REPUBLIC OF RWANDA

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Health Financing Sustainability Policy

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Foreword

The Health Financing sustainability policy is based on the overall health sector policy which is also in compliance with the Vision 2020 of the Government of Rwanda. The health sector has been characterized by successful innovations in health financing such as the Community Based Health Insurance Schemes (CBHIS), the Performance Based Financing (PBF) approach for both health facilities and the Community Health Workers (CHW) cooperatives whose positive impact has been documented.

The Health Financing Policy of 2010 provides an overarching framework to ensure coherence of different sources of financing and the various financing mechanisms in the Sector. The Policy focused on five (5) areas i.e. (i) financial access and protection, (ii) allocation and use of resources, (iii) internal resource mobilization and financial sustainability of health facilities, (iv) effectiveness of external assistance, and (v) institutional environment for sustainable financing. The existing financing mechanisms are functioning effectively, however there is a need to put in place strategies to ensure sustainability and additional innovative ways to finance the health sector.

The revisions to the current policy emphasize on domestic resource mobilization and aligned strategies including the private sector involvement, Public Community Private Partnership frameworks, establishing new income generating projects across all levels of the health system. Strategies presented in this policy, will facilitate Rwanda to continue its path to maintaining Universal health Coverage through financial access to quality health services in an equitable and efficient manner and in a more sustainable way.

MINISTERE DE LA SANTE
REPUBULIKA Y'U RWANDA

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal Care
ART	Anti-retroviral Treatment
BTC	Belgium Technical Cooperation
CBHI	Community-Based Health Insurance
CHUB	Teaching Hospital University Butare
CHUK	Teaching Hospital University Kigali
CHW	Community Health Worker
CPA	Comprehensive Package of Activities
CSO	Civil Society Organization
DDP	District Development Plan
DH	District Hospital
DHS	Demographic and Health Survey
EDPRS	Economic Development and Poverty Reduction Strategy
EICV	Household Living Conditions Survey
EML	Essential Medicine List
FP	Family Planning
FY	Fiscal Year
GBS	General Budget Support
GDP	Gross Domestic Product
GFATM	Global Fund for Aids, Tuberculosis and Malaria
GOR	Government of Rwanda
HC	Health Centre
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
IEC	Information, Education and Communication
IFMIS	Integrated Financial Management and Information System
IMCI	Integrated Management of Child Illness
JAWP	Joint Annual Work Plan
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MOF	Ministry of Finance and Economic Planning/Minecofin
MOH	Ministry of Health/Minisanté
MLGSA	Ministry of Local Government and Social Affairs
MMI	Military Mutual Insurance
MPA	Minimum Package of Activities

MTEF	Medium Term Expenditure Framework
NGO	Non-Governmental Organization
NHA	National Health Accounts
NIS	National Institute for Statistics
OOP	Out-Of-Pocket (expenses)
PEPFAR	The President's Program for AIDS Relief
PBF	Performance-Based Financing
PFM	Public Financial Management
SDC	Swiss Development Cooperation
SBS	Sector Budget Support
SWAp	Sector Wide Approach
THE	Total Health Expenditures
USAID	United States Agency for International Development
US$	United States Dollar
WHO	World Health Organization

1. Introduction.

In line with Vision 2020, and after completing five years of implementation of EDPRS I, the Government of Rwanda developed the Economic Development and Poverty Reduction Strategy - EDPRS II (2013-2018), During EDPRS I, Rwanda experienced one of the most significant periods of growth and socio-economic progress in its history and became the tenth fastest growing economy in the world.

Rwanda has benefited from steady economic growth since 2007/8, however, the economy remains vulnerable to external shocks and local factors. In FY 2013/14, Rwanda's economy grew by 5.1%, a slower pace compared to 6.9% growth in FY 2012/13 mainly due to cuts in external budget support leading to a reduction of public spending[1].

The significant achievements in poverty reduction and equality has been well documented. The poverty headcount ratio declined from 56.7% in 2005/06 to 44.9% in 2010/11 with poverty reduction experienced particularly in rural areas where the rate fell from 61.9% to 48.7%. The Gini coefficient of national income equality fell from 0.52 in 2005/06 to 0.49 in 2010/11. It is clear that during this period, the greatest part of the Rwandan population has shared in the benefits of growth (EICV3, 2010/11). Nevertheless, persistent inequality between men and women in accessing economic resources remains one of the main challenges in addressing rural poverty[2].

