**627**	**659**	**691**	**726**	**763**	**6,165**

To finance the health sector for the next 10 years, it is projected that a total of US$ 6.1665 billion will be required.

10. Conclusion

The development of Rwanda's first Health Financing Policy marks an important step in the evolution of the health sector. Many countries lack a coherent health financing policy after many years of reform and un-costed health strategies that prove unsustainable in the long run.

The objective of the policy – to ensure that quality essential health services and particularly MDG-related interventions are financially accessible to the whole population in an equitable, efficient and sustainable manner under a result-based financing framework – is fully consistent with other commitments made in various health and government-wide policy documents. Furthermore, this first Health Financing Policy is informed by sound analytical work, based on global and national experiences on what can works to ensure efficiency, equity and sustainability.

This Health Financing Policy brings together all fragmented policies and clarifies the policy options priorities and mechanisms going forward. More importantly it aligns sources of funding, financing mechanisms and health sector functions. In addition to identifying policy directions, this policy document outlines implementation arrangements and cost implications associated with implementation of the financing policy. The analysis suggests an average financing gap of US$11 per capita. It is significant that this is the same gap estimated in Health Sector Strategic Plan 2009-2012, even though the estimation approach was different.

Looking to the future, the challenge is to agree on an implementation strategy and mobilize the necessary resources to facilitate implementation. Implementation will also be accompanied by significant learning and for that reason a strong M&E framework will be developed to facilitate learning and course-correction as implementation progresses.

References

Public Expenditure Review, World Bank

National Health Accounts 2006 (USAID/Abt Assoc.)

Public Expenditure Review (World Bank)

Health Financing Review of Rwanda – Options for Universal Coverage 2009 (World Health Organization)

Country Status Report on Health and Poverty in Rwanda 2009 (World Bank).

2020 Vision

Economic Development and Poverty Reduction Strategy (EDPRS)

Health Sector Policy and Health Sector Strategic Plan (HSSP-II) 2009-2012.

NISR 2002. Rwanda General Population and Housing Census (RGPH)

EICV2 2005-2006

MINECOFIN GDP estimates, February 2008

NISR; EICV2, 2005-2006

DHS 2005, IDHS 2008.

CTAMS, August 2008.

Twubakane Decentralization and Health Project
2006 Rwanda Health Center and Hospital Cost Study

Appendices

Annex A. Logical Framework of Health Financing Strategic Plan

Overall Programme Objective	***Key Performance Indicators***	
Ensure that quality essential health services and particularly MDGs related interventions are financially accessible to the whole population in an equitable, efficient and sustainable manner under a result-based financing framework	Levels of utilization of modern health services (curative care, maternal and child health services) : • General population • Poorest 40% of the population Out-of-pocket health expenditures (RwFrancs) per capita: • General population • Poorest 40% of the population Incidence of catastrophic health expenditures (% of households which have experienced catastrophic health expenditures during the year)	

Sub-programme Objectives	***Strategic Interventions***	***Outcomes***	***Indicators***
Risk pooling for improved financial access and household income protection of Rwandan families in the health sector strengthened	Ensure financial access and equity for the population to health services	- Enrolment in health insurance schemes among populations employed in the rural and informal sectors maintained at a high level - Effective coverage of subsidy schemes for providing health insurance among the poorest 20% - Copayments among beneficiaries of health insurance schemes are based on ability to pay - Mandatory health insurance for employees of formal sector enterprises reinforced	- % of the population enrolled in health insurance schemes - % the poorest 20% households who benefited from health insurance coverage through targeted subsidies - % of the poor and vulnerable groups exempted to pay copayments in health facilities - % of formal sector employees who are covered through health insurance plans supported by their employer
	Strengthen risk-pooling mechanisms of the mutual health insurance system	- Government allocation to the national risk pooling mechanism increased - Legal framework for increasing private and social health insurance schemes contributions to the national risk pooling mechanism strengthened - Viable risk-pooling mechanisms at all levels	- RwFrancs X billions of Government resources allocated to risk pooling mechanisms - % of private and social health insurance schemes revenues transferred to the national risk pooling mechanism - Pooling risk reimburses 100% of eligible hospital bills on a timely basis
	Extend appropriate payment modalities for improved risk-sharing under contractual arrangements between health insurance organizations and health care providers	- Mutuelles maintain adequate levels of reserves - Mutuelles contributions to the financing of health centres increased significantly - Mutuelles contributions to the financing of district hospitals increased significantly - Levels of reimbursement of health care providers revised periodically based on inflation in the pharmaceutical sector	- Ratio of mutuelles reserves over mutuelles monthly expenditures - % mutuelles which reimburse partner health centres and district hospitals on a timely basis - Availability of regularly revised tariffs for reimbursing health care providers reflecting the cost of services

