



INTERSECTORAL CASE STUDY

IMPROVING HEALTH THROUGH INTER-SECTORIAL ACTIONS: LESSONS FROM HEALTH FINANCING IN RWANDA

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Improving health through intersectorial actions: lessons from health financing in Rwanda

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SUMMARY

Introduction: Rwanda has registered significant progress in many social sectors, such as: health, poverty, combating hunger, and illiteracy, which have had direct effects on improving health (NISR, 2011). MoH was able to attain most key health targets that were set over the last 10 years (Rwiyereka, 2013). The infant mortality ratio decreased from 86 per 1000 live births in 2004 to 50 per 1000 live births in 2010 and the under five mortality ratio declined from 152 to 76 per 1000 live births over the same period (RDHS; 2010). If the rate of this decline continues, Rwanda will most likely meet the maternal and child mortality MDGs targets by 2015.

This case study is intended to examine how intersectoral actions (ISA) have contributed in improving health insurance financing and UHP. The case study spans from 2005 to 2012, when key health financing policy innovations were adopted and others scaled up from pilots to cover the whole country through the decentralization policy.

Purpose and Objectives: The purpose of this case study is to examine how intersection activities have improved key health targets (national and international) through implementation of innovative health financing policies.

Methodology: Document Review and Stakeholder Meeting: The documents reviewed mainly involved international and national policy, strategic plans, and peer reviewed papers as well grey literature. Individual stakeholder meetings were conducted to ascertain the views of implementers in the ISA.

Policy Processes for Intersectoral Action: The intersectoral collaboration has contributed greatly in achieving the above results. The MINECOFIN has been increasing its budget share to health over years and is still committed to increasing. The Ministry of Local Government has strengthened governance structures at all level to ensure that strong administrative structures are in place to support implementation processes for most government programs, including those of health. With structures in place, the implementation of various health innovations was possible. Due to CBHI, Community-Based interventions have improved access to health services greatly through creation more feeder road networks to reduce physical barriers and CBHI.

Under high level political leadership (presidents' office, Ministry of Local Government, and Ministry of Finance and Economic Planning) and with support from development partners, the country engaged in national scale up of CBHI and by 2004, enrolment rate had reached about 85%, and by end of 2011, the enrolment rate hit record 92%. The informal sectors are all covered by formal insurances and the package is relatively good. The organizations such as the USAID provided technical support during the policy design and financially and technically supported evaluation studies to inform the policy makers. Particularly, Management Science for Health (MSH) has greatly supported and promoted CBHI from pilots to countrywide scale up.

Conclusion: Through the support of other sectors, the MoH has managed to develop innovative health financing policies and effectively implemented. The results have been applauded by the many in the international community calling for other LMIC with similar context to learn more about Rwanda in reforms. In span of 10 years, Rwanda's 92% of its 11 million population was insured and protected from catastrophic health care expenditures. The PBF payment has a bit stabilized the health workers because of PBF payment system. The health outcomes especially the priority targets have been on the steady increase, and Rwanda is on clear path to achieve the MDG # 4. Whereas the achievements have been outstanding, the sustainability remains a big challenge for both the government and donors.

Introduction

In Rwanda, the health indicators especially those related to MDGs have substantially improved during the last decade. Through improved intersectoral actions, government commitment to national and international targets, boosted by donor support; the MoH was able to attain most key health targets that were set over the last 10 years (Rwiyereka, 2013). The infant mortality ratio decreased from 86 per 1000 live births in 2004 to 50 per 1000 live births in 2010 and the under five mortality ratio declined from 152 to 76 per 1000 live births over the same period (RDHS; 2010). If the rate of this decline continues, Rwanda will most likely meet the maternal and child mortality MDGs targets by 2015. Despite increase in donor support in last decade, the government spending on health has been increasing since 2005: 2005 (8.2%) 9.1% (2007); and 11.5% (2010) (MoH, 2011a, 2011b). Through the Ministry of Finance, the level of government spending on health in 2010 was within the reach of Abuja declaration (15% by 2015) targets for national budget allocation towards the health sector (MINECOFIN, 2010).

The intersectoral collaboration has contributed greatly in achieving the above results. The MINECOFIN has been increasing its share of spending to health over years and is still committed to increasing even further. The Ministry of Local Government has strengthened governance structures at all level to

ensure that strong administrative structures are in place to support implementation processes for most government programs, including those of health. With structures in place, the implementation of various health innovations was possible. Community-Based Health Interventions improved access to health services greatly due to the removal of most financial obstacles, but also creation of more feeder road networks to reduce physical barriers. The introduction of Community-Based Health Insurance (CBHI), facility and Community PBF to stimulate demand and supply of health services are all implemented at various levels and supported by various administrative structures (DHS, 2010). CBHI covers primary health care services that are mainly delivered at health center and community levels.