Additionally, population growth stabilized and the country made great strides towards achieving the Millennium Development Goals (MDG). Significant gains were also recorded in non-income dimensions of poverty. In health, maternal mortality decreased from 750/100,000 in 2005 to 476/100,000 in 2010 and child mortality was reduced from 152/1000 live births in 2005 to 72.3/1000 live births in 2012 and infant mortality from 86 to 48.6/1000[3]. The fertility rate declined from 6.1 in 2005 to 4.6 in 2010. Over the same period, the nutritional status of stunted children fell from 51% to 44%. In education, more children attended school with enrolment in primary school reaching 96.5%. Access to improved sources of water increased to 73%[4]. Electrification has been expanded to cover 18% of households in 2012 (population census, 2012) from 3% in 2006.

While making significant strides in improving Rwanda's health status, the Health Sector remains heavily dependent on increasingly volatile and decreasing external funding. External assistance is estimated to be roughly 61% of total public spending on health[5]. To sustain the achievements

[1]BNR Annual report 2013/14, pg. 31
[2]EICV2010/11, pg.5
[3]Government of Rwanda, MoH_ Annual report, 2012-2013, Ministry of Health, November 2013, P21.
[4]Population census2012
[5] NHA 2010

of the health system, there is a critical need to mobilize public and private sector resources and to improve efficiency allocation and use of existing resources. Hence the need for an updated Health Care Financing and Sustainability Policy in line with the recently approved Health Sector Policy to support the GoR and health sector goals. This Policy is aimed toward strengthening the current health sector financing systems and guide the development of strategic innovations to improve and sustain financial accessibility and resourcing.

2. Situational Analysis

2.1 Health Financing in Global and Rwandan Health sector reform context

The importance of health financing for global and national economic growth and poverty reduction is well documented leading to health reforms. In 2001, African heads of state committed to allocating at least 15 percent of national budgets to improving health sector impact. In May 2005, the 58th World Health Assembly adopted a resolution urging member states to commit to reducing catastrophic health service expenditure and inaccessibility through increased risk pooling among populations. The World Health Organization (WHO) report of 2010,states that access to critical interventions - including for non-communicable diseases - will cost more than US$ 60 per capita per year requiring critical need for innovative strategies for mobilizing significant resources. [6]

The health system has been highly supported by development partners and Rwanda needs to take over to respond to the emerging health priorities. The Rwanda Vision 2020 considers health financial accessibility as a key priority among its strategic direction. Health is also a foundational issue developed under an EDPRSII thematic area. Financial accessibility especially stood out as a priority in the Rwanda development journey. This Health Financing sustainability Policy is aligned with the Health Sector Policy 2014 and EDPRSII which aim to ensure universal financial access to quality health services in an equitable, efficient and sustainable manner. In respect to the latter, it will contribute to the following areas: (i) Economic growth through workforce development, attraction of foreign investments in health and exports of quality health services; and (ii) Contribution to poverty reduction through reduction of catastrophic health expenditures. This will enable the Health Sector to be more contributor to GDP rather than being only consumer.

2.2 Country context

2.2.1 Population health status

Rwanda's health sector has made tremendous progress in improving the health status of the population. The reduction of maternal mortality and child mortality was respectively 56% and 61% from 2000 to 2010. A recent maternal deaths audit indicated that the number of maternal deaths in district hospital has reduced from 211 in 2010 to 175 in 2012/13.[7]Still, maternal mortality (476 deaths per 100,000 live births) and infant mortality (50 deaths per 1,000 live births) remain unacceptably high. The most frequent causes of death for all ages groups in health centers, district and provincial hospitals are neonatal illness(33.3%), prematurity(13.8%)

[6] WHO Global Health Expenditure Atlas 2012.
[7]MoH, Annual report 2012/13 p.20.

and malaria(7.2%)[8]while the top causes of morbidity in health centers are acute respiratory infections (28.8%), respiratory acute others(22.5%) and malaria(20.6%) [9]

The improvements in the health status of the population are mirrored by the improvements in health services utilization. According to Rwanda annual health statistics booklet, the primary health care utilization rate increased from 0.81 to 0.94 visits per inhabitant from 2009 to 2013[10]. According to EICV data, there has been a significant increase in service utilization between 2005 and 2010, especially within the lowest social-economic category. The proportion of the population reporting an illness and /or accident who consulted a medical practitioner increased from 31% to 40%[11]. This achievement is largely attributable to good governance and demand-side finance innovations such as Community-Based Health Insurance (CBHI).
Key health system challenges remain including continued reduction of child and maternal mortality and the increasing demand for services to address non-communicable diseases that is associated with high costs of care.