Sub-programme Objectives	***Strategic Interventions***	***Outcomes***	***Indicators***
Efficiency in the allocation and use of health resources and coverage of high impact interventions improved	Allocate health sector budget according to priority areas based on needs	- Public health functions are adequately funded - Resources allocated to high impact interventions (reproductive health services, IMCI) increased - User-fees for targeted high impact interventions(reproductive health services, IMCI) removed at health centres	- % of public health expenditures allocated to health promotion, health information and disease surveillance activities - RwFrancs per capita allocated to high impact interventions(reproductive health services, IMCI) - High impact interventions (reproductive health services, IMCI) for which user-fees have been removed at the health centre level
	Increase resources allocated through performance-based financing mechanisms to deliver quality health services at the community, health centre and district hospital levels	- Resources allocated to high impact interventions through performance-based financing mechanisms increased - Resources allocated to home and community-based interventions through performance-based financing mechanisms increased - Resources allocated to support quality of care at health centre and district hospital levels through performance-based financing mechanisms increased	- RwFrancs per capita allocated to high impact interventions through performance-based financing mechanisms - RwFrancs per capita allocated to community health workers through performance-based financing mechanisms - RwFrancs per capita allocated to health centre and district hospital levels through performance-based financing mechanisms
	Increase the level of resources for extending geographical access in underserved and poorest areas	- Needs base transfers to districts and facilities expanded on the basis of a formula based on population, poverty and disease burden - Poor rural districts receive a larger level of public health subsidy than richer urban districts - Availability of qualified health personnel in poor rural districts improved	- Resource allocation formula based on population, poverty and disease burden developed by 2012 - % of needs base transfers to districts and facilities expanded on the basis of a formula based on population, poverty and disease burden - RwFrancs per capita of public health subsidy allocated to poor rural districts - RwFrancs per capita of public health subsidy allocated to richer urban districts - Population/physician ratio in poor rural districts

Sub-programme Objectives	***Strategic Interventions***	***Outcomes***	***Indicators***
Internal resource mobilization for sustainable funding of the health sector improved	Improve internal public spending in the health sector	- Per capita total health expenditures increased - Government allocation to health increased to reach the Abuja 15% target - Districts allocation to health increased to at least 10% of district budget - Share of internal public spending in total health expenditures increased - Increased internal resource mobilization by health facilities	- Per capita total health expenditures (US$) - Share (%) of health in the government expenditures - Share (%) of health in the Districts expenditures - Share (%) of internal public spending in total health expenditures - Share (%) of internally generated revenues in recurrent budget o Health centers o District hospitals
	Improve mobilization of private (households and enterprises) resources in the health sector through prepayment mechanisms	- Progressivity of household contributions into the health insurance system improved - Private sector enterprises contributions to health sector financing through health insurance increased - Share of private spending in total health expenditures increased	- Per capita contributions (RwFrancs) into the health insurance system by quintile - % of private sector enterprises health spending channeled through health insurance schemes - Share (%) of private spending in total health expenditures
Effectiveness of external assistance in the health sector improved	Improve alignment and harmonization of aid	- External assistance to health channeled through budget and sector support mechanisms is increased	- % of external assistance to health channeled through budget and sector support mechanisms
	Align the use of external resources to health sector priorities	- Increased share of external assistance are allocated through the Government performance-based financing mechanisms - Increased share of external assistance are used to provide health insurance coverage to the poor and vulnerable groups - Improved alignment of off-budget resources to health sector priorities	- Share (%) of external assistance in total health expenditures - % of external assistance allocated through the Government performance-based financing mechanisms - % of external assistance allocated to the provision of health insurance coverage to the poor and vulnerable groups

Sub-programme Objectives	***Strategic Interventions***	***Outcomes***	***Indicators***
			- % of off-budget resources aligned to health priorities
Institutional environment for sustainable financing of the health sector strengthened	Empower citizens and families for improved participation in the health sector	- Public education on rights of citizens and patients in the health sector expanded - Citizens representation in health committees and boards of autonomous health service provider organizations increased - Citizens report card and community score card implemented in the health sector	- % peer leaders among members of boards of district hospitals and management committees of health centers - % clients who are satisfied with health services
	Improve financial and administrative management capacities of autonomous health service provider organizations	- Financial and administrative management capacities of mutuelles are strengthened - Financial management and procurement capacities of health care provider organizations are strengthened - Autonomous health insurance organizations and health care provider organizations are externally audited on a regular basis	- % of mutuelles with computerized financial and administrative management systems - % of health facilities with computerized financial and administrative management systems - Number of health insurance organizations audited per year - Number of health care provider organizations (public and agree) audited per year
	Improve public sector management capacities in the health sector	- Financial management capacities of health authorities strengthened at the district level - Ministry of Health and District health officials trained in evidence-based planning and budgeting techniques - Financial information base (NHA, PER, PETS, MBB) to support decision-making, resource allocation and budgeting improved in the health sector	- Number of district health officials trained in MBB - Public expenditure review produced every year - Public expenditure tracking survey organized every two years - National health accounts produced every two years

