REPUBLIC OF RWANDA

MINISTRY OF HEALTH

HEALTH FINANCING STRATEGIC PLAN 2018-2024

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Contents

Foreword

The Health Financing Strategic Plan (HFSP) 2018-2024 as one of the critical sub strategies to implement the Health Sector Strategic Plan IV (HSSP IV) serves as an instrument for accelerating progress towards achieving Universal Health Coverage (UHC) in Rwanda. The strategic goals, objectives and interventions are linked inextricably to the vision, policies and strategies endorsed by the Government of Rwanda (GoR) and in other documents. These other documents include Vision 2020, the National Strategy for Transformation (NST1) and Rwanda vision 2050 that express the country's overarching commitment of ensuring high attainable standards of living for all people living in Rwanda and attaining lower middle income status by 2024, upper middle-income country status by 2035 and a high-income country by 2050. The HFSP abides also with the guiding principles of the 2015 Rwanda Health Sector Policy namely: people-centred, integrated and sustainable health care services. These core principles are expressed through mutually reinforcing strategic objectives and innovative interventions.

This strategy intends to design and implement innovative and effective strategies for the health sector to successfully improve the health financing system, to provide financial protection for all people living in Rwanda and to promote access to and efficiency in health services use, based on people's health care needs.
Given the significant health gains realised in the past decades, the MoH is deeply committed to ensuring that this HFSP remains a living document that will not only drive efforts in resource raising, effective pooling of resources, and strategic purchasing of health services but also achieve a more robust and resilient health system. Due to an anticipated continued decline in external funding, a major focus of this HFSP is to outline key strategic directions for the Ministry of Health to innovatively increase domestic resource mobilisation to ensure that resources are sustainable and predictable.

The MoH is committed to take on the task of leading the implementation of the HFSP and acknowledge that single-handed efforts of the health sector cannot achieve the mission and strategic objectives in this important document. Therefore, concerted efforts and new partnerships will be formed to identify new sources of funding and harness the active engagement and support of all partners and stakeholders including other Government ministries and public institutions, the private sector, academia, civil society and international development partners. The MoH will continue to reinforce coordination efforts for the alignment of its implementation using evidence-based approaches while providing room for innovative strategies for private sector engagement and Public-Community-Private Partnership.

The HFSP was developed through a wide consultative process and benefitted from ideas and inputs from the concerned health sectors stakeholders. I thank all the stakeholders especially members of the Planning and Health Financing Technical Working Group for their engagement and tenacity in producing a document of the highest quality and strategic importance. I urge that we continue to join hands as we move the process forward from a strategy document to tangible results.

Dr. Diane GASHUMBA
Minister of Health

List of acronyms

BoD	Board of Directors
BNR	National Bank of Rwanda
CBHI	Community Based Health Insurance
CHW	Community Health Worker
CIT	Corporate income tax
CPA	Complementary package of activities
CSOs	Civil Society Organisations
DRG	Diagnostic Related Groups
EMR	Electronic Medical Records
GDP	Gross Domestic Product
GoR	Government of Rwanda
HFSP	Health Financing Strategy Plan
HRTT	Health Resource Tracking Tool
HSSP IV	Health Sector Strategic Plan IV
IFMIS	Integrated Financial Management Information System
IGAs	Income Generating Activities
IMF	International Monetary Fund
LMIS	Logistics Management Information Systems
MDGs	Millennium Development Goals
MIGEPROF	Ministry of Gender and Family Promotion
MINECOFIN	Ministry of Finance and Economic Planning
MIS-UR	Medical Insurance Scheme of University of Rwanda
MMI	Military Medical Insurance
MoH	Ministry of Health
MPA	Minimum Package of Activities
MRS	Medical Record System
NGOs	Non-Governmental Organisations
NHIC	National Health Insurance Council
NIDA	National ID Agency
NST	National Strategy for Transformation
PAYE	Pay as you earn
PBF	Performance Based Financing
PFM	Public Financial Management
PHC	Primary Health Care
PIT	Personal income tax
PPCP	Public-Private and Community Partnerships
PPP	Public-Private Partnership
PSF	Private Sector Federation
RAMA	Rwandaise d'Asssurance Maladie
RBC	Rwanda Biomedical Centre
RCA	Rwanda Cooperative Agency
RDB	Rwanda Development Board
RHIC	Rwanda Health Insurance Council

RRA	Rwanda Revenue Authority
RSSB	Rwanda Social Security Board
RUHF	Rwanda Universal Health Fund
Rwf	Rwanda Franc
SARA	Service Availability and Readiness Assessment
SPIU	Single Project Implementation Unit
STA	Single Treasury Account
US$	US dollars (currency)
USAID	United States Agency for International Development
WHO	World Health Organization
WHT	Withholding tax

Executive Summary

Background

Despite regional and global uncertainties, Rwanda's economy recorded a good performance over the past years and is steadily approaching middle income status, which indicates important progress in reducing poverty and increasing fiscal capacity. The country continues to operate a decentralised system, where local communities are empowered and can participate in decision making over issues that affect them. Public financial management is guided by the Organic Law number 12/2013/OL of 12/09/2013 on state finances and property. While many achievements have been made to improve public financial management with the IFMIS that has been rolled out in all hospitals and health centers, a few challenges remain.

While there have been many achievements, the Government of Rwanda should continue to increase spending in key sectors as access to external grant and concessional funding declines along with achieving middle- to high-income status. In this context, the Health Financing Strategic Plan 2018-2024 will serve as an instrument to advocate for increasing the domestic budgetary allocated to the health sector, and ensure that funds are pooled effectively together to strategically purchase health services to ensure equitable utilisation of health services in Rwanda. Also, the Health Financing Strategic Plan is useful to address efficiency, design appropriate benefits packages and maximize household financial protection from the cost of healthcare and accelerate progress towards achieving universal health coverage (UHC) in Rwanda.

Health financing Situation in Rwanda

Although Rwanda has met the Abuja target by devoting about 17% of Government resources to finance health services, the external funds are still higher (accounting for about 60% of total health expenditure) compared to the domestic funds. According to the most recent data available, health sector budget amounts increased from Rwf 321 billion in 2010/11 to Rwf 360 billion in 2014/15 and Rwf 413 billion in 2015/16, reflecting an increase of 12% and 27%, respectively. The HSSP IV provides an estimate of US$60 (Rwf 44,826.92) per person per year as needed to finance health services in Rwanda between 2018 and 2024.

The two major insurers in the country — CBHI scheme and RSSB formal sector employees' medical scheme cover more than 90% of the population. However, CBHI has been operating at a deficit for a long time. In 2016/17, CBHI recorded a deficit estimated at Rwf 12.6 billion compared to a surplus of Rwf 7.6 billion for RSSB formal sector employees' medical scheme and the cumulative surpluses from RSSB formal sector employees' medical scheme between 2013 and 2017 (Rwf 46.3 billion) is very close to offsetting the deficits recorded for CBHI (Rwf 49.7 billion) over the same period. Out-of-pocket payments remain favourably low in Rwanda, accounting for about 8% of total health financing in 2014/15. This has improved

financial protection to the poor against catastrophic spending. Private sector contributions have been minimal, and there is an ongoing discussion to increase private health sector contribution which currently accounts for 1.7% of the country's GDP compared to a target of 5%.

The Rwanda MoH introduced the Performance-Based Financing (PBF) strategy in 2004 and later institutionalised it in 2008, and it was heavily funded mainly by development partners. While there have been positive outcomes from the PBF, the major challenge relates to its sustainability. Even though the GoR took over slowly and has become the major funder of the PBF, external funds still account for a significant share. In 2015/16, the Global Fund accounted for about 35% of the PBF budget.

The health financing system in Rwanda has three major functions: i) raising sufficient revenues from different sources (tax revenues, loans and grants, and household spending etc.) to provide quality health services; ii) pooling resources and risks to maximise solidarity between the rich and poor, healthy and sick, and old and young; and iii) allocating and using resources efficiently and strategically to achieve Rwanda's health goals.

Analysis of health financing in Rwanda according to its functions

Revenue raising: Based on data from the HRTT, in 2014/15 Government funds alone, primarily taxes, account for about 29% of total health financing with external funds off-budget (28%) and on-budget (25%) accounting for a substantial share. Out-of-pocket payments and health insurance together accounted for about 19%. CBHI category I members are subsidised by Government and external funds while the other categories pay premiums directly. Overall, there is a need for increased domestic funding of the Rwanda health system, especially as external funds have been declining. Public health insurance system needs to be strengthened.

Revenue pooling: The major pools in Rwanda include Government taxes, contributions to CBHI and RSSB formal sector employees' medical scheme. Private health insurance pools are relatively small. The CBHI and RSSB formal sector employees' medical schemes are managed by the RSSB but as separate pools. To improve the pooling of CBHI, the GoR instituted the principle of cross-subsidisation, where other health insurance schemes contribute 5% of their revenues to the CBHI. However, this is not sufficient to reduce CBHI deficits. Cross-subsidy contributions represent about 8% of the total CBHI revenues. Overall, Rwanda has made significant progress since 1994 in improving the pool of funds in the health sector. However, there is fragmentation of pools as the share of funds that each pool has does not reflect the share of the population that it serves. Although it was originally planned that the pools will cover different population groups, inequality in the coverage of the population is not a favourable outcome—spending per CBHI member remains smaller than spending per RSSB formal sector employees' medical scheme member and the benefits are accordingly different.

Purchasing health services: In Rwanda, health services are purchased by different organisations through different mechanisms — MINECOFIN, the MoH, RBC, RSSB, districts, MMI funds and private health insurance funds as well as households. Government agencies, public and faith-based health facilities are allocated budgets based on the traditional input-based approach and disbursements are done every quarter. Public health budget supports staff salaries, facility capital, pharmaceuticals, supplies and operating costs. Apart from PBF that purchases outputs and outcomes, public resources allocation is based mainly on the traditional input-indicators. CBHI beneficiaries are by law entitled to a comprehensive range of preventive, rehabilitative and curative services throughout the country in public facilities, and recently to private health posts at the primary health care (PHC) level. Members of RSSB formal sector employees' medical scheme, MMI, MIS-UR and private health insurance schemes are also entitled to a comprehensive benefits package that includes inpatient, outpatient and emergency services in both public and accredited private health facilities. Payment to providers in Rwanda remains mainly on a fee-for-service basis across the schemes. Overall, there are elements of strategic purchasing in the Rwanda health system. However, there is room for improvement, especially in ensuring that the purchase of health services for the population is in line with the needs of the population and that quality health services are provided.

Health financing strategies for Rwanda

Based on the major challenges with the Health Financing system in Rwanda, a couple of strategies have been proposed to address the challenges and to ensure that Rwanda achieves Universal Health Coverage. The primary health financing strategies are summarised below.

Major strategies for revenue raising for health in Rwanda

1.1 Increase GoR revenues/resources allocated to the health sector
1.2 Support and incentivise public health facilities and institutions to generate internal revenues through income generating activities (IGAs)
1.3 Strengthen the long-term financial sustainability of the CBHI scheme and implement strategies to generate revenues for the CBHI
1.4 Advocate for the funding alignment and harmonisation of external resources and for more aid resources to flow through the GoR for funding predictability
1.5 Increase private sector engagement through large private businesses in Rwanda to make substantial contributions to finance health services
1.6 Explore the feasibility and practicality of implementing innovative health financing strategies to raise more revenues for the health sector
1.7 Mobilise diaspora to increase contributions to the health sector

Major strategies for effective revenue pooling for health in Rwanda

2.1 Increase pool size and coverage of health risk pools

2.2 Set up a risk equalisation mechanism and enforce health insurance coverage in Rwanda

Major strategies for active health service purchasing in Rwanda

3.1 Strengthen the links between purchasing and quality of health services provision using a strong autonomous accreditation body

3.2 Design essential benefits package and strengthen the capacity of the purchaser (RSSB in the short- to medium-term) to be a strategic purchaser

3.3 Strengthen the incentive mechanisms for CHW programme, including community PBF and ensure sustainable quality service provision.

3.4 Strengthening and automating various systems (PFM, HIS, HRTT, drug procurement, etc.) to provide the needed support structures for achieving and sustaining strategic purchasing.

3.5 Strengthen the PFM capacity in the health sector

3.6 Maximising efficiency in the allocation and use of existing health resources and improving coverage of high impact interventions

Funding gap analysis

In addition to assessing the overall health financing system in Rwanda, the Health Financing Strategic Plan provides a snapshot of funding gaps for the health sector using information from the HSSP IV and international conventions.

The HSSP IV provides an estimate of US$60 (Rwf 44,826.92) per person per year as the amount needed to finance health services in Rwanda by 2024. This translates to Rwf 4.3 trillion over the life of the HSSP IV. There is a need to ensure that increases in domestic financing, matched with the decline in donor funds will be able to raise sufficient funds to finance health services in Rwanda.

Using the projected cost of the HSSP4, this Health Financing Strategic Plan estimates a shortfall of Rwf 660 million to finance essential health services for universal health coverage in Rwanda between 2018 and 2024. These expected shortfall calls for a multi-pronged approach to increase domestic resources for health and continue to protect households from shouldering the burden of the high cost of healthcare.

However, it is important to note that the health financing strategic document provides a much richer analysis than just a means to close the financing gap. Apart from raising revenue, the health financing strategic plan is useful to address efficiency, design appropriate benefits packages, and ensure that funds are pooled effectively together to strategically purchase health services to ensure equitable utilisation of health services in Rwanda.

Conclusion

Key strategic interventions have been identified for each major strategy. Also, a detailed monitoring and evaluation framework has been developed to accompany these key strategies. Furthermore, a funding gap analysis was performed taking into consideration the health spending requirements to finance HSSP IV. The analysis in this Health Financing

Strategic Plan show that sustainable allocation and strategic use of resources will help to ensure that Rwanda uses its resources efficiently to achieve impressive health goals. The successful implementation of this health financing strategy plan will provide Rwanda with an opportunity to consolidate on progress already made on several fronts and accelerate the country towards universal health coverage and achieving the Sustainable Development Goals (SDGs).

Linkages to the health policy and other sector development agenda

The development of the HFSP in Rwanda is guided, among other things, by key national and international policies and goals. The HFSP is developed at the time of renewed global and national commitment to achieving universal health coverage (UHC) and sustainable development goals (SDGs)[2,3]. The development of the HFSP 2018-2024 is a great accomplishment for the health sector to move towards a more sustainable and resilient health system. The HFSP is inspired and guided by the Health Sector Policy 2015, Health Insurance Policy 2010, Health Sector Strategic Plan (HSSP IV), and Health Financing and Sustainability Policy 2015, which outline the vision for the health sector together with a prioritised set of actions that are recognised to improve population health outcomes and achieve UHC.

The Strategy is also aligned with relevant strategies and priorities endorsed by the Government of Rwanda, as expressed in the Vision 2020, the National Strategy for Transformation (NST1) 2017-2024 and Rwanda Vision 2050 (Rwanda we want). The Rwandan Constitution of 2003 and the amended constitution of 2015 stipulate that "all Rwandans have the right to good health." The GoR has the duty to improve the general welfare of the population and ensure access to a clean and healthy environment. The constitution further entitles all Rwandan population to enjoy rights of equal access to public services, including health services, education, safe water and sanitation.

The vision and mission of the HFSP is built around the "Rwanda's Vision 2050" that presents a set of key priorities and actions to be undertaken in transforming Rwanda into a hi-high income nation by 2050, where Rwandans have the potential to reach and maintain the highest attainable standards of living in a stable and secure society. Vision 2020 further places its people squarely at the centre of its short-, medium- and long-term plans in ensuring socio-economic transformation and accelerating poverty reduction. The attainment of optimum levels of health and wellness among the population is vital to the achievement of these ideals.

The HFSP is fully aligned with the priorities expressed in the National Strategy for Transformation (NST1) 2017-2024 and linked with the aspirations of the Vision 2050, aimed at attaining upper middle-income country status by 2035 and becoming a high-income country by 2050. The vision 2050 acknowledges the importance of ensuring universal access to quality education and health care in promoting the wellbeing of Rwandan citizens. The health sector remains a crucial foundation for achieving Rwanda's aspiration of providing a high quality of life to all citizens and accelerating access to quality healthcare and services.

