Rwanda

Making Provider Payment Mechanisms More Strategic: Removing the Roadblocks to Implementation

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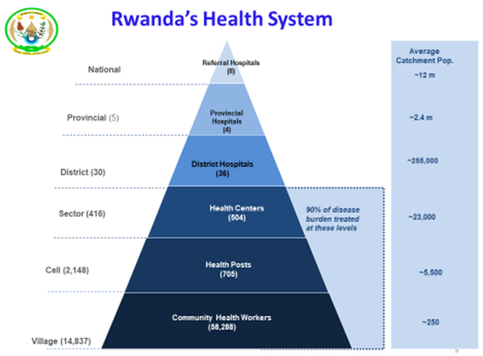
Context:

Population	12M
GDP/ Capita	$729 (USD)
THE/ Capita	$53 (USD) *Gov't spending comprises 16% of THE*

Organization of the Health System



- Referral system from lower to higher levels of care is only mandatory for community-based health insurance members
- Network of private clinics, hospitals and pharmacies support public health facilities in medical services delivery
- Public and faith-based health facilities get subsidies from the government and internally generate revenues through service provision to be paid by patients and or insurance companies

Funding

- Government subsidies or direct budget to health facilities
- Payment by insurance companies using premiums collected from their members
- Out of pocket payment by uninsured persons

Monitoring

- Monthly dashboards track cost drivers and inform operational focus

Provider Payment Mechanisms

1999 – 2003
Capitation
Pilot phase of CBHI in 3 districts;
Pilot phase of PBF

2004 - 2009
Capitation & Fee for Service;
Introduction of national PBF model; Health insurance established as national policy

2010 – 2015
Fee for Service; Linked PBF to hospital accreditation;
Membership peaks at 91% before declining

2015 – Present
Fee for Service; Providers paid from one national pool;
Management of scheme moved from MoH to RSSB

- **Public health budget** supports staff salaries, facility capital, pharmaceuticals, supplies and operating costs.
- **PBF** purchases outputs and outcomes and pays for outputs; Mutuelles, pays **fee for service;** Public resources allocation based mainly on the **traditional input-indicators**.

Mechanism	Pros	Cons
Fee for service	• Payment to health facilities each and every service, drug, consumables • Provides opportunity for patients to 'roam' as they access services outside of their catchment areas	• Increases volume of services, without a commensurate improvement in quality and efficiency, as many staff and person-hours are needed to review every line item corresponding to patients' visits and treatment • With manual, paper-based processes and high primary healthcare utilization rate of 1.65 per capita, also increases the verification time for facility invoices
Capitation	• Providers had incentive to increase health promotion activities and be more efficient	• Patients had to be registered in specific health facilities; this curtailed their ability to roam.
PBF	• Providers have incentive to improve the quality of service delivery and motivate staff as a retention strategy	• PBF payment amounts may not be of sufficient value to incentivize providers to invest adequately in quality improvement

Innovations

2016: Government established a national risk pool and mechanism of transfers to redistribute funds and reduce financial vulnerability of Mutuelles and provider. Establishment of the national risk pool and movement of this function to the Rwanda Social Security Board (RSSB) was aimed at improving financial management and efficiency.

- **Successes:** Consolidation played critical role in improving efficiencies in the scheme as the administrative costs related to district-level administration were eliminated
- **Challenges:** Staff rationalization as a result of consolidation of the district pools into one national pool was against Rwanda's core value system of community solidarity

Policies, Progress and Challenges for UHC

Key Achievements

- Health insurance law published in January 2016, providing for **mandatory insurance** for all citizens, whether nationals or foreigners;
- **Establishment of National Health Insurance Council (NHIC**, whose members are representatives of all stakeholders from public and private sector: insurances, services providers, insured persons
- Various insurances institutions and companies, public and private, all united under **Rwanda Health Insurers' Association (RHIA)**, a local non-government organization (NGO) created to promote interests of insurers, especially vis-à-vis the services providers who are also united under Rwanda Medical Private Practitioners Association (RMPPA)
- Health insurance **coverage over 90% of Rwanda's population**
- **Improvement in geographical access** with a ministerial instruction mandating the building of a health post in every cell without a health center.
- The **purchaser-provider split** between RSSB and the Ministry, which encouraged greater efficiency in fund management and reduced administrative costs of Mutuelles. The RSSB now maintains a single pool from which all claims are paid out centrally by the RSSB
- **Performance Based Financing (PBF)** program which serves as a powerful financial instrument for enhancing the performance of the health system as well as the quality of health services

Key Challenges

- **Rising medical costs:** High medical costs driven largely by fee-for-service incentives and mark-ups on medications coupled with low capacity for oversight given manual systems
- **Administrative costs**: Move to RSSB meant in part to address high administrative costs but the manual paper-based administration contribute to high costs
- **Delays in payment:** Scheme struggles to keep up with the monthly load of invoices, due in part to large quantities for fee for service and manual processes. The RSSB is considering shifting to more automated systems over time
- **Benefits:** Existing benefit package is not being efficiently delivered, given some uncertainty around exclusions, limits and caps. This uncertainty, delays in payment, as well as supply side gaps (e.g., medicine stock-outs) and inadequate financial management at the facility level, result in providers being unable to deliver services to paying members
- **Enrollment:** Net drop in enrolment rates from a peak of 91% in 2010

Lessons Learned

✓ **Political will to regulate reimbursement mechanisms between health facilities and insurances is important to avoid conflict between stakeholders**

✓ **Providers respond to incentives: with fee for service, there is a focus on providing more services and with PBF, there is a renewed focus on quality**

✓ **Fee for service with high utilization and a manual, paper-based claims adjudication effect has a negative ripple effect with delays in verification, delays in payment and reduced cash flow to health facilities**

Next Steps

- Conducting a thorough assessment of all possible PPMs to determine strengths, weaknesses, feasibility and pre-requisites to implementation to allow decision makers to make the best decision for Rwanda's context
  - Identification and organization of multi-stakeholder team
  - Agreement on objectives, goals and scope of review
  - Decision on next steps for context-based reforms based on evidence