Rwanda has registered significant progress in other social sectors, such as: poverty, combating hunger, and illiteracy, which have had direct effects on improving health ((NISR), 2011). This case study is intended to examine how intersectoral actions (ISA) have contributed in improving health insurance financing and UHP. The case study spans from 2005 to 2012, when key health financing policy innovations were adopted and others scaled up from pilots to cover the whole country through the decentralization policy. In subsequent chapters, we explain the methodology applied to respond to the purpose of this case study, the brief background of the policy, policy initiation, policy description, the ISA (description of mechanism and tools applied for intersectoral collaboration, lessons learned, conclusion and recommendations, and limitations).

1. General Background

According to the UNDP's Human Development Index (HDI), Rwanda ranks 167 out of 187 countries (UNDP(HDI), 2013) and is in the category of countries with a low HDI. With a HDI of 0.429, the country is below the regional average of 0.463. The vast majority of the population depends on agriculture for their livelihoods. Recent Integrated Household Living Standards Survey (IHLSS) (2012) indicated that the percentage of people living under poverty has dropped by almost 12% from 56.7% in 2006 to 44.9% in 2012 ((NISR), 2011). In 2011, the National Institute of Statistics of Rwanda (NISR) (2011) showed that the population density was estimated to be 4,161 people per KM² with the total population now approximately 11 million ((NISR), 2011). The population of Rwanda is young with 43% < 15 years old. Moreover, women account for about 52.6 % of the population.

Although relatively poor, Rwanda has been widely acknowledged for attaining universal health protection (WHO, 2010). Some countries and donors are trying to learn with interest how Rwanda was able to achieve such improvement in a relatively short time. The UHC has significantly contributed to improving key maternal and child health indicators (Lu, 2013; MoH, 2011a; WHO, 2010). According to UNICEF report (2012), Rwanda has achieved Millennium Development Goal # 4 (MDG4)— the report highlights that child mortality rates in Rwanda have been reduced from 156 deaths per 1000 children in 1990 to 54 deaths per 1000 children born annually in 2011, which reflects a two-thirds reduction. The decrease signifies that the country is on track to reach MDG 4 – reducing child mortality by two thirds by 2015 (UNICEF, 2012).

1.1 purpose and objectives

Many studies have indicated that universal health coverage has significantly improved access to health services, especially those of Maternal and Child Health (MCH); and this has contributed towards reaching the MDG number 4 (DHS, 2010; Lu, 2013; MoH, 2011b). Various sectors, including the MoH managed to effectively coordinate efforts and resources to improve health insurance coverage to attain UHC to break financial barriers. The purpose of this case study is to examine how intersection activities have improved key health targets (national and international) through implementation of innovative health financing policies. To respond to this purpose, we proposed to look at the key relevant sectors or policies involved in the ISA and how the policy implementation was coordinated. We in addition,

examine key drivers shaping the health financing policy implementation, the available opportunities as well as challenges in implementing ISA and limitation met while documenting this case study.

1.2 The proposed methodology

This section describes the rationale and the processes for selecting the case study, the study design, data collection processes, and data sources. It also highlights the tools used to collect the data, and concludes with methodological limitations.

1.3 The rationale for selecting this case study

WHO recommends LMIC to strive for UHC as best way to break financial barrier and avoid to catastrophic expenditures for the poor and disadvantaged segments of the population (WHO, 2010). Some in the international community consider Rwanda as a model to countries in low- and mid-income in terms of attaining UHC and improving service delivery. The selection of this case study was based on the hypothetical question that while Rwanda is a relatively poor country; it has done much better in terms attaining UHC than countries in the same or higher income levels (an example Rwanda is on clear track to achieving MDG # 4).

1.4 The study design and data collection tools

The design of this case study heavily relied on Robert K. Yin's (2008) model for case study designs (Yin, 2003). A Harvard professor, Yin is widely known from his work as a social science researcher. In his book, "Case Study Research: Design and methods", Yin demonstrates that the type of the case study design will mainly depends on the research question (s) or the problems the case study intends to answer. In our context, the case study intends to examine how intersectoral actors have coordinated efforts to improve health financing. Yin, emphasizes that the "how" and "why" questions often "favour the use of case studies" and that case study findings should be "generalized to theories" (Yin, 2003). Our research question mainly falls under "how" category and "focuses on contemporary events" (events occurring at the same time or from time to time).

There are various ways of getting information needed for the case study. Palena Neale, et al. (2006), concur with Yin (2003) that the type of data collection instruction depend on the type of questions for case study (Neale, 2006; Yin, 2003). Ideally, our case study design suggests using desk reviews and stakeholder interviews as main source of data. Therefore data sources for our case study were derived from document review and stakeholder interviews.