Also, important global commitments and policies have been considered and provided the foundation and direction for the development of this HF Strategic Plan. These international commitments include, but not limited to, the Sustainable Development Goals (SDGs), the Paris Declaration, Abuja Declaration and Ouagadougou Declaration. It is worth noting that the focus of this document is to strengthen Rwanda's health financing system and contribute to the improvement of population health which can only be achieved if adequate domestic resources are available to finance health sector priorities. The sum of these efforts will improve health status and contribute to higher productivity and longevity among the Rwandan population.

Process for HFSP development

This document represents the culmination of a highly consultative process led by the Ministry of Health and has considered inputs from various stakeholders including the Ministry of Finance and Economic Planning (MINECOFIN), Rwanda Development Board (RDB), Rwanda Social Security Board (RSSB), Social Cluster Ministries and their affiliated implementing agencies, Development Partners and service providers (both public and private), Private Sector Federation, Academia and Civil Society Organisations and Community Health Workers. A central tenet of the consultative approach was to attain an extensive stakeholder engagement while responding to opportunities for constructing strategic partnerships at all levels. The key features of the planning process were as follows:

Establishment of the Health Financing Core Team: This core team was formed to provide technical oversight and guidance to the development of the HFSP 2018-2024 from inception to the completion of the assignment. The team was chaired by the Director General of Planning, Health Financing and Information System in the MoH and composed of different staff in the MOH and RBC, Development Partners, academia and the private sector actors. Also, two consultants (a national and an international consultant) worked on the assignment under the technical guidance of the Core Team.

Initial meetings: These were held between the consultant team and the core team to agree on the methodology proposed to perform the assignment. The inception report was presented and approved. It highlighted the methodology, main deliverables, the list of key informants, and the work plan to address the scope of work.

Desk review: In-depth review was done for all relevant documents including policy documents, health sector strategic plan, evaluation reports, government budget documents, health surveys reports, and research sources as well as national, regional and international commitments and obligations. Data were analysed and validated through a process of triangulation. Desk review was used to develop a comprehensive situation analysis of the health financing landscape that informed future health financing reforms and strategic orientations. This was done closely with core team members.

Stakeholder engagement through interviews with key informants: Government and non-Government officials were interviewed to gather additional and qualitative data on the main challenges in financing health services in Rwanda as well as information on which health financing strategies are useful in the context of Rwanda. Key informants included key officials from the MoH, MINECOFIN, MINALOC and Districts. Interviews were also held with staff from the RBC, RSSB, RDB, Rwanda Health Insurance Association, development partners, private health care providers, Academic institutions and Community Health Workers.

Consultative stakeholder workshops: These involved the consulting team, the core team members and other key players. Four stakeholder consultative workshops and several meetings were organised to obtain information for developing the HFSP. Recommendations from formal stakeholder consultations and meetings were used to enrich both the situation analysis and the HFSP as well as to validate the information and for priority setting.

Preparation of the comprehensive situation analysis: At least two drafts of the situation analysis document was reviewed by the core team members including other key international stakeholders from different institutions and agencies. A summary situation analysis was suggested and drafted to provide a very short overview of the health financing situation analysis.

Preparation of HFSP 2018- 2024: Drafts of the HFSP were produced and discussed among the core team members including key international stakeholders. Comments received from the core team, development partners and other key stakeholders were used to enriching the HFSP, and the final version was based on the comments. A national validation and dissemination of the strategy is planned as part of the final processes.

CHAPTER 1: SITUATIONAL ANALYSIS

1.1 Introduction

The right to good health is stipulated in the Rwanda constitution. Rwanda's Vision 2050 and the National Transformation Strategy (NST1) are also geared towards transforming Rwanda into a high-income country. Achieving this will make Rwanda reach and maintain the highest attainable standard of living in a stable and secure society. Under the Government of Rwanda's overall goal, the vision of the Ministry of Health (MoH) is to "continually improve the health of the people of Rwanda, through coordinated interventions by all stakeholders at all levels, thereby enhancing the general well-being of the population and contributing to the reduction of poverty"[4].

The Rwanda health system has undergone several transformations after the 1994 Genocide against the Tutsis. This began with the provision of free health services in 1994, and then the re-introduction of user fees in 1996/7 and the national roll-out of the Community-Based Health Insurance (CBHI) Scheme in 2006 – the major insurer in the country[5,6]. By 211, Rwanda was among only two African countries that achieved and exceeded the benchmark set by the 2001 Abuja Declaration of allocating at least 15% of government budget to fund health activities across all sectors [22]. Overall, in terms of the health financing landscape in Rwanda, there are still many challenges as laid out in the fourth Health Sector Strategic Plan 2018-2024 (HSSP IV). These challenges include the health sector's significant reliance on external financing that is not sustainable, the insufficient contribution of CBHI members compared to the rising cost of care, limited private sector engagement and contribution to health insurance and fluctuations in CBHI membership, which threaten the sustainability of the CBHI[7].

Three key priority areas for health financing have been laid out in the HSSP IV to ensure a sustainable, equitable and efficient health financing system for all Rwandans through adequate resources mobilization by 2024: (i) ensuring overall financial sustainability of the health sector through increased Government budgets allocated to the health sector, optimisation and efficiency in resource use, and collaboration between the public and private sectors, (ii) promoting new innovative financing mechanisms for high impact interventions and emerging diseases, and (iii) ensuring routine revision of health insurance package offered in Rwanda[7].In doing so, the Government of Rwanda (GoR) envisions that over 95% of the population should be covered by health insurance and that out-of-pocket payments will comprise less than 10% of total household income by 2024[7].

Specifically, the HSSP IV sets out seven health financing strategies and interventions for implementation through 2024: (a) intensify resource mobilisation and increasing resource allocation from the GoR to the health sector to ensure sustainability of the Rwanda health financing system, (b) strengthen the current PBF accreditation to improve quality of care in health facilities, (c) promote the use of innovative health financing mechanisms through for example, the Rwanda Treasury and "health bond" to attract social and philanthropic

investment to unlock additional funding for the health sector, (d) ensure resource mobilisation and efficiency in the management of health facilities resources by improving cost recovery and cost-saving plans for health products, including blood products, (e) establishment of revenue generating projects across the health system through the Promotion of Public-Private and Community Partnerships (PPCP) which will increase resource mobilisation from other partners including the private sector, (f) further consolidate the pre-payment and risk pooling arrangements, and (g) improve the efficiency of existing health services purchasing mechanisms[7]. In addition to these seven broad areas, there is a need to increase efficiency in the management of the CBHI scheme and efficiency at the health facility level.

These priority areas and interventions guide the assessment contained in this document. The first chapter provides a summary of the situation analysis of health financing in Rwanda including major challenges and gaps. It highlights key contextual issues beyond the health sector that influence health financing. The second chapter provides detailed strategies to address the challenges identified as part of the situation analysis.

1.2 Status of the Rwanda health system

Rwanda's overall health sector strategic directions are well reflected in long-and medium-term health policy and strategic plans, including the 2015 Health Sector Policy and the HSSP IV. The country's health system is tiered comprising both the public and private sectors in terms of health financing and health service provision. The public sector has been decentralised to improve service delivery and governance with the MoH, supported by a few implementation agencies, providing the overall policy framework and coordination of the health sector. The MoH is also responsible for (1) policies and strategies formulation, (2) monitoring and evaluation of the implementation of national health policies and strategies, (3) overall capacity building and (4) resource mobilisation. These complex responsibilities require strong leadership, commitment and a well aligned and thought-out strategic plan for actions to achieve national priorities.

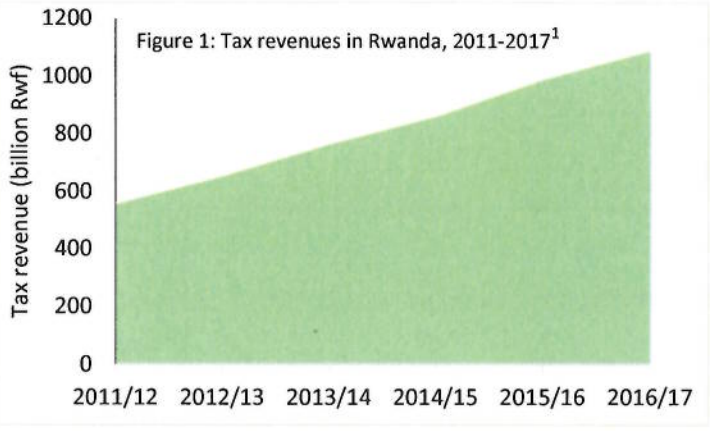
Public health services are the largest in the country and are provided at different levels with a defined minimum package of activities — community health workers, health posts, health centres, district and provincial hospitals, and national referral hospitals. Health centres and health posts represent the main entry point for health service delivery. The public health sector has about 58,298 community health workers (CHW) at the village level, 705 health posts, 504 health centres, 36 district hospitals, 4 provincial hospitals, 3 referral hospitals and 5 teaching hospitals[8]. The private health sector has grown in recent years although private sector investment in health is still small and fragmented. The private sector comprises 177 for-profit health facilities including hospitals, polyclinics, clinics, dispensaries and 216 pharmacies and wholesalers, most of which are in the capital city of Kigali[9].

In terms of health financing, private health financing includes private health insurance premiums from over 10 registered schemes and direct out-of-pocket payments. Private health care providers still use out-of-pocket payments for some operating costs because of the current insurance tariff structure that is unable to cover the full cost of service provision. Limited access to credit and financing has been a significant constraint on the expansion of the private health sector. Public financing, on the other hand, includes allocation from general taxes. Other public health insurance schemes that operate in the country include CBHI, RSSB formal sector employees' medical scheme (RAMA), MIS-UR and Military Medical Insurance (MMI). The Rwanda Social Security Board (RSSB) administers both the formal sector medical scheme and CBHI funds. Under this arrangement, the National Bank of Rwanda (BNR) is responsible for regulating insurance activities in the country. The National Health Insurance Council (NHIC) was recently created and has the mandate of advising, supervising health insurance activities and setting the prices/tariffs for health services as per the Health Insurance Law issued in 2016. Although health insurance scheme membership is mandatory in Rwanda, there exists a portion of the population that is not insured. Data from the HRTT show that a substantial component of health financing still comes from external funds (~60% of total health expenditure).

1.3 Key contextual factors that influence health financing policy and attainment of policy goals

Rwanda's economy recorded good macroeconomic performance in recent years. Using data from the National Institute of Statistics of Rwanda, in 2017, per capita GDP stood at US$774. Despite regional and global uncertainties, Rwanda's economy recorded a good performance in 2016, with real GDP growing by 5.9%, slightly lower than the initially projected 6%[10]. The global financial crisis impacted on the economy leading to a decline in real growth in the 2009/10fiscal year. The major sectors that contribute to Rwanda's economy include services and agriculture, with both contributing over 60% of GDP. The agricultural sector alone absorbs a high percentage of the workforce (>65%)[10,11].

Tax revenues have increased over the past years with a positive impact on domestic revenue performance (see Figure 1). Rwf 1086.8 billion tax revenue was collected in the 2016/17 fiscal year against a target of Rwf 1081.4 billion, translating into a 100.5% achievement or an excess of Rwf 5.4 billion over the target. Between the 2015/16 and the 2016/17 fiscal years, tax revenue increased by Rwf 100.2 billion, translating into a 10.2% nominal growth[1].In the 2016/17 fiscal year, tax and non-tax revenues accounted for 98.5% and less than 1.5% of total central Government revenues, respectively. The major components of tax revenue include indirect taxes (including value



added tax, excise taxes, customs duties and tax on international trade) accounting for about 59% of total tax revenues and direct taxes (including Pay-As-You-Earn (PAYE), personal income tax (PIT), corporate income tax (CIT) and withholding tax (WHT)) representing about 41.2% of total tax revenue[1,12].

Using data from the International Monetary Fund, World Economic Outlook Database, April 2018, Rwanda's Government revenue as a share of GDP, estimated at less than 25% over the past two decades, is "low to medium"[13]. Over the past decade, tax revenue is accounting for an increasing, albeit slow, the share of GDP (still less than 16%)[10]. This means that in the future, there is room for an increase in tax to GDP ratio in Rwanda, especially with an increase in tax compliance. Data from 2016/17 show that about Rwf 138.1 billion in domestic tax revenue was owed in arrears. An increased Government expenditure profile and a slow growth in Government revenue lead to increased deficits. In fact, except for 2005, the GoR has consistently recorded budget deficits[1]. This means that the Government must borrow to finance deficits and it may make it difficult for the GoR to increase budget allocations to the health sector and indeed other social services sectors. The recommendation of the International Monetary Fund (IMF) is that a low-income country like Rwanda should aim to keep its debt to GDP ratio below 40%[14]. In fact, the GoR has been able to bring its debt-to-GDP ratio to less than 40% from 102% in 2000 due to, among other things, prudent borrowing and debt management and external financing several activities including health and other social services. Inflation generally remained high in Rwanda due to heavy rainfalls, drought, world oil price, etc. The foreign exchange market is under pressure in Rwanda, and the pressure on the exchange rate continues to have an impact on health sector costs, especially on the current tariff structure and cost of medical equipment and medical supplies.

In summary, Rwanda's economic performance over the past seven years is modest. There are opportunities for improvements, especially in economic growth and revenue generation. Given the significant progress in health and health outcomes (e.g. under-5 mortality declined from 152 deaths in 2005 to 50 deaths per 1,000 live births in 2014/15) (http://www.moh.gov.rw/), it is believed that improvements in general economic outlook over the next years will improve general well-being. This will, in turn, provide a strong opportunity to strengthen the health system through increased domestic financing for health.

1.3.1 The structure of public administration in Rwanda

Rwanda operates a decentralised system with considerable power at the centre, where local communities are empowered and can participate in decision making over issues that affect them[15,16].

Figure 2: Evolution of Rwanda's decentralisation process

	Before 2001	2001 – 2006	Since 2006
Prefectures	12	-	-
Provinces	-	11	4
Kigali city	-	1	1
Sous-Prefectures	22	-	-
Communes	154	-	-
Districts	-	106	30
Sectors	1531	1545	416
Cells	8987	9165	2,148
Imidugudu (villages)	-	-	14,837

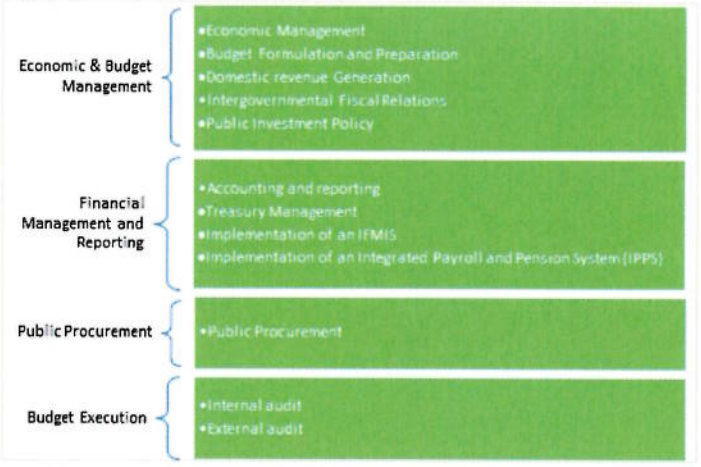
Between 2000 and 2018, three phases of transformation/decentralisation

had occurred (see Figure 2). The current system comprises 4 provinces, the City of Kigali, thirty districts, 416 sectors, over 2,148 cells and over 14,837 villages. Before 2006, provinces had greater prominence in service delivery. Now, their role is restricted to coordinating the districts and controlling the legality of the district council's decisions. Districts coordinate service delivery including health services and manage budgets. They remain financially and legally independent with oversight over hospitals, water, sanitation and schools. They have discretionary powers to allocate resources and ensure that districts' priorities and population needs are reflected in their annual plans and budgets. Rwanda's homegrown *Imihigo* (performance-based contracts, introduced in 2006) is an avenue where the central Government and the Rwandan population can hold sub-national Governments accountable for service delivery including health services.

