PART VI

Improving Human Development Outcomes with Innovative Policies
Rwanda has been moving very rapidly to expand health service delivery. It has dramatically accelerated the trend of progress on health indicators, putting it back on track to reach the health Millennium Development Goals (MDGs). Three interrelated innovative reforms contributed to improvement: community-based health insurance, performance-based financing within a broader framework of reform of management of human resources for health, and fiscal decentralization. This chapter examines these reforms, showing how they worked together to improve health outcomes in Rwanda.

Health indicators in Rwanda improved dramatically in recent years, and projections for the coming years are positive. After an initial surge following the genocide, under-five mortality (the probability of death per 1,000 live births) significantly decreased, falling from 196 in 2000 to 152 in 2005 and 103 in 2007 (figure 22.1). The infant mortality rate decreased from 107 per 1,000 live births in 2000 to 86 in 2005 and 62 in 2007. Improvements were particularly significant among the poor, with the under-five mortality rate among the poorest quintile declining by 50 deaths per 1,000 between 2005 and 2008 compared with 38 deaths per 1,000 live births among the richest quintile. The annual rate of decrease achieved between 2005 and 2008 was 12.2 percent—far greater than the 9.7 percent needed to meet the MDG target of reducing the under-five mortality rate by three-quarters between 1990 and 2015.

These achievements have been the result of innovative strategies to address some of the key challenges affecting maternal mortality. The share of women delivering their babies in health facilities has steadily increased, rising from 28 percent of pregnant women in 2000 to 45 percent in 2008. Many challenges remain, but preliminary data from the Ministry of Health for 2010 suggest that this figure has risen to two-thirds of all pregnant women; the finding should be validated by the 2010 Demographic and Health Survey.

These successes can be attributed largely to an increase in the use of essential health interventions, particularly high-impact interventions that are critical in reducing disease burden in developing countries, including immunization, assisted deliveries, family planning, and the use of insecticide-treated bed nets to prevent malaria. Rwanda has maintained a very high and equitable coverage of vaccination against avoidable childhood diseases since 2000: immunization rates, at 95 percent in 2008, are among the highest in Sub-Saharan Africa. Major progress has also been made in extending the coverage of vitamin A supplementation among children and women, through a mass campaign and integration into routine health facility services. Treatment of acute respiratory infections of children has also increased, including among the poor.
Improvements in the use of women’s health services are also evident, with significant increases in the proportion of assisted birth deliveries and the number of emergency obstetrical cases referred. The use of modern contraceptives increased from 3 percent in 2000 to 27 percent in 2007, one of the fastest increases ever observed. The proportion of women having at least one antenatal consultation rose from 58 percent in 1995–2000 to 96 percent in 2000–07. The proportion of assisted deliveries increased from 39 percent in 2005 to 52 percent in 2007.

Major progress has also been made in controlling communicable diseases—including malaria, a prime cause of morbidity and mortality in Rwanda—and containing the HIV/AIDS epidemic. Malaria incidence and mortality have declined dramatically, largely as the result of increased use of insecticide-treated nets, which among children under five rose from 11 percent in 2005 to 56 percent in 2007. As a result, malaria-specific mortality was cut in half. Rwanda has thus moved from being a country where malaria was endemic to one focusing on eliminating malaria as a public health problem. The HIV/AIDS epidemic has been contained, with 3 percent of the population affected and more than 60 percent of patients needing treatment receiving highly active antiretroviral therapy. Knowledge of HIV/AIDS is better in Rwanda than in any other Sub-Saharan African country: nationwide 54 percent of women
and 58 percent of men had comprehensive knowledge of HIV/AIDS in 2005.¹

This progress occurred in a context in which annual total per capita health expenditures doubled, from $17 to $34 between 2003 and 2006. In 2006 total health expenditures reached 10.7 percent of gross domestic product (GDP) (one of the highest levels of health expenditures observed in low-income countries), up from 3 percent in 2002.

The overall share of public expenditures allocated to health has remained stable, with most of the increase coming from donors. Private expenditures were about $9.40 per capita, and domestic public expenditure about $6.30 per capita, with donors contributing $17.70 per capita, one of the highest levels of donor dependency in Sub-Saharan Africa. Much of this donor funding is earmarked funding for HIV/AIDS.