2.2.2 Health Financing Status

Over the last few years, Rwanda has developed a comprehensive financing framework for health systems building based on best practices in global health care financing. This framework was built along two main channels: (i) on the supply side, the implementation of fiscal decentralization with increased transfers from the central government to local governments and peripheral health facilities on the basis of needs and performance. (ii) On the demand side, the establishment of a health insurance system including cross-subsidies from richer to poor categories.

2.2.2.1. Resource Generation

Total health expenditure has grown from around USD 10 per capita in 1998 to almost USD 40 per capita in 2010. However, most of this growth is due to an increase in funding from donors and alliances which represented 61% of total health expenditure in 2010[12]. The two largest sources of external resources were from the US Government and the Global Fund. Private health expenditure remained lower during these years, with USD 8.2 per capita in 2010. Disease specific programs share a large proportion of total external funding. For example, HIV/AIDS, Malaria and TB programs receive over 85% of total costs from external funding largely from global disease initiatives such as the Global Fund, the President's Emergency Plan for AIDS Relief (PEPFAR), and the President's Malaria Initiative.

2.2.2.2. Resource pooling, Allocation and Purchasing

Funds flow into the Rwandan health sector from numerous sources and through many different channels. The systems of pooling, allocation and purchasing are complex with duplication and inefficient administrative costs. There are numerous direct resource streams to district hospitals

[8]HMIS booklet 2013, pg.27
[9] HMIS booklet 2013 pg.
[10]HMIS booklet 2009, pg.11 HMIS booklet 2013 pg.22
[11]EICV3 report 2010, pg.80
[12] NHA 2010

and health centres including funds from the general GoR budget, donor support, insurance schemes and co-payments as well as out-of-pocket payments from those not covered by insurance. These types of multiple flows could be streamlined in future reforms to decrease transaction costs, increase efficiency and create clearer value for money incentives for the different actors in the health financing system.

The main agents that are responsible for transferring and allocating the public health budget include the MINECOFIN, the MOH, Rwanda Biomedical Centre and Districts. Through these institutions, the public health budget supports health worker salaries, facility capital and operating costs. Aside PBF the public health budget is primarily funding the sector's inputs, not outputs.

Rwanda has achieved close to universal population coverage of health insurance through the innovative design and implementation of a combination of mandatory insurance schemes tailored to fit the needs and financial capacities of different segments of society. The difference in the scheme(s) financial mechanisms has led to inequities in per capita spending amongst the schemes. To mitigate these inequities and improve pooling across income groups, the government is actively engaging in cross-subsidisation across the insurance pools. Since the CBHI Law of 2007, private insurance firms and the government schemes, RSSB and MMI have been mandated to contribute one percent of their revenues to the national pooling risk for CBHI. This percent contribution is expected to increase with the new CBHI law (2014). The new development of the CBHI program includes its institutional review and transfer of its management to RSSB in order to maximize its efficiency.

2.2.2.3. Social Health Protection

The EICV data shows there has been significant improvement in the financial risk protection situation in Rwanda. From 2005 to 2010, the percentage of households who facing catastrophic health expenditure decreased by more than 1.5 percent. Additionally, and importantly, there was a considerable decrease in inequities associated with financial risk protection. By 2010, the risk of catastrophic health expenditure was similar between poorer and richer households and between urban and rural households.

A key objective of health finance reforms was to reduce the burden of out-of-pocket payments. General out-of-pocket dropped from USD 9.5 in 2006 down to USD 4.09 in 2010[13]. According to the DHS IV, out-of-pocket payments for high impact interventions (e.g. Reproductive Health, Child Health, Malaria and HIV/AIDS) are below USD 2 cents per capita. If domestic resources are not increased as external funding declines, there is a risk of losing the financial protection gains made.[4]

2.2.3 Health Financing sustainability challenges and gaps

Rwanda has made great strides towards increasing resources for health, especially from the GoR and external sources. However, there is a critical need for more resources and innovative

[13]Rwanda EICV

strategies to sustain achievements met and to maintain a comprehensive package of essential health services that is accessible to all Rwandans.

Major challenges include:

2.2.3.1. Unpredictability and sharp decrease of external assistance to health program versus need for more quality and diverse health services

As a result of the recent global economic crisis alongside Rwanda economic and epidemiological achievements, bilateral and multilateral funds from development partners are significantly decreasing. Increasingly finite resources requires the need to establish cost-effective priorities amongst health service interventions and target populations for maximum value for money and health status impact without compromising the availability and quality of services. These challenges are coupled with the public health commitment to universal health care, to protect the health of the most vulnerable and to meet the demand from increasing non communicable diseases. Therefore, the Non Communicable Diseases (NCD) prevention and control services are not yet fully available across the health care system (HR capacities, diagnostic and treatment technologies) and existing services are not affordable and accessible to all.