The central Government receives revenue from taxes and non-tax sources including loans, grants, proceeds from sale of assets, etc. while districts receive funds from both local revenues raised (usually less than 20% of total income) and allocation or transfers from the central Government (capital and recurrent block transfers, earmarked transfers and inter-entity transfers)[17].

The recurrent block grants are used mainly to pay wages and salaries while the capital block grants are for infrastructure investment. However, districts have full autonomy in the use of locally generated revenue from local taxes and fees. The general framework for the allocation and efficient and effective use of public resources is contained in the country's PFM guidelines.

Figure 3: Pillars and components of Rwanda's PFM reform



1.3.2 Public sector financial management

Public financial management (PFM) in Rwanda is guided by the Organic Law number 12/2013/OL of 12/09/2013 on state finances and property[17]. The country's PFM reform agenda is to "ensure efficient, effective and accountable use of public resources as a basis for economic development and poverty eradication through improved service delivery."

The following interventions have been implemented to improve the effectiveness of the country's PFM: i) Moving to a Single Treasury Account (STA) to replace existing individual (ministries', other spending units') bank accounts; ii) Introducing an IT-based Integrated Financial Management Information System (IFMIS)in all budget agencies (further rolled out to all district hospitals in FY 2016/17); and iii) Integrating revenue and expenditure management in a single system[18]. The four pillars of the country's PFM reform (see Figure 3) include economic budget & planning, financial management and reporting, public procurement, and budget execution. Evidence from the health sector shows that many health facility managers appreciate the PFM in terms of ensuring that funds are used for prioritised items and that there is increased accountability including the current use of IFMIS. Also, e-LMIS for district hospitals and district pharmacies was rolled out for stock management. Other significant achievements include the roll-out of an e-procurement system in the MoH and the Rwanda Biomedical Center (RBC) as well as the establishment of a billing module for EMR (open MRS). However, there was limited interoperability across systems as well as limited capacities of districts to oversee PFM in health facilities (planning, and reporting).

Across key social services sectors, budget execution is relatively high. However, the health sector's budget execution rate (86% in 2015/16) is low compared to the one at the district level (99.6%)[19], which largely consists of recurrent costs. The divergence is explained by the differences in funding sources between the central Government and district levels: the latter depended less on external funding, which was tougher to predict than domestic revenues. The other key social services sectors record execution rates that exceed 95% between 2014 and 2016[19]. One of the possible explanations is the transition of the Global Fund support to a Results-Based Financing (RBF) model (flowing through the Treasury) in 2014/15 which resulted in reduced absorption capacity as the RBC budget execution trends showed until 2016/17. Key informants explained that bottlenecks have now been addressed. It is important to note that budget execution in the health sector was affected, in some instances, by the realisation of less than projected financial flows largely from delays in disbursement and some cases cancellation of budgetary grants by some development partners as well as delays in big infrastructure projects.

Some of the challenges with the PFM in Rwanda are summarised in Table 1.

Table 1: Challenges with PFM
• Some modules in the IFMIS (for example billing module) are yet to be initiated and rolled out • Limited capacities for health facilities managers especially in planning, accounting and reporting in PFM resulting to inadequate audited financial statements

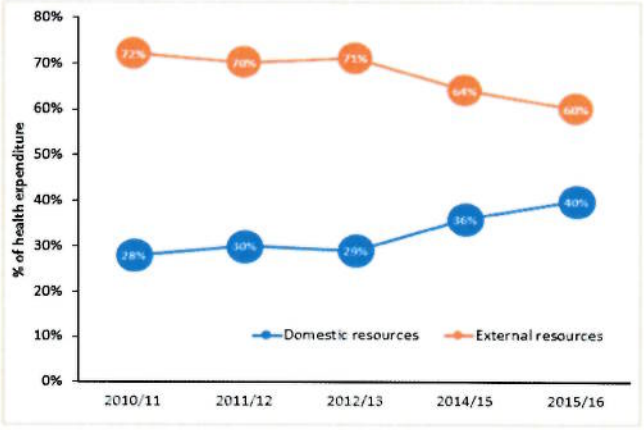
- Most concerns raised in the Auditor General's recommendations were made based on issues of "efficient and accountable use of public resources to deliver quality services."
- Many hospitals do not maintain proper accounting records and do not report consistently on the use of transfer funds from central level.

1.3.3 Health expenditure patterns

There are many actors in the health financing system in Rwanda, with health spending originating and flowing from several sources: public, private and development partners. Health Resources Tracking Tool (HRTT)20 data indicate that health sector budget amounts increased from Rwf 321 billion in 2010/11 to Rwf 360 billion in 2014/15 and Rwf 413 billion in 2015/16, reflecting an increase of 12% and 27%, respectively. Insurance premiums accounted for 11% and out-of-pocket spending on health accounted for 8%, according to the latest available data for 2014/15. This has improved financial protection to the poor against catastrophic spending. By combining insurance premiums and out-of-pocket spending on health, we understand that total household spending on health was approximately 19% of total health expenditure during this period. Private sector contribution have been lower than they could be and there is ongoing discussion about how to increase private sector investment in health, which currently accounts for 1.7 % of the private GDP spent on health , compared to 7.9% overall health spending to GDP .

The HSSP IV provides a cost estimates Rwf 44,826.92 (US $60) per person, per year to finance health services from 2018 to 2024, totalling nearly Rwf 4.3 trillion over the life of the plan by 2024[7].

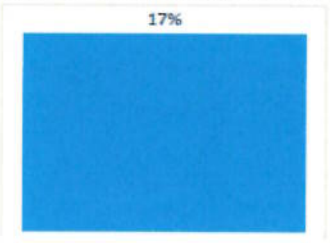
Figure 4: Share of domestic and external resources, 2010-2016



Data from the WHO show that per capita health expenditure has grown from US$ 9 (in 2001) to US$ 33.36 (in 2006) and US$ 40.37 in 2009/10. These estimates are lower than that in the HSSP IV and that proposed by the Commission on Macroeconomics and Health (US$71 in 2012 prices) and the Taskforce on Innovative International Financing (US$86 in 2012 prices)[21]. Over the years, about one-third of external funding is off-budget. Overall, external funding accounted for the largest share of funding (60% in 2015/16) although the share is declining (Figure 4). This decline is mainly due to the exit of some development partners and a slight decline in the share of international NGOs funding.

Rwanda is among the few African countries that have achieved and exceeded the benchmark set by the Abuja

Figure 5: GoR's spending on health

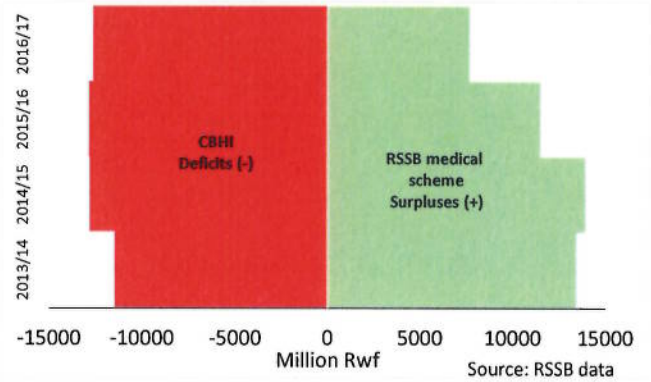


declaration of allocating at least 15% of Government budgets to fund health activities[22]. The share of the public budget devoted to the health sector and health-related activities in Rwanda increased from 8.2% in 2005 to 17% in 2014/2015 (Figure 5).

In summary, Rwanda's health system has greatly benefited from the effective collection, coordination and better allocation of resources to priority areas. However, MoH should continue to advocate for more domestic resources to meet the increased demand for healthcare services, and the costs of running and equipping more health facilities, including the health posts. Additionally, the utilisation of health services has doubled in the last of five years, and more expensive services (i.e. radiography, dialysis, surgery, services, etc.) are offered to patients consulting public health facilities. Furthermore, the decline and unpredictability in external funding for health also represent another major challenge for the health sector. There are several reasons to make a strong case for the GoR to increase allocation to the health sector. Alternative health financing strategies are also needed to fill the funding gap for implementing critical interventions.

With the decline in external funds and the inability of the public sector to adequately respond to this decline, there is an increased desire for private sector engagement to augment shortfalls in resource requirements to fund the Rwanda health system. However, private sector spending on health, including private health insurance and out-of-pocket payments, remains very low. In fact, out-of-pocket payments are estimated to account for 8% (2014/15).In terms of the overall economy, the private health sector accounts for 1.7% of the country's GDP compared to a target of 5%[23]. There is a need for discussions in Rwanda on the way to tap into private sector funds and this is very relevant when discussions of engaging the private sector are brought up.

Figure 6: Income, expenditure and deficit, Rwanda CBHI, 2011 – 2017



The health insurance landscape for the major health insurance schemes, RSSB medical scheme for formal sector employees and CBHI, indicates that CBHI expenditure is consistently higher than income while RSSB formal sector employees' medical scheme consistently records surpluses. In 2016/17, CBHI recorded a deficit estimated at Rwf 12.6 billion compared to a surplus of Rwf 7.6 billion for RSSB formal sector employees' medical scheme[24] (see Figure 6). The cumulative surpluses from RSSB formal sector employees' medical scheme between 2013 and 2017 (Rwf 46.3 billion) is very close to being able to offset the deficits recorded for CBHI (Rwf 49.7 billion) over the same period.

1.4 Analysis and assessment of Rwanda's health financing system

1.4.1 Revenue raising

Health services in Rwanda are financed through a combination of taxes (direct and indirect), health insurance premiums (CBHI, RSSB formal sector employees' medical scheme, MMI, MIS-UR and private health insurance schemes), direct out-of-pocket payments and external funds. For domestic revenue sources, the contribution rates vary for various taxes.

Table 2: Health financing mix in Rwanda, 2014/15

		Percentage share in total health financing
Public funds	Government funds	29%
	External funds (on-budget)	25%
Out-of-pocket payments		8%
Health insurance premiums (CBHI, RSSB medical scheme, private health insurance, etc.)		11%
External Funds (off-budget)		28%

Source: MoH data (2014/15)

Data from the MoH show that in 2014/15 Government funds alone (mainly through taxes) account for about 29% of total health financing with external funds off-budget (28%) and on-budget (25%) accounting for a substantial share (Table 2). Direct out-of-pocket payments accounted for about 8% while all the health insurance schemes in the country accounted for 11% (including both employer, government and household contribution).

For CBHI members, beneficiaries pay premiums according to their *Ubudehe* stratification[25] (Table 3). The "poorest" group of enrollees (CBHI category I) that make up about 16% of CBHI target population are fully subsidised by Government and external resources from development partners through the allocation of Rwf 2,000 per beneficiary per year to the RSSB. Other categories pay premiums directlyCategories II and III contribute Rwf 3,000 while category IV contributes Rwf 7,000 per member per annum[25]. The proportion of CBHI categories I and IV beneficiaries declined between 2012 and 2015. For example, it declined from 24.8% and 2.17% in 2012 to 16.0% and 0.5% in 2015, respectively[6,25]. During this period (i.e. 2012 – 2015), the contribution rates remained the same while the proportion of categories II and III members combined increased substantially from 68.8% (in 2012)[6]to 83.5% (in 2015)[25].

Table 3: CBHI categorisation in Rwanda

Ubudehe	CHBI category	Population coverage		Premium	Membership type
		2012	2015		
Category 1	Category I (Very poor)	24.8 %	16.0%	Rwf 2,000	Non-contributory (Fully subsidised by government and donors)
Categories 2 & 3	Categories II and III (Poor)	68.8 %	83.5%	Rwf 3,000	Contributory (Premium paying individuals)
Category 4	Category IV (Rich)	2.2 %	0.5%	Rwf 7,000	Contributory (Premium paying individuals)

Some of the challenges with revenue raising include low public financing per capita, limited private sector investment in health, declining of external funding , insufficient revenues raised by the CBHI scheme among others. Some challenges are highlighted in the table below (Table 4).

Table 4: Challenges with revenue raising, Rwanda

- Low public financing per capita
- Insufficient internal resource mobilisation
- Decreasing external funding over time as health indicators are

improving. External funding accounts for a higher proportion than the domestic funds.

- Those not covered by health insurance still make high out-of-pocket payments.
- Limited private sector investment in health
- Insufficient revenues from public health insurance scheme (CBHI) to cover health services bills

In summary, there is a critical need for increased domestic funding of the Rwanda health system, especially increased Government spending as external funds decline to ensure household spending on health does not increase and threaten Rwanda's progress in expending financial protection. Also, to raise additional revenues, there is a need to increase the participation of the private sector in health financing, but this does not have to be through increased contributions or membership of voluntary private health insurance schemes. The public health insurance system needs to be strengthened by increasing Government investment, expanding the benefits package, and continuing to optimise member contribution rates regular means testing. The cross-subsidisation between insurances schemes could also be improved.

1.4.2 Fund pooling

The major pools in Rwanda include Government taxes, contributions to health insurance schemes (CBHI and RSSB formal employees' sector medical scheme). According to the Fifth Integrated Household Living Conditions Survey (EICV5), 74% of Rwandans were covered by some form of health insurance in 2016-17, of which 93.5% of these covered by the CBHI scheme and 4.3% by the RSSB formal sector employees' scheme while private health insurance pools are very small[26].

Data from the RSSB and other sources[6,27] show that there is inequality in per capita funding for the insurance schemes in Rwanda as spending per CBHI member represents about 3% of that of the RSSB formal sector employees' medical scheme. In comparison to the CBHI, RSSB formal sector employees' medical scheme comprises a relatively small pool in terms of the number of enrollees but a relatively large pool in respect of the funding per enrollee (Rwf 117,226 in 2016/17).

Recently, the GoR instituted the principle of cross-subsidisation, where other health insurance schemes contribute 5% of their revenues to the CBHI to address some of the inequities in the distribution. In 2015/2016, cross-subsidy contributions represented 8% of the total CBHI revenues most of which (93%) came from public health insurance schemes

(RSSB formal sector employees' medical scheme and MMI). RSSB manages CBHI as a pool separate from the RSSB formal sector employees' medical scheme (RAMA). Despite bringing the CBHI scheme under the purview of the RSSB, there is no direct cross-subsidisation between these pools beyond the mandated 5% revenue cross-subsidy. RSSB formal sector employees' medical scheme coverage declined from 9.1% in 2005/06 to about 6% of the entire population in 2016/17, which could have been due to population growth.

Table 5: Challenges with revenue pooling, Rwanda

Pool size

- Uninsured population: Although insurance coverage is mandated by law, some categories remained uncovered. Identified categories include:
  - Registered employers directly finance health services for their employees (commercial banks, private companies, NGOs etc.)
  - Some small business owners, engineers, lawyers, and others who are not eligible to enrol in RSSB formal sector employees' medical scheme, MMI, etc. CBHI benefits package is not attractive due to the gatekeeping system. Generally, they do contract private health insurance schemes.
- Limited enforcement of health insurance compulsory participation (law)
- CBHI pool size is small relative to the population served: per capita expenditure is small

Pool diversity

- Fragmentation within the health insurance risks pools: CBHI versus RSSB formal sector employees' medical scheme; private health insurance schemes
- CBHI is a large pool in terms of size but with limited resources to cover the members' needs.
- CBHI scheme accumulated financial gap overtime.

Pooling of external funding

- Significant level of off-budget resources from DPs

Dual insurance coverage

In Rwanda, it is mandatory to have health insurance as established by law. CBHI enrolment is possible throughout the year. Although working in a mandatory environment, enrolling to CBHI is still voluntary. Members of other health insurance can still enrol in CBHI when they need which have significant financial risks for, particularly CBHI.

