POLICY BRIEF

Strategic Health Purchasing in Rwanda

A Summary of Progress, Challenges, and Opportunities

JUNE 2021

STRATEGIC HEALTH PURCHASING FOR UNIVERSAL HEALTH COVERAGE IN SUB-SAHARAN AFRICA

The Strategic Purchasing Africa Resource Center (SPARC), a resource hub hosted by Amref Health Africa with technical support from Results for Development (R4D), aims to generate evidence and strengthen strategic health purchasing in sub-Saharan Africa to enable better use of health resources. SPARC and its technical partners created a framework for tracking progress in strategic health purchasing and are applying it in countries across sub-Saharan Africa to facilitate dialogue on what drives progress and to promote regional learning.

RWANDA AT A GLANCE

- Population (2020): **12.7 million***
- GDP per capita (2016/17): **US$774****
- Headcount poverty rate (2016/17): **38.2%*****
- Life expectancy (2020): **67.8 years***
- Total health expenditure (THE) per capita (2016/17): **US$43****
- Domestic government expenditure as % of THE (2016/17): **51%****
- Out-of-pocket expenditure as % of THE (2016/17): **9%****
- External expenditure as % of THE (2016/17): **49%****

Sources:
* National Institute of Statistics of Rwanda
** Health Resources Tracking Output Report: Expenditure for FY 2015/16 and 2016/17
*** Fifth Integrated Household Living Conditions Survey (EICV5)

Health Financing Schemes in Rwanda

Rwanda is a low-income country that is well known for achieving good health outcomes in the past two decades, at much lower levels of health spending than many other African countries. Rwanda's Health Financing Strategic Plan 2018–2024 defines the strategy to accelerate progress toward achieving universal health coverage (UHC). This includes universal access to quality health care services and enhanced efficiency and equity in allocation and use of health sector resources. The goal is to increase the value for money of public spending by, among other things, refining provider payment systems, renegotiating tariffs, and improving the quality of health services through accreditation standards. The strategy also calls for encouraging and incentivizing quality improvement by linking payment to provider performance, strengthening population participation and ownership in health financing schemes, and enhancing patient satisfaction.

Rwanda has the following types of health financing schemes:

- **GOVERNMENT BUDGET FINANCING.** The Government of Rwanda makes an annual allocation to the health sector from government revenue. These funds are used for input-based financing, mostly health worker salaries. This also includes on-budget support for health sector projects funded by external donors.
- **PERFORMANCE-BASED FINANCING (PBF).** The PBF scheme is managed by the Ministry of Health (MOH) and provides financial incentives to health facilities to achieve specific targets. PBF payments are used to top up health worker salaries. The aim of the PBF scheme is to increase the quantity and quality of specific services, with a focus on maternal and child health.
- **COMMUNITY BASED HEALTH INSURANCE (CBHI).** This contributory scheme provides coverage to the majority of Rwandans, especially the rural population and informal-sector workers. The government provides subsidies for the poorest households. Contribution levels are set by the *Ubudehe* system, a community-level socioeconomic classification of households to determine eligibility for government subsidies. Of the four *Ubudehe* categories, only households in the lowest-income category are fully subsidized by the government. This scheme is managed by the Rwanda Social Security Board (RSSB).
- **RSSB MEDICAL SCHEME.** This contributory scheme provides health insurance coverage for public- and private-sector workers and for pensioners. For formal-sector workers, the contribution is shared by the employee and employer; for pensioners, RSSB deducts the contribution from their monthly pension. The scheme is managed by RSSB.

Rwanda has additional health financing schemes that include Military Medical Insurance, the University of Rwanda Medical Insurance Scheme, and private health insurance schemes, which have low coverage.

Table 1 compares the purchasing functions of the main health financing schemes.