Despite the increase in funding, resources are not sufficient to meet the country’s health care needs. Rwanda has therefore pioneered profound reforms, including an innovative health system and a financing model grounded in grassroots initiatives and institutions. Three prominent reforms were adopted to boost both the demand for and the supply of health services: health microinsurance (mutuelles), performance-based financing, and fiscal decentralization. Those reforms have transformed the fiscal space landscape. Revenues generated by health facilities have increased significantly as a result of increased use of health services and health insurance coverage, and an increasing share of domestically generated revenues is captured by health centers, strengthening front-line providers.

In 2007 the Rwandan government adopted its second Poverty Reduction Strategy Paper (the Economic Development and Poverty Reduction Strategy). Its goals for the health sector are to maximize preventive health measures and build the capacity to provide high-quality and accessible health care services to the entire population in order to reduce malnutrition, infant and child mortality, and fertility and to control communicable diseases. The strategy also supports strengthening institutional capacity, increasing the quantity and quality of human resources, ensuring that health care is accessible to the entire population, increasing geographical accessibility, increasing the availability and affordability of drugs, improving the quality of services in the control of diseases, and encouraging the demand for such services. It also sets ambitious targets for slowing population growth, calling for innovative measures in the strengthening of reproductive health services and family planning and ensuring free access to information, education, and contraceptive services.

REFORM STRATEGIES: COMMUNITY-BASED HEALTH INSURANCE, PERFORMANCE-BASED FINANCING, AND FISCAL DECENTRALIZATION

Rwanda has pioneered major programmatic, organizational, and health financing reforms, which are increasing the accountability of major actors in the health sector. Rwanda has a long history of centralized management structures with a clear hierarchy and a relatively low level of corruption. It has progressively moved toward a modern health system design, including full autonomy of facilities, decentralization, third-party payment, and strategic purchasing through performance-based financing. It has transitioned from a faith-based service delivery model in the colonial era to a model guided by the Bamako Initiative, which sought to expand access to health services through the development of local models of primary health care that are managed and financed by communities. Both public and private not-for-profit health facilities charge fees that are locally retained and managed to cover the costs of health services and improve the quality of care.

To improve financial access, the government pioneered a microinsurance scheme and supported its expansion and subsidization. It then introduced a mechanism of performance-based financing to provide incentives to health facilities to deliver high-impact interventions and ensure quality of services. In 2006 it established a fiscal decentralization policy and a legal framework that delineated a clear role for central and local governments and service providers.

Together these three reforms constitute strategies to strengthen accountability for services to citizens as part of Rwanda’s 2006 national decentralized service delivery policy (Government of Rwanda 2006). Fiscal decentralization has been accompanied by measures to strengthen citizen participation and accountability, including mechanisms for establishing accountability links between citizens and local government officials, contractual performance between health services providers and local governments or national policy makers, and contractual approaches between communities and health providers. This policy can be visualized by using the accountability framework laid out in the World Development Report 2004 (World Bank 2004). Accountability of health providers to clients (“client’s power”) is strengthened through micro–health insurance funds that claim and fund health services on behalf of households. Accountability of providers to the government (the “compact”) is
strengthened thanks to performance-based financing mechanisms. Accountability of government to citizens (“voice”) is strengthened through decentralization, citizen report cards, and the possibility of recourse to the ombudsman (figure 22.3).

Rwanda has finally settled into its current decentralized model of care, in which health facilities are fully autonomous entities responsible for the management of financial resources, health service delivery, and human resources for health. Community-based health insurance schemes, which have been established and scaled up nationally, have evolved in response to low levels of utilization of health services. Partly to encourage community members to buy in to these health *mutuelles* schemes, the government developed performance-based financing as a complementary scheme to boost the performance and motivation of staff to deliver higher-quality services as well as to increase the delivery of preventive services.

*Mutuelles* and performance-based financing are two complementary schemes. Both aim to shift health financing mechanisms from inputs-based mechanisms toward output- or results-based contractual mechanisms. The interactions between the two strategies are therefore strong. Whereas *mutuelles* emphasize personal curative care services, performance-based financing emphasizes high-impact preventive services and the quality of services.