Accountability

Limited accountability of existing health insurance schemes

Although the RSSB formal sector employees' medical scheme covers formal sector employees that include low cadre to senior Government officials, there is still limited diversity. This is because enrollees are relatively similar by holding formal employment. The case is similar for MMI, MIS-UR and even more, pronounced for private health insurance that covers those that can afford premiums charged by the private health insurance schemes. In general, the sizes of the pools vary between different insurance schemes. Such variation means that there is an uneven risk pool, especially within the largest insurer in Rwanda (i.e. the CBHI). Data from 2016/17 show that the policy mandating the 5% revenue cross-subsidisation from other insurance schemes has not eliminated annual deficit which stood at 42.6% as at 2016/17. A summary of the various health financing mechanisms in terms of the pooling arrangement is provided in Table 6.

In summary, while Rwanda has made significant progress in improving the pool of funds in the health sector, some challenges remain. One of these challenges relates to the fragmentation of pools. The current arrangement is problematic because the share of funds that each pool does not reflect the share of the population that it serves – spending per CBHI member remains smaller than spending per RSSB formal sector employees' medical scheme member, for instance.

Table 6: Summary of fund pooling arrangements in Rwanda

Financing mechanism	Pool size	Diversity of pool	Participation	Sustainability
General taxes	Substantial size	Very diverse; formal and informal workers – the entire population	Income taxes are mandatory by law. Indirect taxes are mandatory but are based on consumption patterns	Very sustainable as GoR is to be the main player in the health sector. There is a need to increase tax compliance, efficiency and revisit tax rates structure, not necessarily increasing tax rates.
CBHI	Substantial in size of the pool as it is the largest insurer in Rwanda covering the informal sector. However, it is relatively small when the share of funds that flow through the CBHI is compared to the population it serves (>84% of the population).	Relatively diverse covering different socio-economic class, including the rich and non-rich informal workers. However, members from the very top *Ubudehe* category remains very small.	Participation in any health insurance is mandatory by law. However, it is not compulsory to belong to a CBHI unless you do not belong to any other health insurance scheme.	Relatively low given the prevailing provider payment mechanism (fee for service) that is associated with cost escalation and oversupply of health services. Also, the very rich informal workers are not fully exploited in terms of their joining CBHI and their premium structure. On the other hand, increasing the share of revenues that other health insurance schemes allocate to the CBHI (i.e. the cross-subsidy between insurance schemes) may increase sustainability in the short term. One factor that assists in its sustainability is the transfer of management to the RSSB. This was aimed at reducing administrative costs, among other things. However, recent data show that the administrative cost is higher for CBHI compared to RSSB formal sector employees' medical scheme even though they are both managed by the RSSB. In 2016/17, administrative cost comprised over 20% of CBHI total income. This is substantial to induce deficits.

RSSB formal sector employees' medical scheme (former RAMA)	The small size of the pool in terms of the number of enrollees but substantial in terms of the share of total health funds that it has compared to the population it serves (<10%).	Relatively diverse as it covers formal sector employees at all levels (low to high cadres). However, enrollees are relatively similar by holding formal employment.	Participation in any health insurance is mandatory by law. The RSSB formal sector employees' medical scheme is used mainly by formal sector workers. However, not all formal sector workers belong to RSSB formal sector employees' medical scheme.	Sustainability is relatively higher than in CBHI. However, just like the CBHI, the prevailing provider payment mechanism needs to be addressed to achieve cost containment. There is also a need to ensure that the administrative costs of the scheme and use of private health services do not hamper the sustainability of the scheme. Interestingly, administrative costs for the RSSB formal sector employees' medical scheme stood at 7.7% in 2016/17. Based on international evidence, this could be lowered.
MIS-UR	The small size of the pool in terms of the number of enrollees. However, there are substantial funds compared to the population served.	Relatively less diverse as it covers mainly staff and students that are privileged to be at the tertiary institution. Although this is the case, it still covers a spectrum of the university community ranging from poor to rich.	Participation in any health insurance is mandatory by law. MIS-UR is a closed scheme with participation based on being a student or employee at the UR.	If viewed in isolation, sustainability is relatively high. This is because the source of funds for this scheme is relatively guaranteed. Again, the use of private health facilities may impact on its sustainability unless there is continuous monitoring to ensure similarity in tariffs and ensure policies are in place to avoid cost escalation, for example. There is also a need to monitor administrative costs to ensure sustainability.
Military Medical Insurance	The relatively small size of the pool, which is primarily because of the target population. This is a 'closed' insurance scheme with eligibility criteria determined by the nature of employment.	The pool is relatively diverse as security personnel range from recruits to senior officers.	This is compulsory	Relatively sustainable because the population covered will remain in employment and would continue to contribute. Also, Government support will continue.

Private Health Insurance	The very small size of pools. Each private health insurance policy represents a pool. There is no cross-subsidisation between private health insurance pools in Rwanda.	There is limited diversity per pool (i.e. insurance scheme). This is because each pool has a relatively wealthy population that can afford premiums. The poor are heavily underrepresented in private health insurance pools in Rwanda.	Voluntary	Not sustainable due to cost escalation and small pools.
Out-of-pocket payments	The extremely small size of the pool. In fact, there is no pooling with out-of-pocket payments.	Each payer is unique. So, there is no diversity in each pool.	-	Not sustainable. This is because each individual or household pays out-of-pocket for health services. Out-of-pocket payments also comprise co-payments made by insured individuals. In some case, individuals have complained about such co-payments (including co-payment for an ambulance and patient transport) and that this may have a negative impact on their use of health services. To achieve Universal Health Coverage, out-of-pocket payments need to be minimised considerably and the poor segment of the population needs to be exempted even when there is any need to retain co-payment.

1.4.3 Purchasing health services in Rwanda

In Rwanda, health services are purchased by different organisations through different mechanisms. Purchasing organisations that are responsible for transferring and allocating resources include the MINECOFIN, the MoH, RBC, RSSB, districts, MMI funds and private health insurance funds. Government agencies, public and faith-based health facilities are allocated budgets based on the traditional input-based approach and disbursements are done every quarter. Public health budget supports staff salaries, facility capital, pharmaceuticals, supplies and operating costs. Apart from PBF that purchases outputs and outcomes and pays for outputs, public resources allocation is based mainly on the traditional input-indicators.

Table 7: Challenges with strategic purchasing

- Limited level of strategic purchasing across all public health insurance schemes (CBHI, RSSB formal sector employees' medical scheme, MIS-UR)
- Although CBHI provides a comprehensive benefits package, the availability and completeness of products, commodities, and services for treatment at partner health centres need to be improved.
- Need to revisit the current different benefits packages or define an essential comprehensive benefits package covering the population needs
- Fluctuations in drugs prices due to the lack of pricing policyStatic tariffs irrespective of pool size
- The current costing of health services need to be reviewed to reflect the actual cost Inefficiencies in purchasing from intermediaries
- Limited compliance with referral system
- No focus on quality as criteria for contracting and payment of providers

Some external funds are allocated to facilities to support different programmes. RSSB and MMI work directly with public and private facilities countrywide to ensure access to quality service for all members. CBHI contracts mainly public facilities and health posts under PCCP framework. For effective purchasing arrangement, the accreditation of health facilities remains critical. The MoH initiated the accreditation system in 2012 in the context of PBF, and a comprehensive assessment of health facilities is ongoing. There is a need to strengthen the integration of the PBF and accreditation of health facilities which began in 2015 to ensure continuous quality improvement and more sustainable outputs and outcomes for health[28]. Overall, accreditation of health facilities grew fast between 2013 to 2018,with many health facilities achieving level 1 (highest level) accreditation by 2018. The impact of this accreditation process has been positive showing that neonatal asphyxia dropped from 28% in 2013 to 7% in 2018 in Kibungo hospital, for instance, and post-caesarean section infection dropped from 8% (in 2014) to 1.4% (at the end of 2017) in Bushenge hospital[28].

Benefits package

CBHI beneficiaries are by law entitled to a comprehensive range of preventive, rehabilitative and curative services throughout the country in public facilities, and recently to private health posts at the primary health care (PHC) level. Benefits packages include inpatient and outpatient care and a list of essential drugs. The Government defined CBHI benefits packages at each level (health post, health centre, district and national referral hospitals) to ensure beneficiaries have access to a minimum (MPA), complementary (CPA) and tertiary services packages. The health centres and health posts serve as gatekeepers to mitigate moral hazard at the hospitals. CBHI also reimburses ambulance costsand a referral system is used to determine the route by which different services are accessed. Patient roaming system is also introduced to allow CBHI beneficiaries to access care anywhere in the country. Despite the comprehensiveness of the packages covered by the CBHI, some services, products and commodities at partner institutions are not available, leaving insured patients to pay for services/ commodities out-of-pocket at some private establishments[29].

Members of RSSB formal sector employees' medical scheme, MMI, MIS-UR and private health insurance schemes are also entitled to a comprehensive benefits package that includes inpatient, outpatient and emergency services in both public and accredited private health facilities. Although the defined benefits packages are almost identical at all levels of care across health insurance schemes in Rwanda, RSSB formal sector employees' medical scheme, MMI, MIS-UR and private insurance schemes have extended drug coverage (beyond the national list) and cover higher health costs.

Provider payment mechanism

Overall, health service purchasing in Rwanda can be described as passive. In general, payment to providers in Rwanda is based on fee-for-service across the schemes. Based on international experience, this payment mechanism often leads to the escalation of cost of care and increased supply of services. Rationing mechanisms applicable to all schemes include cost-sharing upon treatment (15% for MMI/RSSB, 10% for CBHI); one-month waiting time and list of medicines/services covered. The reimbursement rates are based on the standards and regulations set by the MoH.

Performance-Based Financing (PBF)

The Rwanda MoH introduced the Performance-Based Financing (PBF) strategy in 2004 and later institutionalised it in 2008. This was to, among other things, strengthen the health system and improve the provider payment mechanism. It restructures the flow of resources to reimburse for specified health outcomes rather than merely reimbursing for the processes or services that health workers delivered.

During the last decade, Rwanda has successfully introduced PBF at all levels of the healthcare delivery system. This has strongly contributed to improvements in health

outcomes and yielded efficiency gains for the health system. It is noted that PBF is among the mechanisms that helped the country to attain health-related MDGs. For the last few years, considerable improvements have been made such as linking PBF to the accreditation programme at the hospital level to ensure quality and sustainable outcomes including health outcomes. However, the sustainability of PBF remains a challenge. Even though the GoR is currently the major funder of the PBF programme, development partners still provide substantive support. Using data from the MoH, in 2010-11, Global Fund accounted for 56% of PBF budget, and this declined to 35% by 2015/16. It is estimated that domestic funds will cover the PBF almost entirely by 2024 if the current trend persists.

A summary of health service purchasing in Rwanda is provided in Table 8. Overall, there are elements of strategic purchasing in the Rwanda health system. However, there is room for improvement, especially in ensuring that the purchase of health services for the population is in line with the needs of the population and that quality health services are provided. To ensure this, the information system in the country must be aligned to provide timely and relevant information for decision making.

Table8: Summary of health service purchasing in Rwanda

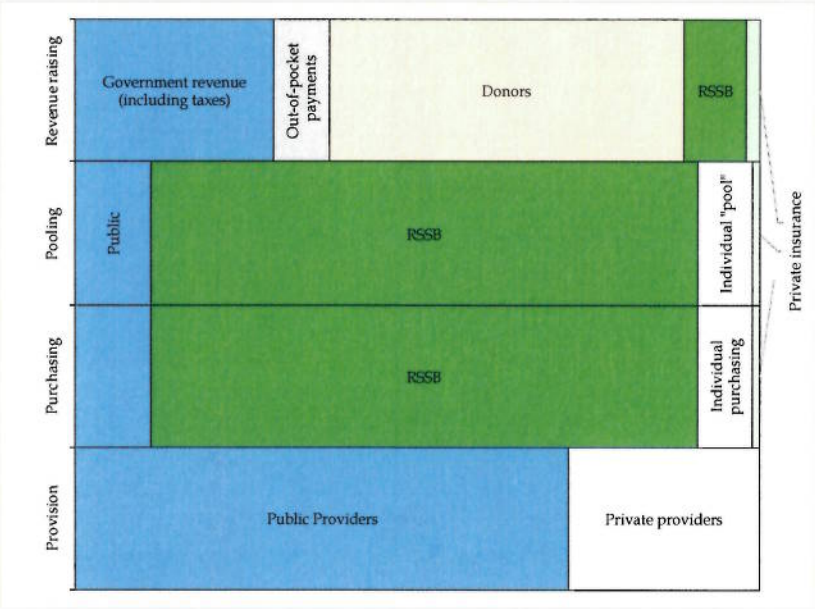
Financing mechanism	Benefits entitlements	Provider payment structure	Co-payment	Strategic purchasing elements
GoR (through general taxes)	All Rwandans	• Budget: Transfer of funds to cover the costs of services through staff salaries. • PBF	-	PBF
CBHI	Government defined CBHI benefits package at each level (community, health post, health centre, district and national referral hospitals) Both inpatient and outpatient services in public health facilities. These include preventive and curative services, ambulance, laboratory and pharmacy services. Recently, out-patient care at private health posts and public-private community partnership health posts. In some case, referrals can be approved by the RSSB Medical Committee to King Faisal hospital The referral system is mandatory with exceptions for accidents and other emergency cases.	Fee-for-services	• Flat co-payment fee at health centres and health posts (Rwf 200): Members pay Rwf 200 co-payment at each health centre visit • 10% of bills at hospitals	Contracted health facilities Audit provider claims
RSSB formal sector employees' medical scheme (i.e. former RAMA)	Both inpatient and outpatient care in public and private facilities	Fee for service	• 15% of bills	Contractual arrangement Audit provider claims
MMI	Both inpatient and outpatient care in public	Fee for service	• 15% of bills	

	and private facilities			
Private health insurance	Both inpatient and outpatient care in public and private facilities	Fee for service	• Vary	

1.1 Summary assessment of Rwanda's health financing system

Rwanda's success in health financing reforms including PBF strategy and CBHI scheme has contributed to the significant improvements in equity in health service usage, financial protection and overall health profile of the population. The country was able to cover a very high proportion of the population with health insurance within a relatively short time. This was made possible by strong political will and the general desire of the country to achieve universal access to health services.

Figure 7: Summary of health financing, by functions, Rwanda, 2014/15



Sources: USAID (2015); HRTT (2014/15); CBHI report; USAID private

Overall, a snapshot of the health financing landscape in Rwanda is shown in Figure 7.

In summary, revenue raising is predominantly from external funds with some substantial share from Government funds. There are substantial pooled funds in Rwanda predominantly through the RSSB that oversees the CBHI and the RSSB formal sector employees' medical scheme. Purchasing of health services is predominantly through the RSSB.

More than 90% of the population is covered through the CBHI and the RSSB formal sector employees' medical scheme where there is greater access to public providers than private providers. Individual purchasing occurs through out-of-pocket payments, including co-payments while a small share of purchasing is through private health insurance. Provision of health services is predominantly from public facilities in Rwanda. Private services, apart from those provided through health posts, concentrated mainly in Kigali City, is growing steadily. There is also a need to increase investment in health infrastructure to improve access to health care.

1.2 Conclusion

Rwanda's health financing system has substantially evolved over the past 25 years. While health services were free of charge immediately after 1994 Genocide against Tutsis, the

need to introduce user charges was based, among other things, on cost recovery and revenue generation.

Rwanda's health insurance system was born to address some of the challenges facing the country including the need to protect the poor and vulnerable – a commitment that is at the heart of the GoR. Specifically, the CBHI reform has been hailed as one of the most successful health sector initiatives in Africa. In fact, with the mandatory enrolment law, over 90% of the population is currently insured. Although the CBHI is the largest insurer, other schemes that exist in the country include some social health insurance schemes (RSSB formal sector employees' medical scheme, MMI, MIS-UR) and a few private health insurance plans. Currently, the CBHI scheme and RSSB formal sector employees' medical scheme are both housed within the Rwanda Social Security Board. The GoR has made significant strides in financing health services. However, external funds still comprise the bulk of the health portfolio in the country. With this, the sustainability and/or improvement of the current health financing system is critical in order to sustain the gains and cover future needs associated with the growing burden of diseases.