2.2.3.2.National Commitment for Health Financing

The public health budget for the health sector increased from 8.2% in 2005 to 11.5% in 2010/11[14]. This increased to 15.5% in 2012/13 given resources allocated to health within different ministries and institutions.[15]. Based on the above figures, Rwanda has met the targets of Abuja commitments.

GoR has scaled up Community-Based Health Insurance (CBHI) nationwide. Through CBHI, Rwanda has established an effective, affordable health insurance system for households operating in the informal sector. However, the fluctuation in membership of CBHI has been documented as a significant challenge towards reaching universal coverage.

There is an urgent requirement to mobilize new domestic resources with a focus on the private sector. While the private sector has been identified as a potential significant source for health investment , there remain many challenges in increasing their involvement and incentivizing their participation. These challenges are significant but not insurmountable. There is opportunity to leverage the private sector in ways that improve risk pooling, access and increase the financing and quality of health care goods and services. This Policy will layout the foundation for the private sector to complement and supplement the public sector and improve quality, accessibility, and efficiency in health care.

In addition, there is a demand from other countries for Rwanda to share its success and

[14]MoH Annual report 2012/13, pg.70
[15]MoH annual report 2012/13, pg.70

achievement in health. However, there is not a legal framework or formal systems in place to foster this new market niche. **2.2.3.3. Inefficient systems**

There is much opportunity to improve health service delivery efficiencies at all levels of the health sector.

Management inefficiencies have been documents amongst health insurance schemes. For example, an analysis of administrative costs as a share of total expenditure showed significantly high ratios e.g. 23% for CBHI. Outlier administrative costs are noted particularly for the compulsory social health insurance providers. Encouraging these institutions to increase their benefit packages or to cross-subsidize other financing agents may increase the value from resources allocated to them.

Other key opportunities to improve health services efficiencies include: ,

Improve the efficient use of health facilities assets, health personnel and commodities.

- Embrace new technologies and apply advanced communication tools to improve productivity and outputs when performing recurrent activities such as clinical care, training, M&E and oversight activities
- Improve finance management performance including financial recording, accounting, expenditure tracking and compliance with procurement rules.
- Improve the monitoring or expenditures in health facilities receiving funds from various sources such as MINECOFIN, MoH, district budgets, development partners, as well as generating their own revenue
- Better management of medical equipment and infrastructures, including a good maintenance strategies

This policy will help to rethink cost saving strategies through process improvement and reengineering in areas including management and administrative costs, supply chain, and health program interventions.

2.2.3.4. Governance and Stewardship

The Ministry of Health is improving the stewardship of the health financing system across all levels, especially putting emphasis on coordination of planning, implementation and reporting for different partners and funding sources. There is need to use national systems to ensure sustainability and foster transparency and accountability. Challenges and gaps include:(i) Only 4.7% of DP support used the GoR's budget execution procedures in 2010/11 and thus reduced the predictability of aid, (ii) over half of DP support comes from one DP source and a large amount is conducted as off-budget support, (iii) the M&E framework of the sector is considered comprehensive but also complex and does not capture the work plans of the private sector.

3. Policy Orientation

3.1. Vision

In line with the mission of Rwanda's health sector, the health financing and sustainability vision is to ensure that Rwandans have universal financial access to quality health services in an equitable, efficient and sustainable manner.

3.2. Guiding Principles and Values

The Health Sector is guided by the following guiding principles and values:

Guiding Principles:

- Equity;
- Efficiency;
- Sustainability;
- Coherence.