Table 1. **Purchasing Functions in Rwanda's Health Financing Schemes**

	Government Budget Financing	Performance-Based Financing (PBF)	Community Based Health Insurance (CBHI)	Rwanda Social Security Board (RSSB) Medical Scheme
% of Total Health Expenditure (2015/16)*	49%		8%	5%
Main Purchaser(s)	MOH	MOH	RSSB	RSSB
Governance	The annual budget appropriation process is led by the Ministry of Finance and Economic Planning (MINECOFIN). MOH is led by the minister and departmental heads. Public facilities receive input-based budgets and do not have autonomy to reallocate budget funds across line items.	The annual budget appropriation process, including on-budget support from external sources, is led by MINECOFIN. MOH's Department of Planning, Health Financing, Monitoring and Evaluation oversees day-to-day activities related to the implementation of PBF nationwide. At the district level, district steering committees provide direct oversight and verification. Health facilities are allowed to use received funds only for staff incentives.	The scheme is managed by RSSB, a government agency under the oversight of MINECOFIN. MINECOFIN remits the subsidy for *Ubudehe* category 1 to RSSB; RSSB collects other member contributions. RSSB is led by the director general and the management team. Public facilities have financial autonomy to manage CBHI funds.	The scheme is managed by RSSB. Member contributions are collected directly by RSSB. Public facilities have financial autonomy to manage scheme funds.
Financial Management	Budgets are based on MINECOFIN budget estimates from the Medium-Term Expenditure Framework (MTEF) and historical expenditures. Budget overruns are not allowed.	PBF budgets are based on the previous year's expenditure and available funds from both domestic and external sources. Budget overruns occur, and when PBF funds are depleted and are not sufficient to pay facility claims, the health facilities finance the deficits through internally generated facility revenue.	Budgets are set by management, based on membership and projected revenue. Overruns occur, and MINECOFIN provides additional funding to bridge deficits. Other health financing schemes, such as the RSSB Medical Scheme and private health insurance, cross-subsidize CBHI. Additional domestic funds and subsidies are made available to CBHI to improve the viability of the scheme.	Budgets are estimated based on the previous year's expenditure plus 15%. The budget is approved by MINECOFIN. The scheme has not had budget overruns. Surpluses are invested.
Benefits Specification	No explicit benefit package for budget funding.	PBF pays for a set of maternal and child health, malnutrition, HIV, tuberculosis, and eye care indicators. PBF targets services offered by public facilities and community health workers.	A benefit package is set by ministerial order. It includes preventive, curative, and promotional services and curative care at public facilities, private health posts, and private specialist facilities. A list of essential medicines is defined.	A benefit package is set by ministerial order. It includes preventive, curative, and promotional services and curative care at public and private facilities. Reimbursable medicines are reviewed regularly.
Contracting Arrangements	Loose agreements for input-based financing of public facilities	Annual contracts with public facilities only	Loose agreements with public facilities and selective contracting with private facilities for a few specialized health services (e.g., dialysis, eye care, imaging services, and orthopedic and prosthetic devices)	Loose agreements with public providers and selective contracting with private facilities and pharmacies
Provider Payment	Providers are paid through input-based budgets, mostly for health worker salaries and facility operation and maintenance budgets.	Fee-for-service based on achievement of targets	Fee-for-service	Fee-for-service
Performance Monitoring	Monthly facility activity reporting on DHIS2 and the Integrated Financial Management Information System (IFMIS), MOH facility inspections, annual financial report, internal and external audits, and annual reporting in the Health Resources Tracking Tool	Monthly facility activity reporting on DHIS2, verification of invoices before payment, central-level data verification	Electronic medical records, Mutuelle Membership Management System (3MS), facility inspections, annual financial report, and facility inspections and audits	Electronic medical records, client membership management database, facility inspections, annual financial report, internal and external audits

** Health Resource Tracking Tool Report FY 2015/16 and 2016/17*

Progress and Challenges in Strategic Health Purchasing

Rwanda has been lauded for its high level of coverage of citizens and its progress in reducing fragmentation in health financing by merging the previous district *mutuelles* into one national pool: CBHI. In 2015, the Government of Rwanda transferred management of the CBHI scheme from the MOH to RSSB in an effort to consolidate management, improve strategic purchasing, and reduce administrative costs. This consolidation of purchasing within one institution has created the opportunity to increase RSSB's purchasing power, although this has not been fully realized. Schemes in Rwanda use output-based provider payment methods that are linked to the services provided. Contracting is linked to quality standards and performance monitoring, particularly in the PBF scheme. Performance monitoring is partially automated and includes mechanisms for system-level performance monitoring.

Highlights of progress and remaining challenges in each of the purchasing functions are described below.