CHAPTER 2: VISION, MISSION AND HEALTH FINANCING STRATEGIES

2.1 Vision

All Rwandans have access to a comprehensive package of quality and people-centred health-care services without financial hardship.

2.2 Mission

The mission of the Health Financing Strategic Plan is to strengthen financial risk protection for all Rwandan citizens and ensure universal access to quality health services (including prevention, promotion, treatment and rehabilitation) to achieve towards UHC.

2.3 Strategic Objectives

The overall objective of this strategy is to strengthen current financing mechanisms for health and accelerate progress toward UHC through raising sufficient resources and ensuring an equitable distribution of health resources, improving equity and efficiency in health financing system.

This overall objective will be attained through the following strategic objectives:

1. To strengthen effort towards resources mobilisation to ensure availability of adequate and sufficient resources to finance the delivery of health services in line with HSSP IV;
2. To increase effective pooling and strengthen strategic purchasing mechanisms that ensure the attainment of equitable and efficient resource allocation and delivery of quality health services
3. To promote equity in access to and utilisation of health services and reduce barriers to health care services
4. To enhance efficiency and equity in allocation and use of health sector resources to increase the value for money of public spending
5. To strengthen coordination mechanisms that will ensure effective partnership among public sector, private sector and development partners in financing and delivery of health services.
6. Encourage and incentivise quality improvement in health care delivery and enhance the population's satisfaction and engagement in healthcare decisions;
7. To enhance systems for the timely production of quality and credible health budget and expenditure information to inform policy dialogue and decision making.

2.4 Comprehensive Strategic Framework

This document outlines the key strategic objective and interventions mainly along with the three main health financing functions (revenue raising, pooling and strategic purchasing). It is recognised that other factors lie outside the health sector, i.e. the social determinants of health, that are important to address to ensure that the health financing system performs well. While these Social Determinants of Health are not within the scope of this work, substantially investing in the social determinants of health needs to happen in Rwanda.

The following set of criteria guided the development of health financing strategies:

- Relevance to the Rwanda health system
- Evidence-based – i.e. following critical challenges identified in the situation analysis
- Alignment with existing national policies and strategies (including the Health Sector Policy, Health Financing Sustainability Policy, HSSP IV, National Strategy for Transformation (NST1), Vision 2050)
- Adherence to the guiding principles of the 2015 Health Sector Policy namely, people-centred, integrated; and sustainable health care services.
- Efficiency gains and cost containment
- Measurability – can be measured with indicators
- Understandable – everyone agrees and understands the importance
- Achievable (feasible) and time-bound
- Can contribute to ensuring access, equity, efficiency, accountability, and health system performance

It is important to know that each intervention is significant and important. Thus, the approach to prioritisation of these strategies, as adopted in this document, is to label each intervention as a short-term, medium-term or long-term. Short-term interventions are those that can be implemented within a relatively short period while long-term interventions will only be achieved over an extended period, typically more than 10 years.

2.5 STRATEGIC FOCUS 1: Revenue raising strategies

Accelerating progress toward UHC requires that Rwanda's health financing system routinely generates sufficient, equitable, predictable and largely domestic resources. Revenue raising strategies are intended to address the current challenges of limited fiscal resources to finance the health sector, limited private sector engagement in health, dependency on external resources with much less predictability, and for strengthening PFM.

Several revenue-raising strategies are envisioned in the short-, medium- and long-term. The

Box 1 below contains a summary of the key strategies.

Box 1: Major strategies for resource raising for health in Rwanda

1.1 Increase GoR revenues/resources allocated to the health sector
1.2 Support and incentivise public health facilities and institutions to generate internal revenues through income generating activities (IGAs)
1.3 Strengthen the long-term financial sustainability of CBHI and Implement strategies to generate revenues for the scheme
1.4 Advocate for the funding alignment and harmonisation of external resources and for more aid resources to flow through the GoR for funding predictability
1.5 Increase private sector engagement through large private businesses in Rwanda to make substantial contributions to finance health services
1.6 Explore the feasibility and practicality of implementing innovative health financing strategies to raise more revenue for the health sector
1.7 Mobilise diaspora to increase contributions to the health sector

2.5.1 Strategy 1.1: Increase GoR revenues/resources allocated to the health sector

Although Rwanda has met the Abuja target, spending 17% of Government budget across all sectors on health and health-related activities, per capita Government spending on health remains inadequate to meet the needs of the people of Rwanda — the HSSP IV estimates that $60 per person will be needed[7]. Also, external funds have declined substantially over the last decade. The MoH should actively engage in continuous dialogue with the Government (especially with MINECOFIN) to articulate its needs (i.e. make a strong case for increasing its allocation from domestic budget) through effective planning and discuss possible financing options for supplementing external funds and closing financial gaps. The increased allocation could come from a growth in the tax base and increased tax compliance, which needs to be improved. There should also be discussions regarding the use of "sin tax"[1] to finance health services in Rwanda.

To do this, there is a need to strengthen stewardship and governance within the MoH to provide evidence in support of the increased need for more allocation to health that will not jeopardise allocations to other key Government activities.

Strategic interventions

1.1.1 Developing business cases to improve resource mobilisation capacities especially for underfunded interventions
1.1.2 Ensuring that revenues raised should aim to meet the minimum of $60 per capita based

[1]In the context of Rwanda, this is an excise tax for some products that are considered harmful to health.

	on the HSSP IV
1.1.3	Advocating for increased funding for underfunded priority areas according to the HSSP IV

2.5.2 Strategy 1.2: Support and incentivise public health facilities and institutions to generate internal revenue through specific income generating activities

In the very short-term, public health facilities and institutions should be supported and incentivised to establish income generating activities/projects (IGAs) to raise more internal revenues and to meet the need of the population they serve. Because this requires that the services provided through these income generating activities be paid for out-of-pocket, this should not be used as a long-term strategy. Such income generating activities should be limited to services like hotel services, class wards, private wings, etc. Further, there needs to be a guideline in terms of how health service users pay for services provided through the IGAs and the transparent and accountable use of resources generated.

Capacity building in resource generation and allocation is a high priority area, as all the levels in the sector, from primary to tertiary and central levels are constrained by limited skills to initiate and implement IGAs. Health facilities managers need to receive further leadership, management and business-oriented training to strengthen their capabilities in resource mobilisation to raise additional revenues for health facilities.

Strategic interventions	
1.2.1	Establishing legal and policy framework on IGAs (including opportunities for specific products or services depending on location and local market)
1.2.2	Building the capacities of health managers and District Health Management Teams (DHMT) in creating and implementing IGAs for health facilities
1.2.3	Supporting and incentivising public health facilities and institutions to generate internal revenues through income generating activities (IGAs)
1.2.4	Promoting access to financing and technical support to implement and monitor identified income generating projects based on institutional requests
1.2.5	Strengthening accountability mechanisms for reporting internal revenues in public facilities
1.2.6	Creating a peer learning network among facilities on IGAs

2.5.3 Strategy 1.3: Strengthen the long-term financial sustainability of CBHI and Implement strategies to generate revenues for the scheme

The contribution of the CBHI scheme in accelerating progress towards UHC in Rwanda is remarkable. However, the sustainability of CBHI is threatened by financial constraints. CBHI

deficits[24]are projected to rise to over Rwf 20 billion by 2021 if the current trends in deficits persist. Thus, there is a need to ensure its sustainability. GoR should consider/envision to increase people's contribution to the CBHI scheme as the economy grows. Because it is envisaged that in the long-term, public health insurance schemes in Rwanda will be harmonised, the strategies to ensure the sustainability of the CBHI will be short- to medium-term.

Strategic interventions

1.3.1 To conduct a study on CBHI sustainability to provide evidence on the actual cost of health services at public health facilities vis-a-vis the current CBHI benefits package and to provide information on CBHI Financing gap and the quantified strategies to be implemented to close this gap.

1.3.2 Developing alternative funding sources for the CBHI according to the CBHI sustainability study findings

1.3.3 Conducting an actuarial study to estimate the appropriate contribution levels for the population and determine an optimum level of cross-subsidy, over and above the current 5% of incomes from other health insurance schemes, to the CBHI to substantially reduce deficits. This may not be the same percentage for each health insurance scheme in Rwanda.

2.5.4 Strategy 1.4: Advocate for the funding alignment and harmonisation of external resources and for more aid resources to flow through the GoR for funding predictability

Although there is a decline in external funds in Rwanda, external resources still account for about 60% of health financing[7]. In this regard, it is crucial to improve the alignment and coordination among current externally funded projects. This will improve efficiency and value for money and minimise the duplication of efforts. MoH needs to strengthen joint planning and budgeting of external funds, for both on- and off-budget support to ensure coherence and alignment with sector priorities.

Strategic interventions

1.4.1 Constantly consolidating and aligning implementation of development initiatives to national needs and priorities, even in the case of off-budget support

1.4.2 Continuing to advocate for sector budget support or other effective forms of financial aid to buy more results through accountability and a results-based financing framework

2.5.5 Strategy 1.5: Increase private engagement through large private businesses in Rwanda to make substantial contributions to finance health services

There is an ongoing discussion on how to increase the participation of the private sector in financing health services in Rwanda. While voluntary health insurance schemes should be minimised substantially in financing for UHC, there are other avenues that Rwanda can explore to increase collaborations between the public and private sectors.

Based on the direction of the GoR, the MoH and RDB have indicated interest in making Rwanda a medical tourism hub for the region. As part of this, the promotion of medical tourism will attract foreign money into the Rwandan general revenue system which could be allocated to the health sector. These medical tourists will be charged full costs (without Government subsidies) when using public health facilities. Also, private health facilities will be required to contribute a given fraction of receipts from medical tourists into a shared pool to subsidise, e.g. CBHI or other Government activities in short- to medium-term. Because of the centrality of a healthy workforce for productivity, and as part of a broader corporate social responsibility (CSR), medium to large private businesses should be encouraged to donate a given percentage of their annual turnover as an investment towards financing health services in Rwanda. To make this option attractive, the Government could make this portion tax-exempt.

There are also avenues to raise money by the private sector investing in specialised care.

Strategic interventions

1.5.1	In the medium- to long-term, customising Public Private Partnership (PPP) guidelines for the health sector based on the law to attract local and foreign investment in health and make Rwanda a medical tourism hub in the region
1.5.2	Enhancing the policy dialogue with the private sector (including a platform for information sharing between the public and private sectors)
1.5.3	In terms of corporate social responsibility, a policy should be developed for medium to large private businesses to contribute a given share of their turnover (before tax) to the health sector. This portion could be tax-exempt
1.5.4	Attracting private sector to invest in specialised care
1.5.5	Creating a platform for information sharing on potential investment opportunities in the health sector
1.5.6	Continuous analysis of opportunities, trends, and potential risks for private investment in health in Rwanda

2.5.6 Strategy 1.6: Implement innovative health financing strategies to raise more revenue for the health sector

The HSSP IV refers to the promotion of innovative mechanisms including the use of "health bonds" to attract social and philanthropic investment into the health sector to raise additional revenue[7]. Other possible innovations include revenues from traffic fines, revenue from vehicle registration, etc. to financing health services without reducing overall

allocation to the health sector. Depending on many factors, these could raise substantial revenues for the health sector.

Strategic interventions

1.6.1 Studying the feasibility of different innovative financing mechanisms including the development of impact bonds (short term, with MINECOFIN)

1.6.2 Strengthen structures (e.g. institutions, legal framework, human resource capacities, etc.) to ensure the sustainability of the various innovative funding sources.

2.5.7 Strategy 1.7: Mobilise diaspora to increase contributions to the health sector

Rwanda has a significant number of highly educated citizens in the diaspora with the potential to play a critical role in Rwanda development process. The country can continue to step up efforts to involve its citizens around the world in the country's transformation agenda. This provides a good base to advocate for donations to finance health services.

Strategic interventions

1.7.1 Establish transparent fundraising mechanisms from diaspora members directed to benefit the health sector. Such funds should be harmonised to avoid fragmentation.

Table 9: linking strategies to major challenges identified in the situation analysis (revenue raising)

	Strategy	Timing	Some major challenge(s) being addressed
1.1	Increase GoR revenues/resources allocated to the health sector	☑ Short-term ☑ Medium-term ☑ Long-term	Low per capita Government funding (<$60 per capita)[7]
			Substantial portion of external funding which is decreasing
1.2	Support and incentivise public health facilities and institutions to generate internal revenues through income generating activities (IGAs	☑ Short-term ☐ Medium-term ☐ Long-term	Limited capacity of public health facilities and institution to generate and use internal resources
1.3	Strengthen the long-term financial sustainability for CBHI and Implement strategies to generate revenues for the scheme	☑ Short-term ☑ Medium-term ☐ Long-term	Insufficient revenue from CBHI. In fact, a consistent deficit in the CBHI (over Rwf 12 billion in 2016/17)[24]
1.4	Advocate for the funding alignment and harmonisation of external resources and for more aid resources to flow through GoR for funding predictability	☑ Short-term ☑ Medium-term ☐ Long-term	Substantial portion of external funding which is decreasing
			Fragmented external resources (e.g. vertical financing of programmes).
			A substantial portion of external funding for health remain off-budget
1.5	Increase private sector engagement through large private businesses in Rwanda to make substantial contributions to finance health services	☑ Short-term ☑ Medium-term ☑ Long-term	Limited private sector engagement in health financing
			Limited promotion of corporate social responsibility (CSR) activities in health
			Limited capacity within the MoH, RDB and RBC for effective PSE and PPP development
			Insufficient regulatory frameworks of PSE and PPP in health
1.6	Explore the feasibility and practicality of implementing innovative health financing strategies to raise more revenue for the health sector	☑ Short-term ☑ Medium-term ☑ Long-term	Substantial portion of external funding which is decreasing
			Low per capita Government funding (<$60 per capita)[7]
1.7	Mobilise diaspora to increase contributions to the health sector	☑ Short-term ☑ Medium-term ☑ Long-term	Low per capita Government funding (<$60 per capita)[7]

2.6 STRATEGIC FOCUS 2: Effective revenue pooling strategies

Revenue pooling is an important health financing function. In the context of UHC, international evidence supports the use of mandatory pooling systems as opposed to voluntary schemes to guarantee access to health services. Although necessary, raising substantial revenues to attain the Abuja target or the $60 per capita estimated in the HSSP IV is not enough to guarantee UHC. Revenue pooling deals with the size, coverage and fragmentation of the risk pool, the diversity of the risk pool and the extent of risk and income cross-subsidisation of pools. The viability of any health financing system depends heavily on the effectiveness of the pooling function.

Box 2: Major strategies for effective revenue pooling for health in Rwanda

2.1. Increase pool size where possible and coverage of health risk pools
2.2. Set up a risk equalisation mechanism and enforce health insurance coverage in Rwanda

2.6.1 Strategy 2.1: Increase pool size and coverage of health risk pools, set up a risk equalisation mechanism and enforce health insurance coverage in Rwanda

One of the challenges of the CBHI in Rwanda is the diversity of the pool and the size of the pool. Some individuals remain uninsured. There is a need to sensitise the public, including the youth aged between 20-35 years (who represent 27% of the population) to enrol and generate additional resources for the health insurance scheme, especially the CBHI in short- to medium-term. The following activities have been proposed, mainly as short- to medium-term strategies.

Strategic interventions

2.2.1 Enforcing coverage and compliance of all registered employers in the health insurance schemes (e.g. RSSB formal sector employees' medical scheme) and register new employers

2.2.2 Enhancing, sensitising and facilitating young people's enrolment through the Rwanda Cooperative Agency (RCA) and other organised platforms or channels

2.2.3 Strengthening partnership with RCA, RDB, RRA, PSF and other organised groups/platforms to register new scheme members

Table 10: linking strategies to major challenges identified in the situation analysis (revenue pooling)

	Strategy	Timing	Some major challenge(s) being addressed
2.2	Increase pool size and coverage of health risk pools, set up a risk equalisation mechanism and enforce health insurance coverage in Rwanda	☑ Short-term ☑ Medium-term ☐ Long-term	Enrolment in CBHI is not complete. There exists an uninsured population even though insurance membership is mandatory.