The nationwide expansion of both strategies has occurred rapidly since the pilot schemes were launched, thanks largely to government ownership and commitment, which have propelled these strategies forward. The nationwide implementation of *mutuelles* was closely followed by the implementation of performance-based financing. *Mutuelles* revealed the need for improvements in staff motivation and incentives to deliver high-quality health services, which in turn served as the driving force for performance-based financing. As the implementation of performance-based financing in the pilot districts proved successful in improving staff motivation and health outcomes, performance-based financing became a major pillar within the Ministry of Health Strategic Plan (2005–09). In 2006 the government, with the support of external partners, expanded performance-based financing to the entire health sector (table 22.1).

Rwanda has continuously learned from and adapted its health service delivery strategies. The ability of the government to adapt strategies—as evident in the scaling up of successful pilot schemes to the national level, in light of the changing macroeconomic and health sector environment—was also essential to strengthen health services. Independent controls and quality checks under contractual arrangements have been essential for the monitoring and evaluation of health facility performance. Performance-based financing is a prime example of a system in which independent controls on performance are in place to ensure proper monitoring and reporting of health centers and district hospitals on the quantity and quality of services delivered, which in turn drive facilities’ reimbursement.

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**Figure 22.3  Decentralization of and Accountability for Health Services in Rwanda**

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*Note:* *Imihigo* are performance contracts in which the region and its districts promise the president of Rwanda that they will implement the measures outlined in the annual plans.
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<tr>
<td>Enrollment in mutuelles (percent)</td>
<td>0</td>
<td>1.6</td>
<td>2.6</td>
<td>4.7</td>
<td>7</td>
<td>27</td>
<td>44</td>
<td>73</td>
<td>75</td>
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<td>Number of districts with performance-based financing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>14</td>
<td>23</td>
<td>30</td>
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<td>Assisted deliveries (percent)</td>
<td></td>
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<td>Key policy milestones</td>
<td>Rwandaise d’Assurance Maladie (RAMA) created; fiscal decentralization policy</td>
<td>Fiscal decentralization law passed; decentralized service delivery policy includes performance-based financing and mutuelles</td>
<td>Health insurance law passed</td>
<td></td>
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<tr>
<td>Key implementation milestones</td>
<td>Community-based health insurance pilots launched in three health districts since July 1999</td>
<td>RAMA established</td>
<td>Performance-based financing pilots launched in four districts</td>
<td>Integration of performance-based financing and subsidies to mutuelles in national budget</td>
<td>Fiscal decentralization</td>
<td>Full autonomy given to public health facilities, including over hiring and firing</td>
<td>National guarantee fund established</td>
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<tr>
<td>Per capita health expenditures (National Health Account)</td>
<td>$15</td>
<td>$37</td>
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Source: Authors.

Note: RAMA = Rwandaise Assurance Maladie.
Community mobilization and intersectoral collaboration have contributed significantly to the implementation of health reforms. Cultural and social factors, particularly solidarity within communities, have contributed to the success of several health service delivery innovations. The rapid proliferation of health mutuelles was made possible by the strong solidarity within Rwandan society, in which community members encouraged one another to join. This solidarity has been long-standing in Rwanda, evident even before the start of health mutuelles. In the case of health mutuelles, cultural barriers initially thwarted implementation, particularly because Rwandans were used to seeking care from traditional healers and because patients of traditional healers were able to pay in kind rather than making cash payments.

**Community-based health insurance**

Health insurance has been scaled up at the national level on the basis of community-based health insurance schemes, with strong support from the government of Rwanda. Coverage of health mutuelles increased dramatically between 2003 and 2008, rising from less than 7 percent to 85 percent of the population in just five years.

Health mutuelles have had a significant positive impact on health service utilization, income protection, and household health behaviors (Sekabaraga, Diop, and Soucat 2010). Health insurance coverage increased the use of modern health services by children under five between 2000 and 2007. In the general population, use of modern services by the insured population is nearly twice as high as use by the uninsured (figure 22.4). In addition, health mutuelles seem to protect against expenditure caused by unexpected illness, because uninsured households spend directly twice as much as insured households for illness-related expenditure. Health insurance coverage has thus significantly reduced household out-of-pocket health expenditures (Ministry of Health of Rwanda and World Bank 2011). Among women who gave birth during the period 2000–05, 77 percent were affiliated with Rwandaise d’Assurance Maladie (RAMA). About 42 percent of women affiliated with a health mutuelle were assisted by a skilled health professional during delivery compared with 35 percent of women with no insurance (Sekabaraga, Diop, and Soucat 2010).