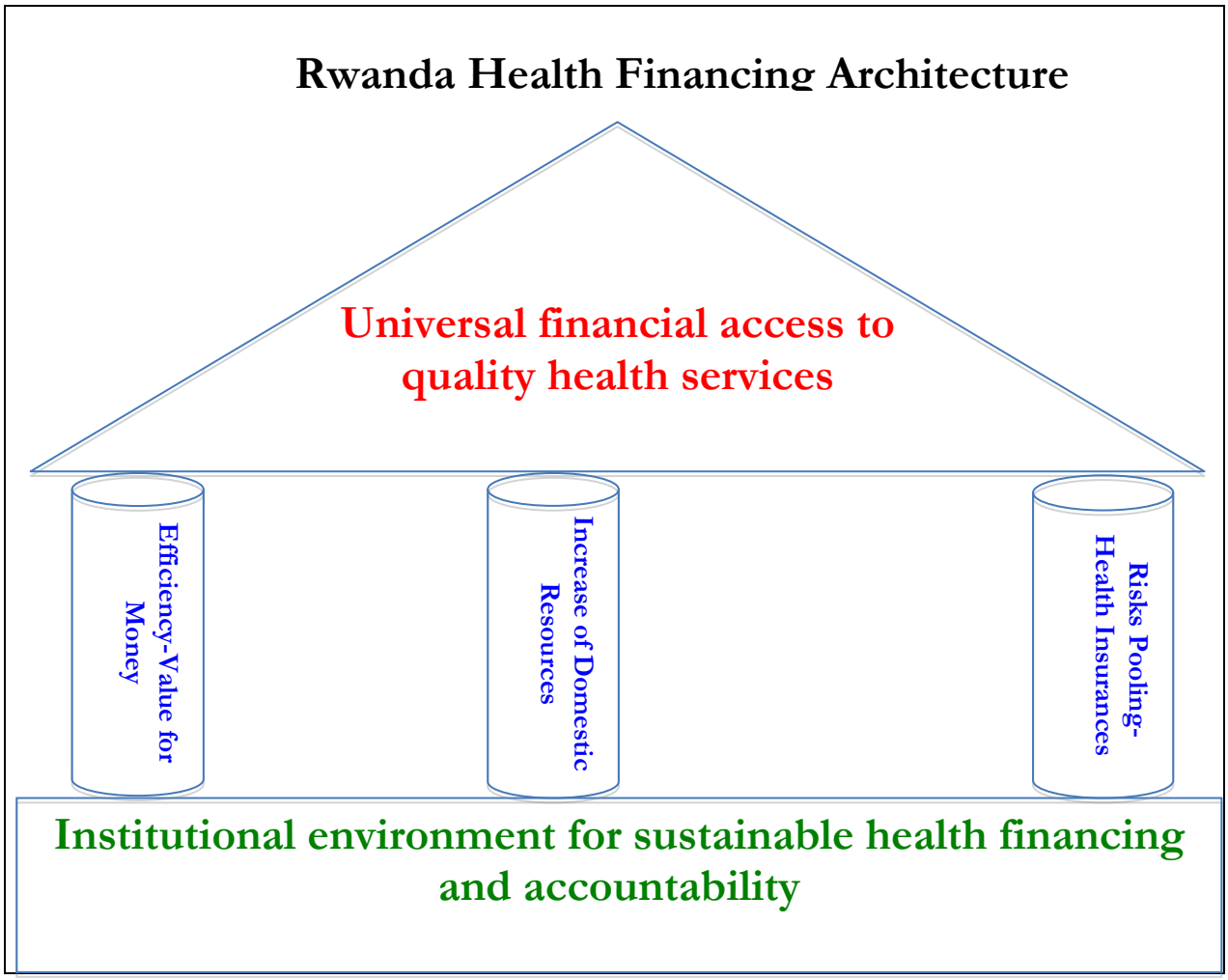
Values:

- Solidarity;
- Ownership;
- Accountability.

3.3. Goal and Policy Objectives

The goal of the Health Financing and Sustainability Policy is to strengthen current health financing systems and guide the development of new initiatives and strategies to improve financial accessibility and resourcing towards a sustainable Rwandan health sector. This policy will be focused on reaching the following objectives:

- To increase efficiency for improved quality and service delivery (value for money);
- To strengthen Health Insurances and risk pooling systems;
- To enhance strategies and interventions for increasing domestic revenue for health including the community and private sector to monetize available expertise;
- To strengthen the institutional environment for sustainable financing and ensure accountability in the health sector.


Rwanda Health Financing Architecture
Universal financial access to quality health services
Efficiency-Value for Money
Increase of Domestic Resources
Risks Pooling-Health Insurances
Institutional environment for sustainable health financing and accountability

4. Policy Directions

4.1 Increase efficiency for improved quality and service delivery (value for money)

There is considerable space for increasing service delivery efficiencies and equity in the health system by improving public health budget design, allocation and utilization processes in several ways:

Explore opportunity for improving categorizing of health budget finance flows to reduce . transaction costs. Examine which elements of the health budget can be used to purchase outputs instead of inputs. For example, facility operating , could be built into fee schedules for outputs. By examining variations in health sub-system health financing and delivery mechanisms, it becomes clear that there is significant opportunity and multiple options for improving efficiencies. A situational analysis showed that Rwanda health system's opportunities to improve efficiencies are: (i) To reduce administrative costs, reducing transaction costs and sharing management costs, (ii) To develop increased performance or result-based financing, and (iii) To improve aid efficiency.