2.7 STRATEGIC FOCUS 3: Strategic purchasing

The health financing purchasing function is very critical to ensuring that people get the services that they need. This requires that health purchasing strategies should aim for achieving and sustaining efficiency gains in the health sector by, among other things, reviewing provider payment systems, re-negotiating tariffs, and improving the linkage between quantity and quality of health services through accreditation standards. It should also encourage desired service delivery improvements and strengthen population participation and ownership.

The strategies (short- to long-term) presented in Box 3 have been suggested to achieve strategic purchasing in Rwanda, in line with the core principles of UHC.

Box 3: Major strategies for active health service purchasing in Rwanda

3.1 Strengthen the links between purchasing and quality of health services provision using a strong autonomous accreditation body

3.2 Design essential benefits package and strengthen the capacity of the purchaser (RSSB in the short- to medium-term) to be a strategic purchaser

3.3 Strengthen the incentive mechanisms for CHW programme, including community PBF and ensure sustainable quality service provision.

3.4 Strengthening and automating various systems (PFM, HIS, HRTT, drug procurement, etc.) to provide the needed support structures for achieving and sustaining strategic purchasing.

3.5 Strengthen the PFM capacity in the health sector to ensure efficient and accountable use of public resources to deliver quality health services

3.6 Maximising efficiency in the allocation and use of existing health resources and improving coverage of high impact interventions

2.7.1 Strategy 3.1: Strengthen the links between purchasing and quality of health services provision using a strong autonomous accreditation body

The provision of quality health services is key to achieving sustained good outcomes in the health sector. Accreditation can be useful to institutionalise quality improvement and efficiency in purchasing continuously.

An autonomous entity should be created and charged with the responsibility of institutionalising quality improvement. The accrediting entity requires clearly defined legal functions and rules, along with the organisational structure, roles and relationships.

Strategic interventions

3.1.1 Establishing and strengthening an autonomous accreditation body to accredit health service providers (public and private) continuously
3.1.2 Expanding accreditation programme to private providers and PHC facilities
3.1.3 Strengthening regulation of quality for medicines, consumables and medical equipment
3.1.4 Using accreditation as a basis for contracting and purchasing health services (from both public and private providers) to provide quality services.

2.7.2 Strategy 3.2: Design essential benefits package and strengthen the capacity of the purchaser (RSSB in the short- to medium-term) to be a strategic purchaser

In the short- to medium-term, given that the RSSB will be a major player as laid out in Figure 8, there is a need for strengthening its capacity to among other things, initiate and manage contracts with service providers, adapt appropriate cost-containing provider payment mechanisms, ensure that services provided by providers (public and private) are in line with the needs of the population, etc. This could involve training and acquisition of skills and capacities to effectively function as a strategic purchaser. Another important activity is to harmonise the benefits entitlements (to be sustainable, acceptable, accessible and affordable), that should be cost-effective. This will provide access to the same quality and quantity of services based on need.

In terms of provider payment, capitation (including weighted capitation to accounts for demographic and epidemiology profile of the target population) could be the preferred method for primary health services at lower levels of care. At the hospital level, the Diagnosis-Related Group (DRG) classification system could be used to remunerate providers. It is important also to stress that provider payment mechanisms will require continuous refinement based on emerging population needs and changing provider behaviours. Further, to contain costs, the referral system (e.g. gatekeeper mechanism) needs to be strengthened with providers required to show evidence of adhering to the appropriate referral path before reimbursement.

Generally, where possible, the capacities of the RSSB or any other public entity that acts as the purchaser needs to be built and strengthened to administer these activities effectively.

Strategic interventions

3.2.1 Designing a cost-effective essential benefits package entitlement, regardless of scheme, based on the needs and disease burden of the population that is affordable and will be revised and updated every 3-5 years
3.2.2 Designing and continually refine provider payment mechanisms for outpatient, inpatient and PHC services that will ensure cost-containment and provide the right incentives for effective provision of quality health services.

3.2.3	Capacitating the purchaser (RSSB in the short- to medium-term) to effectively function as a strategic purchaser including institutional capacity building and functional information systems for decision making

2.7.3 Strategy 3.3: Strengthen the incentive mechanisms for CHW programme, including community PBF and ensure sustainable quality service provision

Sustainability of the CHW programme is critical to providing access to cost-saving interventions at scale and ensuring UHC. Although CHWs in Rwanda are volunteers, the country has made a substantial investment in CHW cooperatives for incentivising and retaining CHWs. This progress needs to be sustained by strengthening the management of CHW cooperatives. The recent evaluation of the Community Health Programme (CHP) [31] reiterates the need to strengthen the capacity of CHWs to improve health services delivery at the community level. To make CHWs visible throughout the country, their distribution is also critical. There is a need to ensure that they are adequately distributed considering their demands across the country.

Strategic interventions

3.3.1	Assessing performance and effectiveness of CHW cooperatives and continuously revising the model and provide technical support for CHW cooperatives to strengthen management to improve the sustainability of the CHW programme
3.3.2	Ensuring regular assessment of CHW capacity needs and gaps for implementation and sustainability of CHW programme
3.3.3	Improving on the CHWs model to ensure equitable distribution of CHW (e.g. by population density, distance from the facility, and residence/ geographic location)
3.3.4	Reviewing and expanding prevention and promotion service packages into the CHWs programme to benefit from cost-effective investments in the programme
3.3.5	Strengthening the collaboration with the administrative districts through unions of CHWs cooperatives to invest in significant income generating projects.

2.7.4 Strategy 3.4: Strengthening and automating various systems (PFM, HIS, HRTT, drug procurement, etc.) to provide the needed support structures for achieving and sustaining strategic purchasing

Strategic purchasing requires the existence of structures that will ensure equity, efficiency and provision of needed quality health services. Areas that need attention include the PFM, HRTT, drug procurement process, etc.

Strategic interventions

3.4.1 Conducting critical assessments of each support system (e.g. PFM, HIS, HRTT, drug procurement) to identify areas for strengthening and integration of information systems

3.4.2 Consolidating existing health information systems to ensure interoperability and timely availability of data. In the long-term, these should be linked to an automated claims management system

3.4.3 Ensuring that HRTT is strengthened, expanded and institutionalised for timely collection and reporting of information for both the public and private health sectors to inform policy and decision making

3.4.4 Ensuring that the capacities of the central level Planning teams (MoH and RBC) are strengthened for effective and efficient resource tracking activities and reporting for the HRTT

3.4.5 Strengthening integrated inventory, planning and pooled procurement of health supplies including use of LMIS

3.4.6 Reviewing and updating medicine purchasing and pricing policy and encourage the use of generics

2.7.5 Strategy 3.5: Strengthen the PFM capacity in the health sector

Rwanda has made significant progress in its PFM reforms. However, there are still areas that have emerged that need to be strengthened especially regarding human resource capacity in PFM. To this effect, MINECOFIN developed a PFM Learning & Development Strategy in 2016. Based on the findings from the situation analysis, the following activities have been proposed under this strategy.

Strategic interventions

3.5.1 Strengthening capacities (e.g. in planning, budgeting and resource mobilisation, accounting and reporting) for effective PFM in Rwanda to increase accountability and responsiveness of the system to local needs

3.5.2 Strengthening the use of IFMIS in health centres and the integration of external funds, (CDC) into IFMIS including the recovery of data formerly used in TOMPRO.

3.5.3 Strengthening the use of IFMIS in district hospitals, including the quality of accounting and reporting of budget officers and oversight capacity of managers

3.5.4 Reviewing the profile, roles and responsibilities of Boards of Directors (BoD) and strengthen the capacity of the BoD members to oversee and provide feedback on financial performance of facilities.

2.7.6 Strategy 3.6: Maximising efficiency in the allocation and use of existing health resources and improving coverage of high impact interventions

Addressing existing inefficiencies and improving cost containment would generate savings and at the same time improve the ability of the sector to invest in quality improvement, expand services and increase funding sustainability of the health system. Continuous efforts are required to achieve the efficiency gains necessary to accelerate progress toward UHC. This can be done in short to long-term. The appropriate strategy to use will depend on the peculiar situation at a health facility. Therefore, the starting point will be an in-depth analysis of efficiency to identify key drivers of inefficiency. The World Health Organization's Service Availability and Readiness Assessment (SARA) can be used as a starting point. Depending on the major drivers, possible responses include reallocation of capital investment towards primary health care and health posts, refining the provider payment arrangements such as using capitation for primary health care and Diagnostic Related Groups (DRGs) for hospital inpatient services. It is suggested that medicines and medical supplies could be procured via a less expensive channel than that currently in operation, for instance. The suggested strategy here is to procure drugs from elsewhere in order to tap into lower procurement costs and achieve cost containment. These strategies are aligned with those in HSSP IV.

Key activities

3.6.1 Strengthening accountability mechanisms for reporting internal revenues in public health facilities

3.6.2 Performing efficiency analysis and studies for an in-depth analysis of efficiency to identify key bottleneck in terms of overlaps, wastage of resources, and inefficiency at each facility and in the health sector overall (see also the HSSP IV).

3.6.3 Ensuring/promoting efficiency gains in the management of existing health facilities resources (including medical equipment) based on evidence from efficiency studies. Specific actions are required at each health facility and in the health system, based on diagnosis

Table 11: linking strategies to major challenges identified in the situation analysis (purchasing)

	Strategy	Timing	Some major challenge(s) being addressed
3.1	Strengthen the links between purchasing and quality of health services provision using a strong autonomous accreditation body	☑ Short-term ☑ Medium-term ☐ Long-term	Except for the accreditation process linked with PBF, there is a lack of an autonomous accreditation body to accredit public and private providers
3.2	Design essential benefits package and strengthen the capacity of the purchaser (RSSB in the short- to medium-term) to be a strategic purchaser	☑ Short-term ☑ Medium-term ☐ Long-term	Although there is relatively similar benefits package, RSSB medical scheme, MMI, MIS-UR and private insurance schemes have extended drug coverage (beyond the national list) and cover higher health costs
			Although CBHI provides a comprehensive benefits package, drugs are sometimes not readily available especially as some CBHI beneficiaries fill in prescriptions at private pharmacies without reimbursement
			Limited level of strategic purchasing across all public health insurance schemes (CBHI, RSSB formal sector employees' medical scheme, MIS-UR) in Rwanda
3.3	Strengthen the incentive mechanisms for CHW programme, including community PBF and ensure sustainable quality service provision	☑ Short-term ☑ Medium-term ☑ Long-term	Limited sustainability of CHWs cooperatives
3.4	Strengthening and automating various systems (PFM, HIS, HRTT, drug procurement, etc.) to provide the needed support structures for achieving and sustaining strategic purchasing	☑ Short-term ☑ Medium-term ☐ Long-term	Limited interoperability between HIS
			Non-institutionalisation of the HRTT
			Limited availability of information/data on household expenditures and private health expenditures
			Weak PFM in health facilities (especially with regards to planning, accounting, reporting)

			The IFMIS has not been fully operationalised as some modules are yet to be rolled out
			Weak capacity of the BoD of hospitals to conduct PFM oversight
			Lack of integrated and standardised budget process for public health facilities (hospitals, health centres)
3.5	Strengthen the PFM capacity in the health sector	☑ Short-term ☑ Medium-term ☐ Long-term	Weak PFM in health facilities (especially with regards to planning, accounting, reporting)
3.6	Maximising efficiency in the allocation and use of existing health resources and improving coverage of high impact interventions	☑ Short-term ☑ Medium-term ☑ Long-term	Lack of guidelines of use of internally generated revenues (IGR)

PTER 3: FUNDING GAP ANALYSIS

In addition to assessing the overall health financing system in Rwanda, this chapter provides a brief snapshot of funding gaps for the health sector using information from the HSSP IV. A financial gap analysis is critical given the high cost of the HSSP IV plan in order to determine the affordability of the plan and to assess the need for resource mobilization strategies. This section presents an analysis based on current level of funding using the recent data from Health Resource Tracking Output Report and the projected cost of the HSSP IV. This financial gap analysis determines the current and future resource needs and quantify potential funding shortfall for the health sector over the next seven years.

This involves two steps: First, a mapping exercise of current and future funding was conducted to estimate and forecast the resource envelope available to the health sector through 2024. Both internal and external sources of funding, including domestic public (government) resources, on-budget development partner resources, and off-budget development partner resources as well as NGO resources, insurance premiums and out-of pocket payments were considered in this analysis. Second, the available resources were then compared with the projected cost estimates of achieving the strategies outlined in the HSSP4. The analysis was done for six years, following the total cost for HSSP IV, starting in 2018 and going to 2024. Using the projected cost of the HSSP 4, financial gap (shortfall) or surplus for the health sector were determined.

Using the projected cost of the HSSP4 [7], as shown in Table 12, the country will sit with a surplus estimated at Rwf 120 billion in 2018, but this will soon become a deficit in the following years as there will be massive investment needed to achieve greater health outcomes[7]. The total deficit for the entire duration of the plan (2018-2024) will be Rwf 660 billion (see Table 12). This will be the case if the current level of external support remains relatively constant with household spending (out-of-pocket payments) increases at the rate of inflation (about 5%) and insurance premiums rising by a modest of 2.6% annually at the rate of population growth. Ideally, reducing out-of-pocket payments, in line with the move towards UHC will mean that the country will sit with a more significant deficit to be financed. This needs to be borne in mind.

It is important to note that the health financing strategic document provides a much richer analysis than just a means to close the financing gap reported in Table 12. Apart from raising revenue, the Health Financing Strategic Plan is useful to address efficiency, design appropriate benefits packages, and ensure that funds are pooled effectively together to strategically purchase health services to ensure equitable utilisation of health services in Rwanda. This is because filling this financing gap in Table 12 does not guarantee in any way that health services will serve those that need them. Some deliberate attempts and policies are needed. Therefore, all the aspects of the Health Financing Strategic Plan are fundamental to ensure that Rwanda achieves UHC.

Table 12: Projected health sector funding surplus or shortfall, 2018-2024, using the HSSP IV estimates (Rwf Millions)

Year	HSSP IV projected costs (a)	Total health funding (b)	Financing gap using the HSSP IV (C) = (b)-(a)
2018	340,161	460,770	120,609
2019	718,162	477,466	(240,696)
2020	600,151	495,574	(104,577)
2021	658,739	515,217	(143,522)
2022	711,153	536,530	(174,623)
2023	622,617	559,643	(62,974)
2024	639,188	584,748	(54,440)
Total	**4,290,171**	**3,629,949**	**660,222**

CHAPTER 4: MONITORING AND EVALUATION

Monitoring and evaluation (M&E) processes and interventions for this strategic plan will be integrated within existing M&E functions and systems to ensure congruency, transparency and greater participation of key stakeholders. Monitoring the implementation of the strategic plan will also require regular and comprehensive refinement of mechanisms over time, and ownership at all levels of the health sector.

Through the Joint Health Sector Review, Health Sector Working Groups, Planning & Health Financing Technical Working Group and other platforms, M&E indicator package will be regularly reviewed, revisited and disseminated for routine monitoring.

Annex 1: Health Financing Strategic Plan logical framework

Based on the strategies proposed in the HFSP 2018-2024 and the accompanying activities, a logical framework is proposed in the Matrices below. The framework is divided into three sections covering the three health financing functions – Revenue raising, pooling and purchasing.