Document review: The documents reviewed mainly involved policy documents, strategic plans, sectoral evaluation reports, Demographic Health and Surveys (DHS), Integrated Household Living Standards Survey (IHLCS), Economic Development Poverty Reduction Strategy II¹ (EDPRS II), the country's Vision 2020², peer reviewed papers, etc.

A desk review template was developed to guide the review processes. During desk review, we attempted to answer the key issues to respond to the purpose of the case study. Our template involved: name and type of document (Policy, strategic plan, etc.); what health financing issues were identified to be addressed through policy and ISA; lessons in addressing equity issues to address health issues through health financing; what policy issues hinders ISA for health financing; were there policy solution; which sectors were more actively involved in pushing policy agenda; and what was the level of civil society involvement.

¹ EDPRS II is medium-term strategy that guides the Government of Rwanda to attain the long-term Vision 2020 objectives, that aims to transform Rwanda into middle income country by 2020

² Vision 2020 is a document that has been guiding Government of Rwanda since 2000, for planning. The main objective Vision 2020 is to transform the country into a mid-income country in the year 2010.

Stakeholder Interviews: stakeholders from relevant sectors and organizations whose ISA have components directly or indirectly linked to health financing were considered for interviews. Meetings were arranged with senior leaders of the selected institutions and organization for the interviews. An interview guide and questionnaires was developed to guide the interview processes. Emails and phone calls were used to contact selected sectors and organizations for scheduling the interviews. Stakeholders who were not available for interviews and who preferred to respond to the questionnaires through emails or phone call, were given that opportunity to do so. No incentives whether financial or otherwise were provided to participants to be interviewed.

Data Analysis: Relevant information from the document review was sorted out according to the review framework suggested above and then analysed; while the information from stakeholder interviews were recorded in a notebook according to the themes corresponding to the purpose of the case study. Information analysis was guided by the framework for: coordination of policy processes to implement ISA in health financing, key drivers shaping implementation of the ISA, opportunities and challenges in implementing ISA in health financing, and finally the limitation. Results from the desk review and stakeholder analysis was presented in narrative form with quotes where necessary.

2. Initiation of the policy on health financing

2.1 International Call for Innovative Health Financing Reforms

In 2001, the African Heads of State committed themselves to allocate at least 15% of their national annual budgets to improving the health sector (The Abuja Declaration). In May 2005, the 58th World Health Assembly adopted a resolution that urges Member States to ensure that health financing systems include a method for prepayment of financial contributions for health care, with aim to promote sharing risk (WHO, 2005). The world health reports 2008 and 2010 and resolution WHA62.12 and WHA64.9, highlighted universal coverage as one of the 4 keys pillars of primary health care and services through patient-centered care (WHO, 2010). Under resolution WHA62.14 “Reducing health inequities through action on the social determinants of health” (Rio de Janeiro, Brazil, 21 October 2011). Still in WHO report (2010), Rwanda is highly acknowledged for achieving Universal coverage and the report further calls for intersectoral action to strive for sustainable universal health protection through intersectoral and development partners actions.

2.2 National Health Financing Policy Reforms in Rwanda

Rwanda has acknowledged the importance Universal health coverage through effective health financing—as evidenced from EDPRS planning 2012-2018 (MINECOFIN, 2012). Additionally, many authors have consistently identified financial accessibility as the major obstacle to accessing health services in LMIC ((NISR), 2011; Basinga, 2011a; Murray, 2010; Savigny, 2009; WB, 2004). Particularly, Rwanda has had major obstacle related to financial and geographical accessibility, in addition to lack of knowledge for the use of health services. Particularly, maternal and child health services faced unique challenges related to delays to seek health care services. Delays include: taking timely decision to seek care, travel to seek care, waiting for hours at health facility, and delay in making decision to treat or transfer to the next level of care. Through broader consultative processes with partners and relevant sectors, such Ministry of Finance and that of Local Government; and Prime Ministers’ office, the Ministry of health developed a comprehensive health financing policy framework based on national and global health care financing best practices to respond to the financial accessibility problems. The health financing policy is built on the core principal that the country needs to protect all individuals and families in both formal and informal sectors of the economy from out-of-pocket health care expenditures.

In an assessment to document ISA in Rwanda; Policy issues in the Economic Development Poverty Reduction Strategy (EDPRS) such as improving the quality of health care, demand and accessibility of

healthcare were identified as critical policy issues to be addressed (Unpublished Work for WHO Report-Rwanda, 2013). Policy options included expansion of geographical and financial accessibility through construction of feeder roads to improving access to health services as well as avoiding out-of-pocket spending. Supporting the vulnerable and extreme poor by use of social protection mechanisms, ensure increased availability of drugs, vaccines and consumables was also thought about. In addition, the government through financial incentives encourages private sector to play a major role in health care services delivery (MINECOFIN, 2012).