Before 1996 health services in Rwanda were free. Given problems associated with the quality of services and the financial sustainability of the health system, cost-recovery mechanisms were reintroduced in 1996, while policy debates continued over alternative financing mechanisms for reconciling internal resource mobilization and access to health services, including prepayment mechanisms through health insurance schemes. In view of the significant scope of poverty following the war of 1994, the reintroduction of user fees in the health sector in 1996 was accompanied by an exemption policy that allowed for free health care coverage in health facilities for people identified by the local administrative authorities as indigent. Coverage of the poor and vulnerable groups has been integrated in the development of health mutuelles since they were first piloted in 1999.

In 2000 Rwandaise d’Assurance Maladie, the first health insurance scheme for the formal sector, was established for civil servants. Membership in RAMA soon became compulsory in order to increase coverage. To complement insurance schemes such as RAMA and a few private insurance schemes that target the formal sector, health mutuelles covering rural communities and the informal sector were expanded to promote equitable access to quality health services. Health mutuelles were designed to pool or spread the financial risk of seeking care across their membership base. The goal was to respond to the low use of health services (caused in part by user fees) by improving financial access to health services, particularly for underserved populations. The package of services reimbursed by health mutuelles to health facilities has expanded over time and currently covers all services delivered within a health center as well as drugs from the national essential drug list. Health mutuelles also cover most costs for health services and drugs delivered at district and referral hospitals when mutuelle members receive referrals for these higher levels of care.

These schemes have been extended to empower citizens and communities in the health sector and to change their
interactions with health care providers. Through contractual relations between health mutuelles and health care providers, communities and citizens have a tool with which to hold health care providers accountable for services provided. In essence, health mutuelles in Rwanda reflected a bottom-up strategy, driven largely by local communities. The success of the initial pilot schemes motivated the central government to scale up this strategy. Currently, the central government sets national guidelines and policies, including benefit packages and contribution policies. In 2008 it instituted a national guarantee fund for providing general subsidies to support the extension of the benefit packages of health mutuelles. Since 2009 the government has also built on the national network of health mutuelles to elaborate and implement demand-based targeted subsidies, through which the government, donors, and nongovernmental organizations (NGOs) are providing health insurance coverage to poor people, vulnerable groups, and people living with HIV/AIDS. At the operational level, health mutuelles are run and organized by community representatives and local health care providers. They also serve as a forum for promoting dialogue between the community and providers on the quality and range of health services offered. In this way, community members are better able to hold providers accountable for services delivered.

For the majority of the population employed in the rural and informal sectors, an incremental approach was followed in developing mechanisms for pooling health risk. The process of cumulative building of national capacities is a hallmark of the incremental development of mutuelles in Rwanda. Capacity building for local actors involved in setting up, managing, and monitoring health mutuelles began in 1999, with the establishment of mutuelles in three pilot health districts. The geographic extension of the mutuelles was accelerated in 2004, after the adoption of a national strategic framework for their development. The number of health mutuelles grew by a factor of 2.5 in a single year, climbing to 226 nationwide. In 2007 each of Rwanda's 403 health centers had a partner health mutuelle or “health mutuelle section,” and all of the country's 30 districts had a district health mutuelle, which, on average, was linked to 13 health mutuelle sections.

The period of experimentation, which started in 2001, was followed by attempts to adapt the institutional arrangements for health mutuelles to the environment of administrative and political decentralization and by early efforts to expand the mutuelles to other districts of the country. In the absence of an explicit policy framework for coordinating the initial efforts of adaptation and expansion, a variety of local policies and incentives proliferated, initiated by local authorities of all categories (political groups, associations, and so forth) to motivate the population to join health mutuelles (by, for example, linking membership to civil status services, microcredit, and so forth). These initiatives helped develop the health mutuelles and contributed to the growth of social demand for their expansion nationwide.