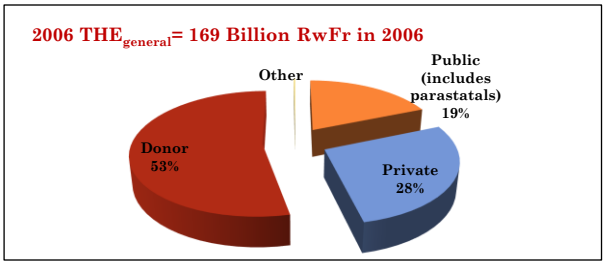
Annex B. Selected Indicators

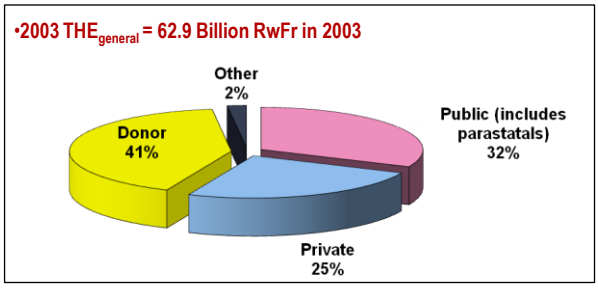
Table 9. International comparison for selected health financing indicators, 2006

Country	External resources for health as % of THE	Per capita government expenditure on health (US$)	Per capita total expenditure on health (US$)	Private expenditure on health as % of THE
Burundi	13.7	1	4	75.4
Democratic Republic of the Congo	28.8	2	6	62.9
Ethiopia	42.9	4	7	39.6
Kenya	14.8	14	29	51.8
Madagascar	50.3	6	9	37.2
Mozambique	56.8	12	17	30.6
Nigeria	5.9	10	32	69.9
Rwanda (NHA data)	**53**	**6.3**	**34**	**28.0**
Uganda	28.5	7	25	73.1
United Republic of Tanzania	35.4	11	18	40.8
Zambia	37.2	23	49	53.2

Sources: WHO database. Rwanda: 2006 National Health Accounts.

WHO PAYS FOR HEALTH CARE IN RWANDA





•Donor share has increased to over 53% of THE

•Private share (mainly HH) is now more than the gov.ernment contributions

Annex C: Projection of resource requirement

Cost break-down by Investments vs Operational (US$ million)

	Year 1	Year 2	Year 3	Total	Av. $/cap/yr	% of total
Investment	133.5	137.6	124.2	395.3	13.0	27.4%
Operational	319.4	338.8	391.8	1,049.9	34.5	72.6%
Grand Total	***452.9***	***476.4***	***516.0***	***1,445.2***	***47.4***	***100.0%***

Average cost per year by strategic and system objective (US$ million)

	1. FP/MCH/RH /Nutrition	%	2. Prevention and Control	%	3. Treatment	%	*Average total per year*	*%*
1. Institutional capacity	5.3	1.1%	3.9	0.8%	7.7	1.6%	**17.0**	***3.5%***
2. Human resources for Health	54.4	11.3%	22.9	4.8%	68.6	14.2%	**145.9**	***30.3%***
3. Financial access	14.5	3.0%	11.8	2.4%	13.8	2.9%	**40.1**	***8.3%***
4. Geographical access	31.3	6.5%	15.3	3.2%	38.5	8.0%	**85.0**	***17.6%***
5. Drugs, vaccines and consumables	22.2	4.6%	25.8	5.4%	54.1	11.2%	**102.2**	***21.2%***
6. Quality of health services	3.1	0.6%	2.2	0.5%	4.8	1.0%	**10.1**	***2.1%***
7. Nat Referral Hospitals and Research	13.3	2.8%	3.9	0.8%	64.3	13.4%	**81.5**	***16.9%***
Average total per year	***144.1***	***29.9%***	***85.9***	***17.8%***	***251.8***	***52.3%***	***481.7***	***100.0%***

Cost break-down by Investments vs Operational (US$ million)

	Year 1	Year 2	Year 3	Total	Av. $/cap/yr	% of total
Investment	133.5	137.6	124.2	395.3	13.0	27.4%
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