The effort to expanded health protection coverage policy took place on was gradual basis, and this required political and broader consultative mechanisms to ensure that formal and informal sectors of the economy are covered. For the formal sector coverage, a medical insurance plan (policy) was established in 2001 [Rwandaise d'Assurance Maladie (RAMA)] to cover public servants and their dependents; plus private sectors (but not individuals). Through Ministry of Defence (MoD) and MoH, the Military Medical Insurance (MMI) was established to cover the military and their civilian dependents. There are several other private health insurances covering a minor segment of the population, mostly those working in the banking sector. For the informal sector coverage, the Community-Based Health Insurance (CBHI) was formally first introduced in 1998 in the 3 districts out of 30 (MoH, 2005, 2011b). Between 2005 and 2005, a standard evaluation demonstrated that the 3 pilot districts had improved financial access (reduced out-of-pocket) and improved utilization of health services (Lu, 2013; MoH, 2011b)

Under high level political leadership (presidents' office, Ministry of Local Government, and Ministry of Finance and Economic Planning) and with support from development partners, the country engaged in national scale up of CBHI and by 2004, enrolment rate had reached about 85%, and by end of 2011, the enrolment rate hit record 92%. The organizations such as the USAID provided technical support during the policy design and financially and technically supported evaluation studies to inform the policy makers. Particularly, Management Science for Health (MSH) has greatly supported and promoted CBHI from pilots to countrywide scale up.

Multilateral institutions, such as the World Bank and UN systems vehemently promote the coverage of the informal sector through CBHI (UN, 2012; WB, 2004). Because the members of the CBHI are poor and compose bigger segment of the population, the government, through health financing policy, introduced a system of co-financing the CBHI whereby other insurances covering formal sector make an annual share contribution (about 1% of their annual collection) to the CBHI to cover the deficits. In addition, the Government contributes to the CBHI fund to further boost pooling in an effort to cover up the deficit. For the poorest, who prove (there is a criteria for wealthy ranking at the community level) they cannot afford the premiums, the government, some partners; including church (faith-based organization) covers their premium.

2.3 Introducing the Performance-Based Financing (PBF) Policy

In 2000, the Government of Rwanda with support of partners initiated PBF and started implementing this provider payment mechanism policy in 3 out of 30 districts. The policy aimed at addressing or improving quality and quantity of the health services offered by health workers as well as to strengthen capacity of institutions in terms accountability and governance (MoH, 2005). The 3 pilot districts were purposively selected. The PBF model remunerated health facilities and health workers (doctors and nurses) for improvement in quality and quantity of maternal and child health indicators. About 5 years later, a standard impact evaluation (treatment-control comparison) was conducted which showed that health facilities that received the program improved indicators (Basinga, 2011b). In 2006, with the support of partners, the health financing policy was scaled up countrywide. In 2009, the PBF was scaled up to the community level to address challenge of access that had been discovered during impact evaluation. In Community PBF model, CHWs are remunerated based on coverage of selected primary

health care indicators, while women are provided with in-kind incentives for up-take of pre-conditioned services—those related to MCH (Humuza, 2010).

In all these processes the Ministry of Health was not acting alone. Other sectors such as Ministry of Local of Government as well Ministry of Finance played key roles in ensuring successful policy design and implementation process. The Ministry of Finance, agreed in the name of Government to cover its share contribution to PBF basket funding. The Ministry of Local government supported the policy acceptance to implement the policy along its district administrative structures and its staff at district levels to get involved in implementation process. Development partners stood upfront to support and promote the initiate. Global Fund, World Health organization, World Bank, USAID implementing agencies, etc. were actively involved to make sure policies were well developed and implemented.

With Universal Health Coverage and using PBF approach to improve health works motivation to deliver quality and quantity of health services, Rwanda has been acknowledged by the international community as an a probable example for other LMIC to improve coverage and protect population from out-of-pocket expenditure, while also improving delivery of health services through supply-side (WB, 2004; WHO, 2010). However, policy makers and development partners are worried of challenges mainly those related to sustainability of the program (see challenges in the next sections of the report).

3. Description of policy process for intersection action

The health financing policy takes seriously the inclusion of the Informal sector (population in informal economy whose taxes are not captured in general tax collection) into the mainstream health financing that constitute majority of the population (about 85%). The Formal health insurance covers less than 15% of the approximately 11 million populations. For the supply side, the Government endorsed PBF payment mechanism implementation policy and pays its share contribution to basket fund where partners also add their share. Below, we describe how the different Government actors and development partners have acted intersectorally to implement health financing policy (Health Insurance and PBF policies). The table below shows targets for the main financing indicators as derived from the Health Sector Strategic Plan III, under its health financing policy section.