Current levels of contributions to health mutuelles are affordable for all but the poorest 10 percent of Rwandans. Affordability of enrollment in health mutuelles is assessed based on the percentage of contributions in household total expenditures and household nonfood expenditures. The cost of membership rises with family size (for many reasons, including high disease burden in large families and the externalities of insurance benefits). Male-headed households have a higher proportion of enrollment than female-headed households, partly because of the income difference between the two groups. Family heads that completed primary school or received some vocational training tend to have the highest rate of enrollment among the least-educated and best-educated households. This trend is also reflected in the enrollment rate by income (expenditure) category, so that middle-income and middle-rich people tend to have the highest participation rates in health mutuelles. Out-of-pocket illness-related expenditures among households enrolled in health mutuelles are twice as high as those of members. Households that live very close to health centers spend more than those living far away. Households that are not covered by health mutuelles spent nearly twice as much for illness-related services as people who were insured.

Information has played an important role in the operational management and monitoring of the development of health mutuelles at the local level and in their strategic management at the central level. Indeed, Rwanda is one of the few African countries where an information system to support health mutuelle management has been developed to permit monthly monitoring of performance. It is also one of the few countries that has adapted training manuals on health mutuelle development, management, and monitoring in line with the local context, including availability in the local language. Numerous other activities to promote and raise awareness of health mutuelles are carried out around the country and at the national level. The Ministry of Health occasionally organizes an annual event on mutual organizations at which prizes are awarded to the best performing health mutuelles.
Performance-based financing and reforms of human resources management

Based on a positive evaluation of a three-year pilot phase in two provinces, Rwanda has implemented a national program since 2005; it has scaled up performance-based financing since 2006 (Rusa et al. 2009). Performance-based financing is currently implemented at three levels: health centers, hospitals, and community levels.

The performance-based financing model is based on the principle of separating purchaser and provider functions in health service delivery (figure 22.5). By distinguishing between and maintaining a split between bodies purchasing services and bodies providing services, this model promotes accountability and avoids conflicts of interest. The model consists of a family of methods and approaches that aim, through differing levels of intervention, to link incentives to performance. In the national model for health centers, payments for performance are based on the quantity of outputs achieved conditional on the quality of services delivered. Through performance-based financing, the central government purchases 13 quantitative indicators and 13 qualitative measurements from health facilities (tables 22.2 and 22.3). At the hospital level, performance is assessed through a peer-evaluation mechanism.

Low intake of preventive services and poor quality of care in health centers served as the impetus for introducing performance-based financing strategies. Quality of care became a particularly salient issue as expansion of health mutuelles increased utilization rates dramatically at all health centers, adding to the workload of health personnel who, at the time, had little or no incentive to take on the additional work. The impetus for the performance-based financing strategy in Rwanda first came from external actors; additional resources and incentives were provided to health workers to improve efficiency and outcomes, under pilot schemes implemented in 2001–05. As a result of the pilots’ success, performance-based financing became a major pillar within the Ministry of Health strategic plan and was implemented nationally.

Rwanda’s institutional performance-based financing model can be classified as “output-based financing,” because

Figure 22.5 Rwanda’s Performance-Based Health Care Financing Model


Note: Purchasers are those who pay for services. They include NGOs, which purchase services with their own funds and act as fundholders or pass-through mechanisms for other donors; the government of Rwanda (in the case of the national model); the U.S. government, through collaborative agencies such as Management Science for Health and Family Health International; World Bank MAP funding, NGOs in the Cyangugu and Butare pilots and purchasing performance through the new national model; and the Global Fund to Fight AIDS, Tuberculosis and Malaria, which is expected to start purchasing through the new national model. Providers can include public and faith-based managed health facilities (health centers and hospitals) and private for-profit health facilities. Controllers are those who control the level of performance, such as district health teams in the Ville de Kigali pilot, who certify a mix of quantity and quality deliverables in health centers and hospitals. District health teams were used in Butare for random quantity control and in Cyangugu I for a quality measure in health centers. A peer-evaluation mechanism for district hospitals was piloted in Cyangugu and partially in Butare.
it pays on a fee-for-service or case reimbursement basis to improve outputs. Although performance-based financing incentives are generally meant to induce providers (the supply side), supply-side incentives in Rwanda work through supplier-induced demand, whereby suppliers actively seek to convince people to use more of certain kinds of services. Such incentives are necessary in Rwanda, where the goal is not to limit excessive supply and unnecessary demand (as is the case in richer health systems) but rather to induce providers to provide more services while also increasing financial revenues at the health facility level.