4.1.1 Reduction of administrative costs, transaction costs and *sharing the management costs*

It is imperative that implementing agencies managing health interventions consider utilization of cost- effective systems to reduce administration costs. There are many illustrative examples where traditional management practices could become more efficient at low cost:

1. Improving inefficient staffing patterns such as retaining personnel as FTE staff when part-time staff would suffice.
2. Applying electronic mechanisms in place of paper-based administration processes.
3. Improving the efficiency of drug and other medical product supply chains
4. Utilization of innovations in common Information &Technology (IT) platforms for health information systems including reporting and billing across all different pools of money including RSSB, CBHI, and PBF and to the extent possible, the general budget. Mobile phone technology is largely used in Rwanda, both in urban and rural areas, as well the low, middle and high-income individuals and families. In some countries, insurance providers are using the mobile phone for membership registration and payment to providers through mobile banking. Studies will be conducted to compare cost-benefit in utilization of IT technologies and its application in the management of health programs.

For the management of hospitals and health centres, a key goal should be to reduce management costs while enhancing performance (quality and outcomes). If possible, estimated cost ceilings and performance should be defined for the same type of service. The public financial management (PFM) processes will be strengthening and outsourcing promoted for the management of public health facilities by private firms. A private agency can establish one management unit for many health facilities, hire highly qualified staff and test and apply IT appropriate technology.

Ensuring rapid progress in the reduction of management costs requires establishing guiding regulations. It includes provision of a ceiling for administrative costs based on the type and budget of the intervention.

The existing funding flows shows potential for improvement to reduce transactions costs. Purchasers/payers of health services should review and apply evidence-based purchasing options including health care provider payment mechanisms. Sharing of administrative costs does not remove or reduce the necessary autonomy of implementing agencies (hospitals and health centers). Rather, cost sharing will be designed and negotiated as a strategic agreement between multiple small administrative units for increasing efficiency. It will be classified within a cost-sharing framework towards efficiency in resource management.

The investment in preventive interventions will be strengthen, especially for some costly health services like HIV/AIDS, Malaria and communicable diseases. It will be a priority of public financing as well as private investment.

Transition from the international supported programs through International NGOs and use the local implementers is also an initiative that will be continued to increase the efficiency and sustainability of health programs.

4.1.2 Development of the performance (PBF) or result-based financing (RBF)

Rwanda has successfully implemented performance based financing (PBF) at all levels of the health care delivery system. It is among the best practices in health financing innovation establishing direct linkages between finances and outputs and outcomes. The PBF system, that purchases outputs and outcomes, has been a key factor in supporting improved efficient utilization of scarce financial resources for health and progress rapidly toward the health Millennium Development Goals. There is a need to have improved integration of the PBF and accreditation process to ensure more sustainable outputs and outcomes for health. Other options for better synergy between PBF and the broader health financing system are also possible and over time stronger linkages and integration between all health purchasing mechanisms can occur.

Some development partners in Rwanda are starting budget support in different sectors using results based financing (RBF) approaches. The MOH will pursue this financing system with other development and health programs.

Financing health programs performance or results based will be among key pillars of Rwanda health financing.

4.2 Strengthen Health Insurance health insurances and risk pooling systems

The costs of health care services increases as new technologies are used and the burden of diseases is stressing existing health systems . Financial prevention and risk pooling for health cost sharing are an important pillar of universal health coverage as stated by the UN General Assembly of the UN as well as World Health Organization. Rwanda has already advanced Health Insurance and risks pooling systems, which attained coverage of more than 85% of the population in 2013 (MoH and RSSB reports of 2013). It includes Community Based Health

Insurance (CBHI), health insurance for civil servants and is open to at least middle size private organizations, commercial or not, Military Health Insurance covering also the national police, university health insurance and more than five private commercial health insurances.

The Health Insurance and risk pooling also include the government budget and health project management units.
All of these systems complement each other and have contributed in the reduction of out of pocket payments.

Health Insurance schemes will be strengthened for universal health coverage, especially the "Mutuelles de santé" which target low income and informal sector categories of the population. The cross-subsidization (increasing contribution by private and public insurances) for the low-income categories will be strengthened.

The design of the risk pooling will ensure performance as well as the efficiency.

With the changes in burden of disease, the benefit package of health insurances will be expanded to include some non communicable diseases and other emerging health priorities while maintaining coverage for Communicable diseases.

The financial health protection will be enhanced for the reduction of out of pocket payment through the reduction of co-payments. The effective management of co-payments will ensure that there are no barriers to service utilization. The health financing strategic and operational plans will define the best ways of establishing variable co-payments. Especially, high cost co-payments will be subsidized by low cost co-payments.