Matrix 1: Logical framework for the revenue generation function of health financing, Rwanda

Strategy Activity		Responsibility	Other collaborating partners	Indicator	Baseline	TIMING	Target (year)	Source of Data
1.1	Strategic objective 1.1: Increase GoR revenue/resources allocated to the health sector			% of GOR budget allocated to health	17% (2016)	Short-, medium- to long-term	~20% (2024)	HRTT report MTF report
1.1.1	Developing business cases to improve resource mobilisation capacities especially for underfunded interventions	MoH RBC	DPs	Number of the business case developed	No business case	Short term	By 2020, at least 2 business case for investment in the underfunded programmes is developed	Business case report
1.1.2	Strengthening the capacity of MoH to advocate for more resources, including the need to increase the country's tax base	MoH, RBC, MINECOFIN	DPs	# of MoH staff trained in health resource advocacy	-	Short to medium term	By 2024, at least 5 core MoH staff capacitated to be able to negotiate and advocate for increased resources for health	Report on training
1.1.4	Ensuring that revenues raised	MoH, RBC, MINECOFIN	DPs, CSOs	Per capita expenditure on health	$53?		At least $60 per capita raised by	MINECOFIN MoH

Strategy Activity		Responsibility	Other collaborating partners	Indicator	Baseline	TIMING	Target (year)	Source of Data
	should aim to meet the minimum of $60 per capita based on the HSSP IV					Short to Medium Term	2024	Report HRTT MTEF
1.1.5	Advocate for increased funding for non-communicable diseases (NCDs) and other key priority areas based on the HSSP IV	MoH, RBC	DPs, civil society organisations (CSOs)	% of GoR expenditure on NCD and health promotion	Limited funding to NCDs	Short to medium term	By 2024, NCDs receive a share of funding that is proportionate to the share of NCDs in the burden of disease in Rwanda	MoH and RBC annual report MTF HRTT
1.2	Support and incentivise public health facilities and institutions to generate internal revenues through income generating activities (IGAs)			**% of health facility revenues from IGAs**	0%	Short to medium term		
1.2.1	Establishing Legal and policy framework on IGAs (incl. opportunities for specific products or services depending on	MoH, MINECOFIN	DPs, Local Governments (administrative districts)	Policy and guidelines on IGA in place and implemented	No specific policy document or guideline exists	Short to medium term	2024, a policy document providing guidelines for IGA developed and implemented	MINECOFIN MoH reports

Strategy Activity		Responsibility	Other collaborating partners	Indicator	Baseline	TIMING	Target (year)	Source of Data
	location and local market)							
1.2.2	Building the capacities of health managers and district health Management Teams (DHMT) in creating and implementing IGAs for hospitals	MoH, MINECOFIN	DPs, Local Governments (administrative districts)	▪	No training exists	Short-term	By 2024, all DHMT fully trained to implement the policy on IGR	Report of training of DHMT MINECOFIN MoH
1.2.3	Supporting and incentivising public health facilities and institutions to generate internal revenues through income generating activities (IGAs)	MoH, MINECOFIN	DPs, Local Governments (administrative districts)	▪ Number (or %) of hospitals undertake feasibility studies for IGAs % of health facilities implementing IGAs	No training exists 2%?	Short term	>80% of health facilities?	Health facilities financial reports HRTT reports
1.2.4	Promoting access to	MoH, MINECOFIN	DPs		None	Short to medium	By 2024, at least 90% of all requests	Health Facilities

Strategy Activity		Responsibility	Other collaborating partners	Indicator	Baseline	TIMING	Target (year)	Source of Data
	financing and technical support to implement and monitor identified income generating projects based on institutional requests					term	for further training or support on IGR activities and projects are attended	reports MoH/ MINECOFIN reports Expert opinion
1.2.5	Strengthening accountability mechanisms for reporting internal revenues in public facilities	MoH MINECOFIN	DPs	Coherent policy and guidelines developed	No specific policy document or guideline exists	Short to medium term	By 2024, a policy document providing guidelines for IGR developed and implemented	IFMS Expert opinion
1.2.6	Creating a peer learning network among facilities on IGAs	MoH, MINECOFIN	DPs, Local Governments (administrative districts)	Learning network or a reference group on IGAs established and fully functional	None	Short term	By 2020, a Learning Network/reference group is fully institutionalised to support planning and evidence-based decision making on IGAs	Minutes of meetings MoH MINECOFIN Health

Strategy Activity		Responsibility	Other collaborating partners	Indicator	Baseline	TIMING	Target (year)	Source of Data
								facilities
1.3	Implement strategies to generate revenues for the CBHI and strengthen the long-term financial sustainability of the scheme			% of CBHI expenses covered by premium payments	63%	Short to medium term		
1.3.2	Conducting an actuarial study to estimate the optimal contribution and determine an optimum level of cross-subsidy, over and above the current 5% of incomes from other health insurance schemes, to the CBHI to substantially reduce deficits. This may not be the same percentage for	RSSB	MINECOFIN, MoH, DPs, MINALOC		Currently, 5% of revenues from other health insurance schemes are allocated to the CBHI	Short-term	By 2020, an actuarial study completed determining the "optimum" percentage of cross-subsidies from other health insurance schemes to the CBHI. These percentages should be specific to each health insurance scheme	Actuary study report

Strategy Activity		Responsibility	Other collaborating partners	Indicator	Baseline	TIMING	Target (year)	Source of Data
	each health insurance scheme in Rwanda.							
1.3.3	Developing alternative funding sources for the CBHI	MINECOFIN, RSSB, MoH	Private sector federation (PSF)	% of resources raised from an alternative source of revenue for CBHI	These alternative sources of revenue do not exist	Short to medium term	By 2020, a detailed study on the feasibility of different alternative financing options conducted. By 2022, the alternative sources should be implemented to raise additional revenues for the Public Health Insurance	MoH Reports MINECOFIN reports
1.4	Advocate for the alignment, harmonisation and coordination of external resources and for more aid resources to flow through the Government of Rwanda for funding predictability			**% of external funding in the form of financial aid**	External resources account about 60%	Short to medium term		
1.4.2	Constantly consolidating	MoH, MINECOFIN	DPs		More than 50%		By 2024, at least 95% of	MoH reports

Strategy Activity		Responsibility	Other collaborating partners	Indicator	Baseline	TIMING	Target (year)	Source of Data
	and aligning implementation of development initiatives to national needs and priorities, even in the case of off-budget support						development initiatives (from off-budget support) are aligned to national priorities	HRTT report
1.4.3	Continuing to advocate for sector budget support or other effective forms of financial aid to buy more results through accountability and a results-based financing framework	MoH, MINECOFIN	DPs		Less than 50% of external funds go through the budget	Short to medium term	By 2024, achieve at least 75% of external funds as on-budget support	HRTT report
1.5	Increase private engagement through large private business in Rwanda to make substantial contributions to finance health services			% of private sector expenditure of overall health expenditure		Short, medium and long term		
1.5.1	In the medium-to-long-term,	MoH, RBC,	DPs, PSF		The proposal is		By 2024, Rwanda should be ready to	RDB, MoH

Strategy Activity		Responsibility	Other collaborating partners	Indicator	Baseline	TIMING	Target (year)	Source of Data
	customising Public Private Partnership(PPP) guidelines for the health sector based on the law to attract local and foreign investment in health and make Rwanda a medical tourism hub in the region	private healthcare providers association, RDB			currently in its infancy	Short term	become a medical tourism hub in the region. This will raise additional revenue for the health sector	
1.5.2	Enhancing the policy dialogue with the private sector (including a platform for information sharing between the public and private sectors)	MoH RDB	PSF DPs private healthcare providers' association		Limited dialogue and no formal platforms and systems for a public and private engagement	Short term	By 2020, MoH should promote greater interaction, partnership and dialogue between MoH and private sector	MoH RDB PSF reports
1.5.3	In terms of corporate social responsibility, a	MoH, RDB	DPs, PSF		No policy exists		By 2022, a policy is developed, and private businesses	MoH reports

Strategy Activity		Responsibility	Other collaborating partners	Indicator	Baseline	TIMING	Target (year)	Source of Data
	policy should be developed from medium to large private businesses to contribute a given share of their turnover (before tax) to the health sector. This portion should be tax exempt.	private healthcare providers	MINECOFIN			Medium term	contribute at least 10% of their turn-over (before tax) to the health sector to finance the Public health insurance (including the expanded public health insurance)	MINECOFIN reports
1.5.4	Attracting private sector to invest in specialised care	MoH RBC RDB	PSF DPs Private providers association,	Legal frameworks for PSE and PPP reviewed and disseminated Communication strategic plan established and implemented in order to attract potential investors based on key priorities/opportunities (including an investment teaser, media, etc.)	No policy exists	Short, medium and long-term	By 2022, a policy is developed, and private businesses contribute at least 10% of their turn-over (before tax) to the health sector to finance the public health insurance (including the expanded public health insurance)	RDB & MoH reports

Strategy Activity		Responsibility	Other collaborating partners	Indicator	Baseline	TIMING	Target (year)	Source of Data
1.5.5	Creating a platform for information sharing on potential investment opportunities in the health sector	MoH RBC RDB	PSF DPs Private providers association,	Platform established and fully functional	Limited dialogue and no formal platforms and systems for a public and private engagement	Short-term	By 2020, formal platforms/spaces for dialogue between MoH and private sector players established and institutionalised	Minutes of meeting Reports
1.5.6	Continuous analysis of opportunities, trends, and potential risks for private investment in health in Rwanda	MoH RBC RDB	Private providers association, PSF		No study identified yet	Short-term	By 2020, relevant studies and desk reviews conducted to benchmark best practices as well as risks for investing in health	Report on situation analysis
1.6	Implementing innovative health financing strategies to raise more revenue for the health sector				# of alternative sources to raise additional revenues for the health sector	Short medium and long-term		

Strategy Activity		Responsibility	Other collaborating partners	Indicator	Baseline	TIMING	Target (year)	Source of Data
1.6.3	Studying the feasibility of different innovative financing mechanisms including the development of impact bonds (short term, with MINECOFIN)	MINECOFIN, RSSB, MoH	Private sector federation (PSF) DPs		This alternative source of revenue does not exist	Medium Term	By 2020, a detailed study on the feasibility of different alternative financing options conducted. By 2022, the alternative sources should be implemented to raise additional revenues for the Public Health Insurance	MoH reports MINECOFIN Reports DPs reports
1.6.4	Strengthen structures (e.g. institutions, legal framework, human resource capacities, etc.) to ensure sustainability of the various innovative funding sources	MINECOFIN, RSSB, MoH	DPs	Legal framework for innovative funding sources disseminated	Legal framework does not exist	Medium term	By 2024, legal frameworks for and innovative funding sources developed, disseminated and implemented	

	Strategy Activity	Responsibility	Other collaborating partners	Indicator	Baseline	TIMING	Target (year)	Source of Data
	Mobilise diaspora to increase contributions to the health sector							
1.7.1	Establish fundraising mechanisms from diaspora members directed to benefit the health sector. Such funds should be harmonised to avoid fragmentation	MoH MINAFET	Rwanda Diaspora Associations	% of health resources generated through Rwanda diaspora	Limited and fragmented support exists	Short to medium term	By 2022, a detailed report on the level of resources that can be obtained from tapping into the diaspora population	MoH & Rwanda diaspora report Expert opinion

Matrix 2: Logical framework the revenue pooling function of health financing, Rwanda

Strategies Activities		Responsibility	Other collaborating partners	Indicator	Baseline		Target	Source of information
2.1.	**Increase pool size and coverage of health risk pools, set up a risk equalisation mechanism and enforce health insurance coverage in Rwanda**			Health insurance coverage increased	% of the population enrolled in CBHI or other formal insurance schemes	Short-medium-long-term	By 2022, 94% of the population insured	
2.1.1	Enforcing coverage and compliance of all registered employers in the health insurance schemes (e.g. RSSB formal sector employees' medical scheme) and register new employers	RSSB Private health insurances	Employers, insurers, Rwanda Health Insurance Council (RHIC), Private Sector Federation (PSF)		Mandatory insurance membership exists in the law (84% in 2017/2018)	Short-term	By 2020, enforcement of enrolment and contribution collection	RSSB annual report Expert opinion
2.1.2	Enhancing, sensitising and facilitating young people's enrolment through Rwanda Cooperative Agency	RSSB Private health insurances	RCA, National Youth Council, Local		Limited coverage of young people	Short-term	By 2020, at least 95% of young people (<30 years) enrolled through RCA or	RSSB annual report Expert opinion

Strategies Activities		Responsibility	Other collaborating partners	Indicator	Baseline		Target	Source of information
	(RCA) and other organised platforms or channels		Governments (administrative districts)				other organised platforms are enrolled in the CBHI scheme	
2.1.3	Strengthening partnership with RCA, RDB, RRA, PSF and other organised groups/platforms to register new scheme members	RSSB	Insurers, Rwanda Health Insurance Council (RHIC), RRA, RDB, RCA, PSF		Limited partnerships	Short term	By 2020, achieve an effective partnership with key stakeholders	RSSB annual report Expert opinion
2.2.5.	Setting up a risk equalisation mechanism to equalise risks between CBHI Scheme and RSSB formal sector employees' medical scheme	RSSB MINECOFIN	DPs MoH MINALOC	Legal framework for RSSB formal medical scheme reviewed to improve cross-subsidisation	5% revenue cross-subsidy	Short to medium term	By 2022, an improved risk equalisation between CBHI and RSSB medical scheme in place and fully implemented	RSSB Annual report
2.3.2.	Planning towards merging the CBHI and RSSB formal sector	MoH MINECOFIN RSSB	DPs		No detailed study identified	Short to	By 2022, a report on the feasibility, opportunities,	RSSB MoH MINECOFIN

	Strategies Activities	Responsibility	Other collaborating partners	Indicator	Baseline		Target	Source of information
	employees' medical scheme together: *Commission a detailed study into the feasibility, opportunities, threats and viability of merging all public health insurance schemes in the country*			Study report		medium term	threats and viability of merging all public health insurance schemes in the country is developed	Reports Expert opinion

Matrix 3: Logical framework for purchasing function of health financing, Rwanda

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
3.1	Strengthen the links between purchasing and quality of health services provision using a strong autonomous accreditation body			**% of public health facilities that are accredited**	National accreditation standards established	Short-term	**Ensure the split of function between evaluator-provider and purchaser**	
3.1.1	Establishing and strengthening an autonomous accreditation body to accredit health service providers (public and private) continuously	MoH	DPs	Autonomous accreditation body in place and fully functional	Both accreditation and PBF exist	Short-term	By 2020, an autonomous body for the accreditation of health service providers is in place.	MoH reports
3.1.2.	Expanding accreditation programme to private providers and PHC facilities	MoH	DPs	% of public and private health facilities accredited	Accreditation limited to public health facilities	Short-term	By 2020, at least 50 % of private health providers have been accredited	MoH reports Accreditation report Expert opinions
3.1.3.	Strengthening regulation of quality for medicines, consumables and	MoH RBC	DPs, Health care providers	Adherence to regulations	The Rwanda Pharmacy Policy 2016 exists	Medium term	By 2022, the regulations will be implemented to mitigate medical	MoH &RBC (MPPD) reports

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
	medical equipment						errorsand improve the efficiency of medical equipment	
3.1.4.	Using accreditation as a basis for contracting and purchasing health services (from both public and private providers) to provide quality services under the unified and expanded public health insurance in Rwanda	MoH Health insurance schemes	NHIC, Healthcare Providers (both public and private)	% of facilities contracted on the basis of accreditation standards	Limited	Medium to long-term	By 2022, accreditation serves as the basis for contracting health service providers to provide services under the unified and by 2024 under the expanded public health insurance in Rwanda	▪ MoH Report ▪ Health Insurance reports ▪ Contract agreements between the purchaser and providers
3.2.	Design essential benefits package and strengthen the capacity of the purchaser (RSSB in the short- to medium-term) to be a strategic purchaser					Short to medium term		
3.2.1.	Designing a cost-effective essential benefits package	MoH, health insurance schemes	NHIC, healthcare providers	Essential benefits package established for the	Limited and associated with ***Equity***	Short	By 2020, a cost-effective essential	MoH & RSSB Reports

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
	entitlement, regardless of scheme, based on the needs and disease burden of the population that will be revised and updated every 3-5 years		(both public and private)	entire population of Rwanda and reimbursed by health insurance schemes	***issues*** *:*Health insurance schemes with different benefits packages	to mediu m term	benefits package entitlement for the entire population that is equitable, accessible and affordable is developed. This is revised every 3 years	
3.2.2.	Designing and continually refine provider payment mechanisms for outpatient, inpatient and PHC services that will ensure cost-containment and provide the right incentives for effective provision of quality health services.	MoH RSSB	DPs RHIC Other public health insurance scheme (MMI, MIS/UR)	Provider payment mechanisms refined to encourage cost containment and obtain efficiency gains	Fee for service remains the main mechanism	Mediu m and Long term	By 2024, provider payment mechanisms are refined to encourage cost containment and obtain efficiency gains	MoH reports
3.2.3.	Capacitating the purchaser (RSSB in the short- to	MoH RSSB	DPs Other public health		Limited capacity as purchasing is	Short to Mediu	By 2020, the RSSB is engaged in strategic	MoH & RSSB Reports