GOVERNANCE. Institutional roles and responsibilities for purchasing are clear, and health facilities have financial autonomy to respond to purchasing incentives for the CBHI, RSSB, and PBF schemes. There are, however, overlaps in purchasing functions. For example, the National Health Insurance Council (NHIC) is mandated to set tariffs for all health financing schemes, but the MOH carries out this function. There are also overlaps across the schemes for each function—with different packages, contracting arrangements, payment rates, and performance monitoring systems.

FINANCIAL MANAGEMENT. A defined process is used to set the purchaser's budget and mechanisms exist for tracking budget execution and spending in all of the schemes, but budget overruns occur in most schemes. Overruns over many years have resulted in deficits in the CBHI scheme, threatening its sustainability. To minimize this, Rwanda introduced a system of cross-subsidization from other insurance schemes, which pay 5% of revenues to CBHI, and mobilized additional domestic resources to subsidize CBHI. The Ministry of Finance and Economic Planning (MINECOFIN) provides additional budget allocations to meet these deficits, but more needs to be done to control costs.

BENEFITS SPECIFICATION. Benefit packages are not well defined and are not a commitment, but they reflect health priorities. Clinical guidelines defined by the MOH are used as service delivery standards in contracting arrangements. The MOH defines the drugs to be included. Schemes lack a systematic process for reviewing benefit packages, but RSSB aims to establish an evidence-based Health Technology Assessment process for revising benefit packages in order to address population needs while prioritizing cost-effectiveness of selected interventions.

CONTRACTING ARRANGEMENTS. All of the schemes include all public providers in loose agreements but contract selectively with private facilities based on defined quality standards. PBF has an accreditation process at the hospital level and formal contracting agreements with all public facilities. Over the past decade, the linking of PBF and the accreditation program implemented at hospital level has contributed to improvements in health outcomes, such as reduction in maternal and infant mortality, ensuring both better quantity and quality of priority health services.

PROVIDER PAYMENT. Schemes use output-based payment linked to service delivery objectives, fee-for-service in all cases, while the government budget uses input-based payment. Fee-for-service tariffs are set by the MOH but vary across schemes. Fee-for-service is an open-ended payment system and threatens the financial viability of the schemes. It also has a tedious paper-based claims process, and reimbursement procedures are administratively complicated and time-consuming for both the service provider and health insurance staff. PBF is paid quarterly as an additional payment to facilities and is used to top up health worker salaries. The separation between PBF and RSSB payments to health facilities is a missed opportunity to use these two sources of payment to improve the quality of care and purchase strategically across the schemes. Health facilities develop facility plans and budgets for government budget financing. These line-item budgets do not encourage efficiency because health facilities have rigid rules that do not allow reallocations, and any savings result in reduced budgets in the subsequent year. Public facilities have financial autonomy for internally generated revenues and are accountable for its management according to MINECOFIN guidelines.

PERFORMANCE MONITORING. Provider-level monitoring and system-level performance monitoring are partially automated. PBF performance monitoring informs purchasing decisions by the PBF scheme. The government budget financing and PBF schemes use DHIS2 to track service delivery. CBHI uses an electronic medical records system for case management and an electronic Mutuelle Membership Management System (3MS) for collecting contributions and for managing registration and membership. The 3MS system is linked to the *Ubudehe* system and national identification databases. These automated systems have led to considerable improvement in the management and administration of CBHI, and 3MS has reduced administrative costs of the enrollment process. The information produced through PBF has been used only for PBF implementation; it could be used to improve contracting arrangements between all purchasers and health facilities and strengthen the strategic health purchasing capacity of all purchasers. These different performance management systems used across the various schemes could be unified to support purchasing functions and purchasing decisions.

Table 2 summarizes progress made in strategic purchasing functions along the dimensions of progress defined by SPARC for the main health financing schemes in Rwanda. (See the annex for a detailed explanation of how the levels of progress are indicated using ○, ●●, and ●●●.)