4.3 Enhance strategies & interventions increasing domestic revenue for health including community and private entity to monetize available expertise

The last National Health Accounts (2010) show that 61% of total health expenditure is external grant or loan. High impact services like reproductive health, child health, Malaria, HIV/AIDS, and other programs are heavily (more than 85% for HIV and Malaria) funded by external financing. It makes Rwanda's health financing system unsustainable and exposed to any rapid shock as external funding is declining and current increase in domestic resourcing not unable to fill the gap.
Innovative options will be developed for raising domestic resources to cover a larger part of health resources. Key initiatives that will be pursued include:

- Establishment of social markets for health products like mosquito nets;
- Development of a sustainability plan for HIV/AIDS and other programs;
- Cost recovery and cost saving plans for health products, including blood products;
- Monetizing accreditation of private health facilities;
- Establishment of new revenue generating projects across all levels of the health system including public hospitals to set up semi-private wings to increase their revenues under the policy for promoting hospital auto-financing;
- Promoting Public Private Community Partnership.

In the context of EAC and as suggested by the High Task Force for health financing, explore studies, dialogue and advocacy for products with a negative impact on health earmarking the funds for health coming from taxes and levies: (i) Sin taxes of tobacco, alcohol, processed food, etc. and (ii) Levies on products like mobile phone, transport, etc. Forum for developing innovations in mobilization of domestic health financing should be established.

The local governments (districts) should invest resources from local taxes; none earmark subsidies and investment funds to health services.

Government to engage with the private sector in order to increase investment in health

1.6% of private GDP is used for health services that is relatively low when compared to 8% Government GDP share allocated to health services. As the private sector becomes increasingly involved in health service provision, the public sector will increase its role in policy, regulation and focus on public goods delivery (Epidemics, routine vaccination, areas with less market for health like rural, displaced population & refugees camps, and low income population).

It is important that the private sector be involved in both supply of health services (including development hospital, clinics, diagnostic centers, education institutions, etc.) and demand for health services, essentially through diversification of the health insurance products. The supply of health services and the access (demand) to these will be developed hand in hand.

The private sector will also be encouraged to invest in hotel health services including medical tourism. This will be promoted by creatingan enabling environment (establish PPP framework under the RBC Business development unit, and jointly with RDB, determine incentives for private investment in the health sector, etc.), designing proposals/cases to interest the private sector to invest in health and creating new opportunities for partnerships.

Public and private partnerships (PPP)will be developed for different projects involving the health sector. These include medical infrastructures and leasing of equipment, maintenance of medical equipment, private management of health facilities and services, creation of private entity that will help the sector to leverage the available expertise, contribute to the global solidarity and proper management of health programs.

The Public, Private and Community partnership initiatives will be strengthened. The creation of health posts under this framework will be scaled up and Cooperatives of community health workers will be supported through efficient use of their net profit to become sustainable business entities and health services provisions outlasts.

The corporate social health responsibility of private companies will be promoted.

4.5 Strengthen the institutional environment for sustainable financing and ensure accountability in the health sector.

The design of innovations for sustainable health financing requires strong leadership and technical capacity. The existing health financing coordination has been focusing on PBF and Mutuelles implementation.

It is important the different purchasing mechanisms be complementary to avoid double payments or unknown gaps.

The Ministry of Health will establish inclusive coordination mechanism for health financing. This will include independent pricing mechanism, which both health insurances and health providers will comply.

The health insurances commission will license and regulate the health insurances and related organizations (Brokers, Surveyors, etc.).

The Government of Rwanda will actively participate under East Africa Community and East Africa Federation for health to provide regional opportunities to establish a market for highly specialized health services and health sector industry especially in regards to the pharmaceutical and medical equipment industry. The EAC will provide framework for the harmonization and lessons learned sharing.

5. Governance Framework

5.1 Organization of the Health Financing and Sustainability System

The linkage between financing and programmatic health interventions is very important. Therefore, integrating the Health Financing and sustainability system in overall health programs financial management will facilitate it. Especially, improving the collaboration and coordination between MOH and RBC units in charge of planning, budget & finances, SWAP and business development.

The Health Financing and sustainability system will provide technical support to agencies implementing health interventions and will manage lessons learned and knowledge sharing. Its scope of work will cover much of the coordination of the health financing, including the development and the implementation of health financing policy and strategic plans. The health financing system will also ensure the monitoring of progress of health financing in general and implementation of related reforms in particular and undertake necessaries revisions (norms, laws, etc.) and institutions arrangements in order to harmonize and strengthen the HF systems. The Health Financing system will have sub-components supporting coordination, health insurances, performance or results based financing and community cooperatives.