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
	medium-term) to effectively function as a strategic purchaser including institutional capacity building and functional information systems for decision making		insurance scheme (MMI, MIS/UR)		mainly passive with limited elements of active purchasing	m Term	purchasing (i.e. services are provided according to the needs of the population, contracts are enforced accordingly, cost-containment is key with provider remuneration aligned to the objectives of efficient and equitable delivery of services, etc). This is in preparation for the merger in later years.	
3.3.	Strengthen the incentive mechanisms for CHW programme, including community PBF and ensure sustainable quality service provision.				**% of primary care encounters**	Short, mediu m and		

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
					delivered by CHW	long term		
3.3.1.	Assessing performance and effectiveness of CHW cooperatives and continuously revising the model and provide technical support for CHW cooperatives to strengthen management to improve the sustainability of the CHW programme	MoH RBC	DPS RCA MINECOFIN Local Government (administrative Districts)	% of CHWs Cooperatives with improved leadership and management	▪ 70% of community PBF financed by external resources from development partners and not sustainable ▪ Limited support provided to CHWs cooperative	Short to medium term	▪ By 2020, a detailed assessment of the state of CHW cooperative finance is done. ▪ By 2020, private companies recruited to support the management of CHW cooperatives. ▪ By 2022, at least 95% of CHW cooperatives are provided with technical support to	MoH Reports RBC Reports Expert opinions

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
							strengthen management and to improve sustainability	
3.3.2.	Ensuring regular assessment of CHW capacity needs and gaps for implementation and sustainability	MoH RBC	DPs	% of CHW cooperative provided with technical support	Limited assessment	Short term	By 2020, a detailed assessment of challenges and needs of CHWs cooperative is	Assessment reports

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
	of CHW programme						done	
3.3.3.	Improving on the CHWs model to ensure equitable distribution of CHW (e.g. by population density, distance from the facility, and residence/ geographic location)	MoH, RBC, district hospitals	Local Governments (administrative districts)	Number of active CHWs per village	Currently, 3 CHWs per village	Medium term	By 2022, conduct a detailed study on the appropriate distribution of CHWs by villages and implement this. This should be based on the needs of the different populations	Minutes of meetings Reports
3.3.4.	Reviewing and expanding prevention and promotion service packages into the CHWs programme to benefit from cost-effective investments in the programme	MoH RBC	DPs	A revised of CHWs package of activities developed, disseminated and implemented		Medium term	By 2020, conduct a review of service packages of CHWs to include some cost-effective interventions that promote the welfare of the population	Reports of meetings
3.3.5.	Strengthening the collaboration with the administrative	MoH RBC District	MINECOFIN, Local Govts (administrativ		Limited number	Short to mediu	▪ By 2020, Partnership is enhanced	Reports of meetings and an

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
	district through unions to invest in big projects	Hospital	e districts), RCA,	Number of CHW unions investing in big projects		m term	through regular stakeholders meeting and taking necessary actions ▪ By 2024, collaborations with the administrative district through unions to invest in big projects is institutionalised	assessment of actions taken
3.4	Strengthening and automating various systems (PFM, HMIS, HRTT, LIMS, drug procurement, etc) to provide the needed support for achieving and sustaining strategic purchasing.					Short to mediu m term		
3.4.1.	Conducting critical assessments of each support system (e.g. PFM, HIS, HRTT, drug procurement) to identify areas for	MoH, RBC	DPs,	Priority areas for strengthening HIS identified in the health sector	Limited assessments	Short to	By 2022, each major support structure needed for ensuring efficient purchasing of health services	Assessment reports MoH

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
	strengthening and integration of information systems		Healthcare providers			medium term	(e.g. PFM, HRTT, etc) should be assessed critically to identify areas where they need to be strengthened	
3.4.2.	Consolidating existing health information systems to ensure interoperability and timely availability of data. In the long-term, these should be linked to an automated claims management system	MoH, RBC, RSSB	DPs, healthcare providers	▪ Automation of processes/ operations around a unified or common IT reporting platforms	Limited interoperability	Short to medium term	By 2024, at least 95% of all the information systems should be interoperable with the expanded public health insurance scheme	MoH reports Expert opinions
3.4.3.	Ensuring that HRTT is strengthened, expanded and institutionalised for timely	MoH	Service providers, Health insurance schemes,	▪ HRTT fully institutionalised to support evidence-based decision making in the	HRTT not yet institutionalised		By 2022, HRTT is fully institutionalised to support evidence-based decision making	HRRT reports on a yearly basis

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
	collection and reporting of information for both the public and private health sectors to inform policy and decision making		All reporting institutions, DPS	move towards UHC ▪ Number of HRTT reports produced			in the move towards UHC,and it collects and reports information on both the public and private sectors	
3.4.4	Ensuring that the capacities of the central level Planning teams (MOH and RBC) are strengthened for effective and efficient resource tracking activities and reporting for the HRTT	MoH	DPs	5 MoH staff in Health Financing Unit Number of HRTT reports produced	Only less than 2 MoH staff actively involved in HRTT	Short term	By 2022, at least 5 MoH staff should be actively involved in the HRTT. This is essential once it is institutionalised.	HRRT reports produced on a yearly basis
3.4.5.	Strengthening integrated inventory, planning and pooled procurement of	MoH RBC	DPs Health facilities		Limited use of LMIS	Short to medium term	▪ By 2022, the health sector characterised by improvement	MoH and RBC Reports Expert opinions

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
	health supplies including use of LMIS						in procurement procedures and reduced duplication of procurement effort	
3.4.6.	Reviewing and updating medicine purchasing and pricing policy and encourage the use of generics	MoH, RBC	DPs, Public Healthcare providers, Private and public Pharmacies Association of private providers	An updated list of essential medicines	The Rwanda Pharmacy Policy 2016 exists	Short-term	By 2024, the Rwanda Pharmacy Policy should be revised to be in line with the new Expanded Public Health Insurance. It should promote the use of generics for cost containment, among other things	MoH RBC reports Expert opinion
3.5.	Strengthen the PFM capacity in the health sector				% of health facility revenues from internal sources	Short to medium term		

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
3.5.1	Strengthening capacities (e.g. in planning, budgeting and resource mobilisation, accounting and reporting) for effective PFM in Rwanda to increase accountability and responsiveness of the system to local needs	MoH, MINECOFIN	Local Governments (administrative districts), DPs	Number of internal audits conducted % of facilities and institutions with clean audit Technical support and supportive supervision increased	Limited. E.g. health facility managers are not very well equipped in planning, budgeting, etc	Short to medium term	By 2020, the capacities at least 95% of health facility managers are built and strengthened for effective PFM in the country	Report of training MoH Report Internal audit Reports Auditor General reports
3.5.2	Strengthening the use of IFMIS in health centres and the integration of external grants (CDC) into IFMIS including the recovery of data formerly used in TOMPRO.	MoH MINECOFIN	Local Governments (administrative districts), DPs	▪ Number (%) of facilities (health centres and institutions with IFMs ▪ % of health facility revenues from internal sources	Limited rolled-out of IFMs in the health centre	Short-term	By 2020, IFMS is fully rolled out in health centres	

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
3.5.3	Strengthening the use of IFMIS in district hospitals, including the quality of accounting and reporting of budget officers and oversight capacity of managers	MoH MINECOFIN	Local Governments (administrative districts), DPs	▪ Number of relevant trainings organised at sub national levels	Limited capacities of health facility managers in planning, budgeting and resource mobilisation	Short-term	By 2020, Mechanism for capacity development (coaching, mentorship & on-job training) reinforced for hospital staff	Report of training Expert opinions
3.5.5	Reviewing the profile, roles and responsibilities of BoD (MoH) and strengthen capacity of the BoD members to oversee and provide feedback on financial performance of facilities.	MoH MINECOFIN	Local Governments (administrative districts), DPs	% of BoDs members trained in a health facility	Limited capacities of BoDs	Short-term	By 2020, profiles, roles and responsibilities of BoDs reviewed, and relevant training conducted	Health Facility reports MoH reports Expert opinions
3.6.	Maximising efficiency in the allocation and use of existing health resources and improving coverage of high impact interventions					Short to medium term		

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
3.6.1.	Strengthening accountability mechanisms for reporting internal revenues in public facilities	MoH, MINALOC	DPs	▪ % of health facility revenues from internal sources ▪ Policy/guidelines on IGRs established	Limited reporting of internal revenues No specific policy document or guideline exists	Short-term	By 2020, a review of the current situation and landscape of IGRs is conducted. This should highlight areas where capacity is needed	Internal audit reports MoH & MINECOFIN reports
3.6.2.	Performing efficiency analysis and studies for an in-depth analysis of efficiency to identify key bottleneck in terms of overlaps, wastage of resources, and inefficiency at each facility and in the health sector overall (see also the HSSP IV).	MoH, MINECOFIN	DPs, Local Governments (administrative districts)	Number of efficiency analysis and study reports	No analysis study identified	Short to medium term	By 2020, a detailed efficiency analysis report (for both public and private sectors) is produced. Significant drivers of inefficiencyare identified	MoH reports Health facilities reports

Strategic Activities		Responsibility	Other Collaborating partners	Indicator	Baseline	Timing	Target	Source of information
3.6.3.	Ensuring/promoting efficiency gains in the management of existing health facilities resources (including medical equipment) based on evidence from efficiency studies. Specific actions are required at each health facility and in the health system, based on diagnosis	MoH, MINECOFIN	DPs	Lists of specific actions to promote efficiency at different levels	Very limited	Short to medium term	By 2024, need to ensure efficiency in resource use is institutionalised based on the specific recommendations from the detailed efficiency study	MoH Reports Expert opinions

Institutional arrangement for the implementation of the Health Financing Strategic Plan 2018-2024

After the approval and national validation of the HFSP 2018-2024, the MoH will develop an implementation plan and annual operational plans in a timely manner. Over the next 6 years, several interventions will be implemented to translate the vision, mission and the strategic objectives of this HFSP into reality.

The implementation of a strategic plan is a complex process involving a wide range of institutions and stakeholders within and outside the health sector. It implies the involvement of public and private sectors and development partners. Strong coordination and advocacy across key stakeholders and institutions should remain targeted and focused, to successfully implement the proposed strategic interventions, and achieve sustainability in the long-term.

Existing coordination mechanisms within the health sector

Rwanda's health sector is managed and coordinated through a mechanism of stakeholders. The existing coordination mechanisms include:

- **Social cluster Ministries:** these include eight ministries — MoH, MINALOC, MIGEPROF, Ministry of Agriculture and Animal Resources (MINAGRI), Ministry of Education (MINEDUC), Ministry of Infrastructure (MININFRA), Ministry of Youth (MINYOUTH), and MIDMAR.

- **Health Sector Working Group (HSWG):** this is under the overall leadership of the MINECOFIN and chaired by the MoH with a co-chair from development partners.

- **Joint Health Sector Review:** this is composed of the MoH, RBC, Development Partners, Civil Society Organisations (CSOs) and the Private Sector. It is chaired by the PS in the MoH and co-chaired by the representative of Development Partners.

Governance, coordination and stakeholder engagement

The roles and responsibilities of key institutions and stakeholders identified as key players in the implementation of the HFSP are summarised below:

The Ministry of Finance will continue to play a key role in collection, mobilisation and allocation of public resources. Particularly, MINECOFIN will continue to oversee the health insurance schemes and cover contribution for the vulnerable population in *Ubudehe* category I. Furthermore, MINECOFIN will strengthen the PFM capacities and skills at all levels. MINECOFIN will explore avenues and feasibility of introducing innovative financing mechanisms to finance the health sector and other social sectors because health resources from development partners are becoming increasingly limited

The Ministry of Health (MOH) is responsible for central functions such as policy and priority setting, financial management, budget execution and audits. The MoH will actively engage in lobbying and advocacy activities for additional resources for the health and will continue to play a leading role in the advancement and enhancement of health financing performance. Additionally, MoH will provide overall leadership and coordination to ensure smooth implementation of the health financing reforms. The implementation of the HFSP does not rely on one department or division within the MoH. All relevant directorates or divisions and structures within the MoH and its affiliated agencies will participate in the implementation of different components of the strategy. Technical working groups, Senior Management and other technical committees will ensure the monitoring of progress of health financing and the implementation of strategic orientations and reforms.

The Directorate General of Planning, Health Financing and Information system (DPHFIS) will provide technical support at central and district levels and ensure coordination of existing mechanisms to strengthen the health financing system as well as a smooth implementation of the health financing strategic plan and the related implementation plan. Also, the Health Financing Unit will produce evidence, share good practices that will support planning and decision making. It is worth noting that some health financing reforms extend beyond the direct functions of MoH and call for the intersectoral collaboration and partnership. An example includes the establishment of the HRTT core team to improve resource tracking activities. This will require coordination and monitoring between different actors and institutions, including the private sector, health insurance schemes, and development partners.

Other line ministries and institutions: the implementation of the HFSP will imply an active collaboration and multi-stakeholders' approach. Some of the key institutions include those ministries in the Social Cluster, the MINECOFIN, MINALOC, RBC, RSSB, RDB, etc.

Development Partners: Given their substantial contribution in financing the sector, the development partners will continue to play a key role in supporting the implementation of the health financing strategies and reforms. Development partners will provide technical and financial support to build local capacity and will ensure the allocation of resources to population needs and priorities. Health development partners will facilitate research and continuous quality improvement of health services through evidence-based programming and planning and ensure effective documentation and dissemination of best practices.

Rwanda Social Security Board (RSSB) will play the leading role in enhancing strategic purchasing (in short- to medium-term) that involves active engagements and negotiations. RSSB will intensify mobilisation to enforce universal coverage of CBHI and compliance of all registered employers in health insurance schemes. RSSB will enhance partnership and sensitisation to register new members in health insurance schemes to improve financial protection for all Rwandans and access to quality health services. RSSB will strengthen the information system through automation of operations.

National Health Insurance Council: This will continue to collaborate with the MoH and health insurance schemes (both public and private) to improve governance and accountability of insurance schemes. In collaboration with MINECOFIN, the NHIC will play a

key role in improving equalisation and cross-subsidisation among health insurance pools and monitor the implementation of health insurance policy as well as equitable risk sharing.

MINALOC and Administrative Districts: the local Government, particularly districts, will continue to ensure successful implementation of PFM reforms in hospitals and health centres and to conduct a regular internal audit of public health facilities. Districts must deal with several actors involved in health especially local communities, the District Health Management Teams (DHMTs), civil society, development partners, private sector and other authorities at the district level. This complex environment requires district health managers to strengthen their knowledge and skills to exercise the stewardship at the sub-national level and promote a district Joint Action Forum (JAF) as well as district SWAP dynamics. In this context, the MoH and its partners will continue to support District Health Units (DHU) and DHMT. More emphasis will be placed on planning, budgeting and management, supervision and coordination of health services, financing and resource mobilisation and allocation as well as participate in designing norms and highest attainable standards. Furthermore, MINALOC will improve the socioeconomic stratification of households into *Ubudehe* categories and increase health system responsiveness to consumers and communities.

Rwanda Development Board (RDB) will register and monitor the private sector. In collaboration with the MoH, the RDB will mobilise private investment in health whereas the MoH will establish platforms for partnership and collaboration.

Private sector Federation (PSF) : MoH will strengthen partnership with the private sector and ensure that there is an increase in private investments in health by engaging large private businesses in Rwanda to make substantial contributions to finance health services. The private sector will play a complementary role in the public sector in terms of increasing geographical access to health services, and an increased scale of services provision.

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Appendixes

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