TABLE 1: BASELINE AND TARGETS IN HEALTH FINANCING OF HSSP III

Key Outputs / Outcomes	Baseline 2011	Targets 2015	Targets 2018
% GoR budget allocated to Health	11.5	12	> 15
Per capita total annual expenditure on health	\$ 39.1	\$ 42	\$ 45
Per capita allocation to PBF (USD)	1.8	2.0	--
% Population covered by CBHI	91	95	--

Source: Health Sector Strategic Plan III, 2012-2018

3.1 The Role of Top Leadership

In this case study report, we consider top leadership to be the high level leaders, such as: HE the Presidents of the Republic and Members of the Parliament. Below, we describe the role played by the top leadership in improving health through intersectoral action in health financing.

HE The President of the Republic

HE the President of the Republic of Rwanda signs performance contracts with District Mayors to enhance service delivery and improve wellbeing and health of the population. One of the critical activities under the performance contracts is Universal Health

BOX 1... CALL FOR ACTION

“Family planning, fighting, malnutrition as well as enrolling in mutuelles is our priority number one, not just talking about it, but implementing it as well.”... President Paul Kagame, 2005....

Protection through improved CBHI enrolment rates. In effect, all District Mayors take serious increasing the enrolment rates in communities because every year, the President’s Office does external evaluation on district performance contracts, and below certain performance levels, mayors are sacked from their position. Additionally, in all public speeches, the president talks about CBHI enrolments as priority issue and encourages everyone in the community to be covered through CBHI if not covered in other insurance forms.

The Members of Parliament

In Rwanda, Members of Parliament (MPs) are considered as opinion leaders. There are several clusters in the parliament, including the health and social welfare cluster. Under this cluster, the MPs have the responsibility to reach out the population in their respective constituencies to explain the country’s policy priorities. Among the policy priorities often cited are explicitly explaining the benefits and encouraging local population to enrol in the CBHI scheme. The community members are given chance to ask any problems or challenges they face. And one of the critical challenges is the relatively low quality of health services in addition to low volume of service package under the CBHI benefits. The Ministry of Local Government has established clear criteria that rank the population according their wealth where the “poorest” are protected from the out-of-pocket health expenditures.

3.2 Other Sectors (Key Relevant Ministries)

The Ministry of Local Government (MINALOC)

MINALOC is involved in all sectoral affairs due its role in governance. Under MINALOC, a crosscutting program called Health, Social Development and Child Protection was been jointly developed with MoH and implemented and this led to joint action for health in health insurance or CBHI, family planning, child immunization, fighting malaria, fighting HIV/AIDS, and Gender Parity. All 30 districts that make up the country were provided with resources to implement relevant activities whose overall effects have had direct or indirect impact populations’ health. In one study to assess the intersectoral action on health, a key informant from MINALOC stressed the country’s need is to strengthen current social health protection efforts through community-based health insurance (see box 1).

MINALOC is in charge of identifying vulnerable groups such People with Disabilities (PWDs), FALG children (Fund for Genocide Survives Children), demobilized soldiers and support them financially to access essential health services based on subsidized service costs. Institutions involved in the support of the initiative include: Ministry of women Gender & Family Promotion (MIJEPROF), National council of children, Ministry of Education (MINEDUC), MoH, Ministry of Youth (MINIYOUTH), Civil Society Organizations (Cos) and NGOs. MINALOC provides overall guidance. The poorest people as categorized by *Ubudehe* (see definition of *ubudehe*)—a MINALOC wealth ranking system. They payment are made by local authorities or through CBHI scheme.

BOX 2...

“Social protection is one of the sector working group in the EDPRS”... This has supported the MoH to break the financial barrier and access essential health services. This sector supports the most vulnerable individual and families in the population and this is the mandate of MINALOC”... a key informant from the MINALOC narrates....

The Role of Decentralized Levels (Districts)

The role of district in supporting the implementation of the health financing policy can be seen from four main dimensions:

First, the districts under the leadership of mayors are units of Local Government—they represent ministry of Local Government. The district leaders work with lowest administrative units (sectors, cells

and villages, through Community Health Workers) to mobilize the population on the advantages of enrolling in the CBHI. The indicator on enrolment rate is included in almost all performance indicators from the district to the lowest administration level (cells and villages). Therefore, the district leaders and other health leaders from within districts work together to mobilize the population and facilitate them to enrol to the CBHI scheme.