Table 2. **Progress Made Across Purchasing Functions in Rwanda**

Purchasing Function	Indicators of Strategic Purchasing	Government Budget Financing	PBF	CBHI	RSSB Medical Scheme
Governance	Purchasing functions have an institutional home that has a clear mandate and allocation of functions.	●●	●●	●●	●●
	Providers have autonomy in managerial and financial decision-making and are held accountable.	○	●●●	●●●	●●●
Financial Management	Purchasing arrangements incorporate mechanisms to ensure budgetary control.	●●●	●●	●●	●●
Benefits Specification	A benefit package is specified and aligned with purchasing arrangements.	○	●●●	○	○
	The purchasing agency further defines service delivery standards when contracting with providers.	○	●●●	●●	●●
Contracting Arrangements	Contracts are in place and are used to achieve objectives.	○	●●●	○	○
	Selective contracting specifies service quality standards.	○	●●●	○	○
Provider Payment	Provider payment systems are linked to health system objectives.	○	●●	●●	●●
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	○	●●●	●●	●●
Performance Monitoring	Monitoring information is generated and used at the provider level.	○	●●	○	○
	Information and analysis are used for system-level monitoring and purchasing decisions.	●●	●●	●●	●●

Despite this progress, a number of factors weaken strategic purchasing in Rwanda. Although purchasing power is consolidated under RSSB, the organization has not used this authority to create the right incentives to improve provider performance. RSSB administers the CBHI and RSSB separately, with different management and administration teams. There is no harmonization of funding flows to the providers from RSSB and the various schemes it manages—CBHI and the RSSB Medical Scheme—which leads to incoherent incentives to providers. Further, there has been no alignment between the RSSB schemes and PBF. This is a lost opportunity to build on the PBF system for accreditation, quality assurance and improvement, and provider performance monitoring. PBF financial incentives could complement RSSB payments to enhance incentives and avoid duplication in payments. Each RSSB scheme has its own benefit package and tariffs, making it administratively difficult to track and manage. These benefit packages are implicit and do not have a well-defined process for review.

Opportunities to Improve Health Purchasing

Rwanda is an African exemplar in strategic purchasing, but there is still much progress to be made. More than 90% of the population is covered by health insurance, and low out-of-pocket spending indicates a good level of financial protection. Improvements in health outcomes can be attributed to the health financing schemes reducing financial barriers and guaranteeing access to quality health services. Rwanda has consolidated purchasing power in RSSB, but administration remains fragmented; harmonizing the administration of the schemes could reduce administrative costs. More needs to be done to harmonize the purchasing functions across the CBHI scheme and RSSB Medical Scheme, secure the CBHI as a viable scheme, and reduce the differential access to care across schemes managed by the RSSB. PBF could be better harmonized or integrated with CBHI and RSSB Medical Scheme payments to align and enhance provider incentives toward health system objectives.

Rwanda may benefit from reviewing the roles of the MOH, NHIC, and RSSB to reduce duplication of effort in benefits specification, contracting, provider payment, tariff setting, and quality assurance.

Further, better alignment of benefits across schemes, as well as a regular and systematic process for updating and revising the benefit packages to reflect the current evidence, changing contexts, and population needs and preferences, would be useful. The current mix of payment methods does not bring significant benefit to the health system. Open-ended fee-for-service worsens cost escalation and threatens the financial viability of the schemes. Better alignment of provider payment systems with objectives and introducing cost management mechanisms could help solve those challenges.

The PBF scheme was crucial to Rwanda's achievement of targets under the United Nations Millennium Development Goals. Rwanda may choose to retain the positive elements of PBF, such as the accreditation process, and linking quality improvement to financial incentives. It could also strengthen accreditation to ensure that uniform standards are applied to all public and private facilities. To ensure equity, it could provide support to health facilities in rural and hard-to-reach areas to improve their performance and meet accreditation standards. Linking RSSB payments to progress toward meeting accreditation standards and PBF indicators could foster sustainability and increase system responsiveness. PBF's financial sustainability remains a challenge because it relies heavily on external sources. Harmonizing PBF with existing RSSB schemes may sustain the positive elements beyond current donor funding and better position PBF as a complementary feature to RSSB payment methods.

SPARC and the technical partners view strategic purchasing as a way to improve resource allocation, provide coherent incentives to providers, and improve accountability for health resources. As next steps, SPARC's partner in Rwanda—University of Rwanda School of Public Health—will validate the SPARC findings with Rwandese stakeholders and determine appropriate actions to make further progress in strategic purchasing as a way to achieve UHC in Rwanda.