As of 2006 the government transferred about $1.80 per capita from the Treasury directly to health facilities at the basic health service level on the basis of a performance-based formula. The program channels funds directly from Treasury to the bank accounts of the more than 400 health clinics in Rwanda (40 percent of them faith based, 60 percent of them public) on the basis of performance agreements.

| Table 22.2 Output Indicators and Unit Payments under Performance-Based Financing Formula |
|---------------------------------|------------------|
| Output indicators               | Amount paid per unit (US$) |
| Visit indicators (number of)    |                               |
| Curative care visits            | 0.18                          |
| First prenatal care visits      | 0.09                          |
| Women who completed 4 prenatal care visits | 0.37               |
| First time family planning visits (new contraceptive users) | 1.83                  |
| Contraceptive resupply visits   | 0.18                          |
| Deliveries in the facility      | 4.59                          |
| Child (0–59 months) preventive care visits | 0.18               |
| Content of care (number of)     |                               |
| Women who received tetanus vaccine during prenatal care | 0.46                  |
| Women who received malaria prophylaxis during prenatal care | 0.46             |
| At-risk pregnancies referred to hospital for delivery | 1.83                  |
| Emergency transfers to hospital for obstetric care | 4.59                |
| Children who completed vaccinations (child preventive care) | 0.92                 |
| Malnourished children referred for treatment | 1.83               |
| Other emergency referrals       | 1.83                          |


| Table 22.3 Quality Indicators Services and Weights Used in the Performance-Based Financing Formula |
|-----------------------------------------------------------------|-------------------------------------------------|
| Service             | Weight | Share of weight allocated to structural components | Share of weight allocated to process components | Means of assessment |
| General administration | 0.052  | 1.00 | 0.00 | Direct observation |
| Cleanliness         | 0.028  | 1.00 | 0.00 | Direct observation |
| Curative care       | 0.170  | 0.23 | 0.77 | Medical record review |
| Delivery            | 0.130  | 0.40 | 0.60 | Medical record review |
| Prenatal care       | 0.126  | 0.12 | 0.88 | Direct observation |
| Family planning     | 0.114  | 0.22 | 0.78 | Medical record review |
| Immunization        | 0.070  | 0.40 | 0.60 | Direct observation |
| Growth monitoring   | 0.062  | 0.15 | 0.85 | Direct observation |
| HIV services        | 0.090  | 1.00 | 0.00 | Direct observation |
| Tuberculosis service| 0.028  | 0.28 | 0.72 | Direct observation |
| Laboratory          | 0.080  | 1.00 | 0.00 | Direct observation |
| Pharmacy management | 0.060  | 1.00 | 0.00 | Direct observation |
| Financial management| 0.050  | 1.00 | 0.00 | Direct observation |
| Total               | 1.000  |       |       |                   |

These funds are flexible and may be used for facility expenditures, including performance-linked salary bonuses, partially substituting for revenues from user fees. Rwanda implemented a three-tier performance-based financing model—including hospitals, health centers, and ultimately the community level—in order to make health services more community oriented.

One of the key objectives of performance-based financing was to introduce bonuses to health workers as incentives for good performance, based on a range of agreed indicators. This system was designed to allow for better monitoring of health personnel activities and hence to enable district and central levels to track staff performance over time. Although the central government determines the overall performance-based financing budget envelope that the health facility receives, based on a formula involving the quantity and quality of services provided, it is the committee within the health facility itself that determines how these funds should be used.

In 2008 Rwanda decentralized wages. As a result, financing and payments for health personnel are increasingly linked to performance in which block grants from the government and donors can be used as salary. Direct spending on wages and salaries by the central administration and transfers to public institutions for salaries of health workers have declined. In contrast, funds channeled to human resources for health through provinces and districts that come from both the government (including performance-based financing) and user fees collected directly by facilities have risen dramatically in recent years (figure 22.6).

It is the policy of the Ministry of Health, in collaboration with development partners, to harmonize the framework for compensation packages of health professionals. The objective is to avoid introducing distortions in the distribution of health workers, which occurs when health workers move from the public sector to donor projects where the pay is higher. In light of this concern, donors, such as the Global Fund, have begun to use national pay scales and to fully integrate staff within the health system at large.