Secondly, the districts are involved in implementing several strategies to achieve certain priorities, including those of health. Health financing policy was imbedded in the implementation of core *Imihigo*³ program targets. *Imihigo* was the term used in Rwanda for centuries by the king, his subordinates and the population/followers (Musahara, 2007). Today, the same concepts are used whereby the President of the Republic signs contracts with District Mayors for attaining certain performance targets. Mobilizing local population to achieve certain CBHI enrolment levels are among priority targets signed in the contract between mayor and HE the president of the Republic. The indicator on enrolment rate is signed under the broader category on: Health, Social Development and Child Protection. *Imihigo* has been widely seen as main driver towards achieving the current high record CBHI enrolment rate in Rwanda (Rwiyereka, 2013).

Thirdly, the district officials work with the local banks known as *Banque populaires* to offer soft loans to the local population who wish to borrow money and pay to CBHI scheme in order to be enrolled. The bank loan repayments often take period of one year. This has worked in most and is more as strategy that can sustain scheme through ownership of the scheme (MoH, 2011b).

At district level, the mayors have the mandate to hire and sack health workers (Doctors, nurses, lab technicians, etc.) from district hospitals and health centers. The district Mayor coordinates implementation of policies including those of health. The mayor through the staff in charge of health at district are responsible for overseeing the health financing policy implementation—ensuring that all inputs necessary for implementation of this policy are in place and reports on output (indicators) on routine basis (manage database for CBHI and ensure remuneration for the staff for CBHI and PBF payments). The development partners at the district level are also responsible for supporting the efforts to implement various policies including health financing.

Ministry of Finance and Economic Planning (MINECOFIN)

High population growth poses a major challenge in Rwanda (MINECOFIN, 2010). The country has chosen to integrate population issues in the broader national development agenda to tackle the problem. The strategic plan aims at ensuring a balance between socio-economic developments build on the foundation of a healthy population (MINECOFIN, 2010; MoH, 2012). Strategies currently include: mainstreaming population issues into sector and District Development Plans (DPP), conduct countrywide mobilization campaign on dangers of high population, the importance of enrolling in the CBHI to access health services whenever there is need, disseminate the national population policy, including health financing and CBHI at all levels and monitor the population indicators with respect to EDPRS, MDGs and Vision 2020⁴ (MINECOFIN, 2012; MoH, 2012). In tracking priority health indicators, the MoH work jointly with MINECOFIN

BOX 3...

We know the important contribution of health to the overall economic development. That's why MINECOFIN has committed gradual increase in the budget share to the MoH.... the share contribution to health sector now stands at 17%, we have surpassed the Abuja target and we will not stop there.... an informant from MINECOFIN narrates of there commitment to ISA..

³ The *Imihigo* was a "positive mechanism in regulating people's efforts and energies in their endeavours to ensure their security and prosperity". It engendered planning, execution of tasks individually or in groups in a competitive but amicable atmosphere. In the implementation of tasks everybody strove to get the best results possible and this encouraged emulation in the society at large. Consequently, the society benefited from such spirit of positive competition

⁴ Vision 2020 is Government leading planning document that seek to transform Rwanda into middle-income country by 2020. All sectoral policies and strategies are aligned to this document.

to ensure that regular reports are submitted on time in order to avoid delays in implementing programs. Like in many countries, the role of MINECOFIN is to work with other sectors to ensure that the priorities are implemented in intersectoral manner to overall improve welfare of the population. The MINECOFIN has supported the MoH efforts to: expand health infrastructure including equipping public health facilities, community mobilization via CHW for full participation in healthcare (enrolment to the CBHI and demand for health care services). “Avoid fragmented of health insurance schemes and improve financial subsidies to the poorest and ensure charges mirror ability to pay”. There are several partners involved in these activities: the main ones include MINALOC, MINICYOUTH (MINECOFIN, 2012). The role of MINECOFIN in the supporting the performance-Based Financing policy has been outlined in the subsequent chapters. An informant from MINECOFIN narrates that there Ministry plan expand further feed roads so that all health centers are interconnected so that ambulances can move freely from one level to the other.

Ministry of Women, Gender and Family Promotion (MIGEPROF)

MIGEPROF is another sector that has areas of intersectoral action with MoH. In 2002, MIGEPROF in partnership with UNFPA conducted a study on “beliefs, attitudes and socio-cultural practices in Rwanda” where among other things; the study illustrated how several socio-cultural practices especially among women have had negative affects on health outcomes (RWAMREC, 2012). Also in the study conducted by UNWOMEN in 2010 (on Masculinity and Gender based violence in Rwanda), the study showed that increasing number of people are abusing alcohol and drug this is the major source of violence. The study showed that excessive alcohol use also leads to most domestic violence, rape, and theft, even death. The Ministries of Youth and that of Culture are working MIGEPROF and MoH to address these behaviours.

A bottom up strategy was suggested such as community-based programs and policies that guide women and men into changing attitudes towards health, education, justice, and economic empowerment (development). Through also community-based approach, MIGEPROF supports the women victims and single mothers who are affected by the consequences of these habits.