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RESULTS FOR DEVELOPMENT

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Annex. **Strategic Purchasing Progress Indicators**

Governance	**Purchasing functions have an institutional home that has a clear mandate and allocation of functions.**	○	An agency or agencies have responsibility for carrying out one or more purchasing functions, but mandates are not clearly defined and capacity is weak.
		●●	An agency or agencies have responsibility for carrying out most or all purchasing functions and capacity is improving, but some overlaps and gaps in responsibilities remain. Mechanisms are in place for stakeholder engagement.
		●●●	An agency or agencies have responsibility for carrying out all purchasing functions, capacity is strong, and there are no overlaps or gaps in responsibilities. There is inclusive and meaningful stakeholder engagement.
	Providers have autonomy in managerial and financial decision-making and are held accountable.	○	Public providers have no autonomy or extremely limited autonomy to carry out financial and managerial functions, and they have limited ability to respond to financial incentives created by provider payment systems.
		●●	Public providers are given a larger degree of financial and managerial autonomy, but accountability mechanisms are weak.
		●●●	Public providers are given a large degree of financial and managerial autonomy, and accountability mechanisms are effective.
Financial Management	**Purchasing arrangements incorporate mechanisms to ensure budgetary control.**	○	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending, but these mechanisms are not well enforced.
		●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, but budget overruns routinely occur.
		●●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, and budget overruns rarely occur.
Benefits Specification	**A benefit package is specified and aligned with purchasing arrangements.**	○	A benefit or service package is defined and reflects health priorities, but it is not well specified, is not a commitment, and/or is not aligned with purchasing mechanisms.
		●●	A benefit or service package is defined, reflects health priorities, and is a commitment, but it is not well specified and/or not aligned with purchasing mechanisms.
		●●●	A benefit or service package is defined, reflects health priorities, is a commitment, is well specified, and is aligned with purchasing mechanisms, and a transparent process for revision is specified.
	The purchasing agency further defines service delivery standards when contracting with providers.	○	The purchaser defines some general standards for delivering services in the package (e.g., for gatekeeping), but enforcement through contracts is weak.
		●●	The purchaser defines some general service delivery standards and some specific service delivery standards (e.g., number of prenatal care visits) that are enforced through contracts.
		●●●	The purchaser defines general service delivery standards and specific service delivery standards in line with national service delivery policies and clinical protocols, and service delivery standards are enforced through contracts.
Contracting Arrangements	**Contracts are in place and are used to achieve objectives.**	○	Loose agreements are in place between the purchaser and public providers for specified services in exchange for payment instead of or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●	Formal agreements are in place between the purchaser and public providers for specified services in exchange for payment or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●●	Formal agreements are in place between the purchaser and public and private providers to help achieve specific objectives, and they are linked to performance.
	Selective contracting specifies service quality standards.	○	The purchaser has loose, nonselective agreements or contracts with all public providers and selective contracts with some private providers based on some definition of quality standards.
		●●	The purchaser contracts at least somewhat selectively with public and private providers based on accreditation or some other definition of quality standards.
		●●●	The purchaser contracts selectively with public and private providers based on uniformly applied quality standards.
Provider Payment	**Provider payment systems are linked to health system objectives.**	○	Some output-based payment is used.
		●●	Output-based payment is used, and payment systems are linked to specific service delivery objectives.
		●●●	Output-based payment is used and is linked to specific service delivery objectives; payment systems are harmonized across levels of care, and they allow purchaser budget management.
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	○	Provider payment rates are determined based only on the purchaser's available budget.
		●●	Provider payment rates are determined based on the purchaser's available budget and at least one other factor (e.g., cost information, priorities, or negotiation with providers).
		●●●	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.
Performance Monitoring	**Monitoring information is generated and used at the provider level.**	○	Some form of monitoring happens at the health provider level (e.g., supportive supervision visits, monthly activity reporting, claims audits, quality audits).
		●●	Provider-level monitoring is at least partially automated and is used for purchasing decisions.
		●●●	Provider-level information is automated, fed back to providers, and used for purchasing decisions.
	Information and analysis are used for system-level monitoring and purchasing decisions.	○	Some form of analysis is carried out at the system level (e.g., service utilization, medicines prescribed, total claims by service type).
		●●	System-level analysis is automated and carried out routinely.
		●●●	Information and analysis are used for system-level monitoring and purchasing decisions.