5.2 Governance oversight arrangements

Health financing cuts across all health interventions and institutions. It requires good coordination for crosscutting issues, essentially its integration in the operations of health interventions and related implementing agencies activities. The current gap is the integration of all existing health financing and sustainability systems. It is currently limited to budgeting and financial reporting & auditing. The overall health financing system should ensure that different agencies implementing health programs integrate all the functions of health financing (resource generation, resource pooling, allocation & purchasing and social health protection), including costing, planning & budgeting, financial reporting, auditing & publication and monitoring & evaluation.

The coordination of health financing is key. It will include: (i) harmonization of the performance framework, including key functions of health financing, the indicators and instruments for reporting; (ii) exchange of lessons learned and (iii) monitoring & evaluation of the entire sub-sector of health financing.

5.3 Partnership and coordination (Role and responsibility of each stakeholder.

1. The Ministry of Health will:
    - Develop policies and guidelines for health financing;
    - Mobilize the resources and
    - Technical assistance to the implementing agencies;
    - Advocacy for Health Financing.

2. The Ministry of Finances and Economic Development will ensure
    - Mobilization, allocation and management including Public Financial Management

3. The RBC will technically lead and coordinate the efforts gearing the implementation of initiatives included in the policy
4. The Agency of Insurances regulations will ensure the health insurances comply to the best practices in covering liability.
5. The Development Agencies will engage private sector in health investment.
6. The Development Partners will provide financial and technical support for the health financing.

6. Knowledge management and Monitoring and Evaluation

6.1. Indicators, data sources and review

There is a need for standard indicators to monitor and evaluate the health financing. Some of them are us

ed for NHA, others for EICV, others for the Resource Tracker or for Public Expenditure Reviews (PER) or HMIS. Standard health financing indicators with appropriate tools for data collection and/or analysis will be proposed within health financing strategic plan's performance framework. The health financing strategic plan will have a health financing performance framework with standard indicators, baselines and targets for key functions and at all levels: (i) Resource Generation, (ii) Resource Pooling, Allocation and Purchasing, (iii) Social Protection and (iv) Governance and Stewardship.

6.2.Reporting, Monitoring and Evaluation

The mechanisms for effective reporting, monitoring and evaluation including reporting templates used at all levels, periodicity data quality assessment and review of the different components of the health financing system will be defined in the Health Financing Strategic Plan.

The selection of indicators and establishment of efficient systems for data collection are only part of the M&E system. It is crucial to continue to strengthen mechanisms for the routine review of sector performance and the adjustment of implementation strategies if required. Key mechanisms are the JADF (Joint Action Development Forum), semi-annual Joint Health Sector Reviews (JHSR) and PHFISTWG.

6.3.Knowledge management

Rwanda's health financing and sustainability system will be strengthened with global best practices.

The health financing system is currently lacking data to inform evidence-based decision-making including cost-effectiveness analysis and data on health insurance, user fees, transaction costs, and private providers of health services (private clinics and hospitals). Such studies will be conducted for policy and strategic design as well as monitoring and evaluation purposes.

Existing health-financing reports, namely the National Health Accounts (NHA), Health Resources Tracker (HRT), Public Expenditures Review (PER) will be institutionalized and benefitted of required national budget.

The EICV and DHS's health financing modules will be strengthened and include standardized indicators of health financing performance framework.

7. Conclusion

The current Health Financing Sustainability Policy is an update the first Policy (2009) and it marks an important step in the evolution of the health sector.

The development of this policy is initiated by the Government of Rwanda (Ministry of Health) with the vision of ensuring that Rwandans have universal financial access to quality health services in an equitable, efficient and sustainable manner. It was also characterized by the involvement of different stakeholders such as the Ministry of Finance and Economic Planning (MINECOFIN), Ministry of Local Government(MINALOC), National Bank of Rwanda(BNR), Rwanda Biomedical Center (RBC), School of Public Health / University of Rwanda, Rwanda Development Board(RDB), Private Sector Federation, Civil Society, Health Insurance Bodies, Health Care Service Providers and Development Partners.

This policy is presenting innovative strategies to ensure sustainability of health financing in the current context of an expected decline of external funding in the health sector. It focuses more on domestic resources mobilization and private sector engagement in health.

The Health Financing Sustainability Policy will ensure that different agencies implementing health programs integrate all the functions of health financing (resource generation, resource pooling, allocation & purchasing and social health protection), including costing, planning & budgeting, financial reporting, auditing & publication and monitoring & evaluation.

Through the health financing policy, the GoR is committed to ensure quality health care access by all Rwandans without any financial barriers.

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