Other NGO Working in Health Sector

Even though the MOH has overall stewardship on all health related issues, 15 other government ministries implement activities that either directly or indirectly impact on the health of the people (MoH, 2012). In addition to the 15 Government Ministries, the health sector is supported by several Development Partners (DPs), Faith-Based Organizations (FBOs), and Non-Governmental Organizations (NGOs). Different cadres with varying qualifications provide services at different levels of the health care system. Many NGO’s play an important role in improving health through the intersectoral action on health financing. For the church (public, confessional, private-for-profit and NGO) are directly involved in the supporting community to provide care and supporting to cover annual premiums subscriptions for poorest category of the population.

4. Experience / lessons learned

Rwanda has made significant progress in improving the availability, distribution and motivation of qualified health personnel through innovative health financing policies. Currently, both formal and informal sectors of the economy have improved access to health services than before. However, policy challenges still remain that can be routinely addressed through future policy reforms.

4.1 The Lessons/Experience learned

With the support of other sectors (MINECOFIN & MINALOC) and development partners, Rwanda has recorded high revenue mobilization from domestic sources, mainly organized in CBHI schemes

and other private insurances; and increased public funds (from tax-based funding). As result of good governance and using the donor money more efficiently coupled with relatively low levels of corruption, there has been sustained increased external funding channelled through general budget support, sector budget, and project support (where the largest share (63% in 2010) of Total Health Expenditure (THE) came from donor funding; compared to a share of 53% of THE in 2006. Due to increased funding, total health expenditure has increased to \$401 million (in 2010) which translates to \$39.1 per capita (having increased from \$34 per capita in 2006) and a reduction in out-of-pocket spending (down from 28%) (NHA unpublished report 2009/10).

Under the MoH leadership, several sectors contributed to the implementation of the innovative health financing policy (CBHI and PBF). The coverage of health insurance in Rwanda has increased dramatically over the years, with over 78% of households estimated to have been covered at the end of 2010, of which 97.7% of households reported insurance coverage under the CBHI (DHS, 2010). The CBHI database showed 85% CBHI coverage in 2011 while the formal sector schemes and private insurance account for about 7% of the population, bringing the total health insurance coverage to 92%. CBHI schemes now cover the entire 30 districts that make up the country. A latest CBHI Policy was developed in 2010 and implemented starting at start of July 2011 to address the emerging challenges of CBHI implementation, such as: institutional capacity building, financial sustainability and improved equitable access, pooling resources from varying sources (Government, donors, civil society organizations, and members and mandatory contribution), and further address issues through cross-subsidization between “better-off” health insurance schemes with high revenues and low risk pools and “worse-off” schemes such as the CBHI have.

Intersectoral actions have been also in where through the MoH, MINECOFIN and central bank, the Government purchases services, by (a) providing direct financial support to health facilities (b) through performance-based funding to health facilities, and (c) direct contributions to CBHI fund to cover the percentage of the population identified as poor. Development Partners (DPs) support the efforts of government through General Budget Support (GBS), Sector Budget Support (SBS), and through contributions to PBF and support to CBHI. Households (HH), if not covered by any insurance, will pay directly OOP for services through user fees at the point of use. The population covered by CBHI, RAMA and MMI have a reasonably comprehensive benefit package that has greatly reduced catastrophic expenditures.

PBF introduces an incentive to facilities to maintain an optimum staffing level in order to maximize financial income and incentives for staff (hence introduces incentives to improve the efficiency of facilities), based on an impact study conducted by SPH/WB in 2011 where PBF was singled out to have had significant impact on institutional deliveries; preventive care visits by young children, improved quality of prenatal care and encourages individual and married couples VCT.

Due to support from the MINALOC and MINECOFIN, the PBF model was scaled from pilot to cover the entire country's health facilities and gradually to other lower levels of the health system, including the community-level. Despite some challenges at the initial implementation stages, PBF is currently considered a key financing mechanism and its implementation is being streamlined and enhanced to include the lowest levels. Within the Performance-based financing framework, providers are reimbursed on a fee-for-service basis, thus creating incentives for “over-servicing”. PBF, as a mechanism for purchasing services, is the second largest expenditure item and represents 10% of the total Medium-Term Expenditure Framework (MTEF) for health. The PBF allocation was more than double the planned public expenditure on human resources for health, including salaries and wages in 2012.

In Rwanda, PBF approach has been widely seen to significantly contribute to the health workers' motivation, improved financial access to health services to clients, and minimized internal migration of

health workers from health facilities to the NGO where they get more pay (MoH, 2011b). Like in many LMIC implementing the PBF approach, Rwanda's critical challenge remains its sustainability as big share of funding comes from the development partners. However, Rwanda is striving to keep the strategy by: increasing more resource allocation to PBF from internally generated revenues, mobilizing more internal resources, and using part of the insuring to finance PBF program. The Government is hopeful that, with these strategies, the PBF approach cannot derail but rather keep surviving. In the HSSP III 2013-2018, the Government through MINECOFIN plans to spend more 2.0% of the capita allocation by 2015, more than 1.5 spent from previous years (MoH, 2012).