Results-based block grants in Rwanda have contributed significantly to the increase in assisted birth deliveries as well as the intake of child health services; the grants have also increased the quality of services. Clinics that received performance-based financing (of about $1.80 per capita per year) performed more assisted deliveries and more post-natal visits than clinics receiving the same funding without a performance contract (figure 22.7). The quality of care of antenatal services was 15 percent higher in performance-based financing clinics than in control clinics (figure 22.8).

The results achieved—in service supply and the enthusiastic participation of all stakeholders—after a few years of experience point to a promising future. However, because it is a dynamic strategy, performance-based financing adjusts to innovative ideas that benefit the population and health care providers. The remaining challenges are related to the permanent oversight requirements, the accuracy of data, and the delicate balance of the pricing of the various indicators. The future of performance-based financing will depend on finding appropriate solutions to these issues.

Figure 22.6  Financing for Human Resources for Health in Rwanda, 2005–08

Figure 22.7  Number of Assisted Deliveries in Rwanda under Performance-Based and Nonperformance-Based Financing, 2006 and 2008

Source: Authors.

Fiscal decentralization

A strong commitment to bring services closer to the people resulted in rapid fiscal decentralization, increased citizen participation, and increased autonomy of health facilities. Fiscal decentralization (adopted as policy in 2001 and enacted into law in 2006) served as an essential component of Rwanda’s decentralization agenda to devolve authority to the district level. As was to be expected, given the presence of such a strong state, a mindset change was needed to move forward on many of these reforms. As in the case of decentralization, some officials at the central level felt disempowered and were initially unwilling to relinquish their control at the outset. Officials at the local level had to adapt to accept their new responsibilities, and donors had to adjust to working with local governments.

The decentralization of authority across sectors was planned through an incremental, three-phased approach. The first phase (2001–05) focused on administrative and political decentralization; it aimed to institutionalize decentralized governance by establishing democratic and community development structures, delineating policies, establishing legal frameworks, and strengthening institutional capacity at local levels. Phase two, which began in 2006 and ran through 2008, focused on making local governments responsible for bringing health services closer to beneficiaries. The devolution of responsibilities in health services and the transfer of resources under fiscal decentralization are the backbone of relationships between the national government and districts in the health sector. It aimed to reorganize roles and responsibilities within local government under the decentralization framework and further strengthen district authority while allowing for greater community participation and facilitating resource allocation to local government. Central government responsibilities in this phase remained regulation and development of policy frameworks, capacity building of local government, and monitoring and evaluation.

Finally, phase three, which began in 2008, granted autonomy to health facilities and transferred fiscal responsibilities and financial resources from the central and local government to facilities. This reform has resulted in relative autonomy in budgeting and financial management within facilities, because health care providers are now contracted with and managed by health facilities.

Fiscal decentralization in Rwanda was government owned and driven, with strong support and collaboration of development partners. The objective was to bring services closer to the people, and to improve the financial viability of districts. The infrastructural changes needed may not have been in place (until June 2007 districts lacked accounting software to manage financial transactions, and local capacity in managing financial and human resources still remains limited), but overall success was striking. The strategy was organized by the central government, which from the outset determined the degree of authority delegated to local levels and delineated relevant policies and standards. In these efforts, the central government received significant technical assistance and guidance from development partners, which organized their support in the form of a sector-wide policy to ensure government ownership over decision making and policy setting; increase coherence between policy, spending, and actual results; reinforce the government’s management systems; and harmonize donor support.

Decentralized units at local levels were given the authority to manage the flow of funds (once received) as well as the delivery of health services. Decentralization transformed health facilities into autonomous entities, with the ability to manage financial and human resources as they deem most appropriate, according to local needs. The process gave them complete control over the hiring and firing of health personnel.

The accountability links between local governments and national policymakers are strengthened through inspections, audits, and Imihigo—performance contracts in which the region and its districts promise the president of Rwanda that they will implement the measures outlined in the annual plans. Decentralization reforms have resulted in increased responsibilities of local governments in many areas and are increasing space for community
participation and community-driven development initiatives. Satisfaction with service delivery is measured through citizen report cards.

CONCLUSION

Fiscal decentralization, performance-based financing, and the expansion of health insurance have led to a dramatic increase in resources for frontline providers. Between 2002 and 2007, public resources flowing to health facilities more than tripled (figure 22.9). The increase in resources took place at all levels, showing no higher priority given to the primary care level. An increasing number of donors are channeling their assistance through on-budget support, and major efforts are under way toward coordinating and harmonizing aid. Most of the increase in publicly managed resources flowed to human resources and to performance-based financing; resources directly managed by donors funded HIV/AIDS activities. On the domestic front, internally generated revenues of health facilities increased significantly as a result of increased utilization of health services and health insurance coverage; an increasing share of internally generated revenues is captured by health centers, strengthening frontline providers.

Rwanda chose to develop a mixed health care financing model, combining decentralization and performance-based financing with a strategy to pool private spending through the building of grassroots, community-based microinsurance. Key reforms included provisions for financial protection and other support for poor people.

Lessons learned from the Rwandan experience provide a strong base for future action. As financial barriers to access to health services are being reduced significantly through health care financing reforms, improving the quality and sustainability of health services will remain among the main challenges facing Rwanda in the coming years.

The success of Rwanda in improving health outcomes, particularly for women, children, and the poor, can be linked to both increased resources and implementation of reforms. Rwanda used the inflow of resources to strengthen its country system, including its public finance and health systems. It designed its own brand of reforms, staying away from donor fads and looking realistically and opportunistically at the balance between sustainability and equity. Reforms focused on results, and results attracted more funding, both domestic and external. Increased resources and reforms mutually reinforced each other as part of a virtuous cycle. Efficient and equitable use of resources required reform, and the success of reforms needed resources.

The success of the health financing innovations is critically linked to the institutional context. Decentralization reforms coupled with performance-based financing ensure that health facility managers have not only the incentives but also the power to ensure that these innovations translate
into changes in the delivery of services. The performance-based financing system is now being extended to provide incentives to community health workers providing outreach services and demand-side incentives to women to continue the increased utilization of key maternal health services.

Strong government leadership, vision, and the step-by-step building of a policy and regulatory framework at all levels have fostered the short- and long-term sustainability of health sector reforms. The Rwandan government showed flexibility and was able to adapt strategies in light of the changing macroeconomic and international health environment. Government coordination of donor funding was critical to ensure that aid was used effectively and aligned with national priorities. Systems for improved accountability, including contractual arrangements, independent controls, and quality checks, were essential for monitoring and evaluating health facility performance. Cultural and social factors, particularly solidarity within communities, also contributed to the success of several health service delivery innovations.

A particularly important feature of the Rwanda experience is the integration of strong mechanisms to evaluate the impact of its policies. Rwanda's experience, as well as that of other low-income countries, in introducing pro-poor financing policies needs to be systematically evaluated using rigorous metrics and standardized benchmarks. It is possible for countries to nest impact evaluation designs when introducing new policies at scale. The donor community needs to support these evaluations if it wants to improve aid effectiveness.

A key issue for the future is sustainability and the necessary evolution of the institutional support for the health financing approach of Rwanda. Like many Sub-Saharan African countries, Rwanda is highly dependent on aid and will remain so for the next decade. Sustained support from the donor community is therefore needed to support the health system strengthening agenda. Mutuelles provide one way to ensure more sustained domestic funding. They represent an efficient way to pool private out-of-pocket spending, but there is a need for the government—with the help of donors—to subsidize the enrollment of the poorest Rwandans and to regulate the package of benefits as well as the provider payments mechanisms to ensure equitable access to quality services.

NOTES

1. Comprehensive knowledge of HIV/AIDS, which can be used as a tracer indicator of general health knowledge in the country, means knowing that use of condoms and having a single, uninfected, faithful partner can reduce the chances of contracting HIV, knowing that a healthy-looking person can have HIV/AIDS, and rejecting the two most common local misconceptions about HIV/AIDS transmission and prevention.

2. At the time, the districts were called Byumba, Kabgayi, and Kabutare. They are now called Gicumbi, Muhanga, and Save.

3. This program has been supported by a broad consortium of donors, including the World Bank, the U.K. Department for International Development, the European Union, Sweden, the African Development Bank, the Netherlands, and Germany.

4. A separate contract channels earmarked funds of global HIV/AIDS programs for another 16 indicators.

5. Imihigo are also monitoring instruments designed to help local authorities plan and act realistically.

REFERENCES