4.2 The Challenges

Notwithstanding the excellent achievements in health financing (health insurance and PBF approach), the following key challenges remain, and if not carefully addressed; the threats might derail the already achieved results.

There are still policy obstacles that affect smooth implementation of health financing policy. The main ones include: weak private sector which make less than 10% of total facilities, access to health services in remote areas still an issue, while improvement to financial accessibility has registered record high, this has also compromised the quality of care and sustainability over years to come remain a issue for both the Government and development partners.

There is still need to strengthen the management structures of the CBHI and consider appropriate interventions for ensuring the sustainability of CBHI funds. Management capacities at the sector, district and national levels still low and needs to be strengthened in order to improve the institutional sustainability of the CBHI.

It is important that MINECOFIN sustain the increase in financial allocation to the MoH in order to sustain the increase in public expenditure on health. However, as the country's income grow, the poor population will afford to buy insurance and actually expand on the service package. MINALOC has been critical in supporting and strengthening the administrative structures and increasing accountability for all staff working for CBHI. Despite the existing coordination mechanisms between the partners and sectors on implementing the health financing policy, alignment and harmonization frameworks in place, the flow of external funds and information are sometimes not aligned as would be expected. There is need to improve strong sectoral and stakeholders' coordination mechanism to strives for enhanced equity in allocation of resources.

5. Conclusions and recommendations

Rwanda has implemented innovative health financing policies. Through the support of other sectors, MoH manage to develop these policies and effectively implemented. The results from the implementation have been applauded by the many in the international community calling for other LMIC with similar context to learn more about Rwanda in reforming their health care system. Rwanda's 92% of its 11 million population is currently protected from catastrophic health care expenditures. The PBF payment has a bit stabilized the health workers because of PBF payment system. The health outcomes especially the priority targets have been on the steady increase, and Rwanda is on clear path to achieve the MDG # 4. Other socioeconomic areas have also been growing with per capita income growth, poverty reduction, and improved food security through agricultural intensification program. The gender-based violence is being addressed intersectorally among the National Police, MIGEPROF, MoH, MINECOFIN, and MINALOC, and some members of the UN System.

Whereas the achievements have been outstanding, the sustainability remains a big challenge for both the government and donors. More than 50% of the funds that finance the health come from donors.

Therefore sustainability is not assured should donors pull out. In addition, the international economic crisis that has hit global economy might affect the results already observed. Therefore donors and Rwandan Government have interest in avoiding any setback that can derail the already achieved results. Rwanda and Donors needs to work out a mechanism that would sustain the results attained thus far. Intersectoral action can contribute heavily to sustaining these results. The ministries whose actions have profound impact on health outcomes needs to be addressed broadly with all pertinent sectors and funding sought to improve health issues in non-health sectors and there is a need for a strong collaboration on this.

6. Limitations to this study

There are three essential limitations of this case study:

- 1) Methodological issues: the study planned to use data/ information from document review and stakeholder interviews. However, the results relied more on the document review. We did few stakeholder interviews—we think by conducting many stakeholder interviews could not have changed the outcome of the case study
- 2) The second limitation was shortage of publication in the peer-reviewed journal for the information we were looking for. There is limited literature particularly for Rwanda. We can expand on this piece of work to document deep intersectoral actions and economics behinds these acts—acting together or not acting.
- 3) We failed to find similar case studies with in the region to attempt the comparison with our case study. It would be helpful to develop similar case studies within the region to examine if intersectoral action in health financing improved health service delivery to the beneficiaries.

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Table of abbreviations

BP	Banque Populaire (popular Bank mostly frequented by local population)
CPBF	Community-Performance-Based Financing
CBHI	Community-Based Health Insurance
DP	Development Partners
EDPRS	Economic Development Poverty Reduction Strategy
HDI	Health Development Index (UNDP)
IHLCS	Integrated Households Living Conditions Survey
ISA	Intersectoral Action
LMIC	Low Middle Income Countries
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MIGEPROF	Ministry of Gender, Women and Family Promotion
MINALOC	Ministry of Local Government
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education
MMI	Military Medical Insurance
MoD	Ministry of Defence
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NISR	National Institute of Statistics of Rwanda
PBF	Performance-Based Financing
RAMA	Rwanda Medical Insurance for civil servants
UHC	Universal Health Coverage
UNDP	United Nations Development Program
UNCEF	United Nations Children Education Fund
WB	World Bank
WHO	World Health Organization

