SUMMARY

Introduction

Universal health coverage has become a global health policy and is considered as a way to address the problem of low access to health care services and catastrophic health expenditures especially in low income countries. With that regard, governments of these countries have undertaken reforms to make progress toward the goal of universal health coverage. There is no “one-fits-all” approach but there is interest to draw lessons from successful experiences and Rwanda is one of them.

Rwanda is hailed for being able to reach the MGDs 4, 5, and 6. A lot of literature is available on the role played by many initiatives in the health sector and outside health sector and two of them are performance-based financing and community-based health insurance in Rwanda. However it focuses only on their outcomes in an isolated way and does not tell anything about the whole architecture. There is then a gap in knowledge on how these health care financing innovations and other reforms in place work hand in hand in driving this progress. We need to fill in this gap as we need to know where we are before we go. The first starting point is to map existing health care financing schemes with a view to contributing to the evidence base for programming and planning purposes. This mapping is also an opportunity to share experiences with other twelve Francophone African countries involved in the collaborative multi-country research project jointly conducted by the communities of practice on financial access to health services and on performance-based financing and financially supported by the French Muskoka Fund. We hypothesize that many actors are involved in implementation of health care financing schemes in countries, with their own objectives, and do not often necessarily realize that they contribute to its universal health coverage.

Aim of the study

The purpose of this dissertation was to conduct a comprehensive description of existing schemes meant to capture critical features for each one, analyse their different combinations and make comparison with other twelve Francophone African countries involved in a multi-country collaborative research on the fragmentation of health care financing schemes.

Methodology

The study was a document review by collecting data with guidance of the research instruments developed for the multi-country collaborative research on the fragmentation of health care financing schemes in Francophone African countries. For each scheme, data was collected on following features: target population, benefit package, financing, payment methods, institutional design and organizational practices. Out-of-pocket payment as a

scheme was excluded. Data sources included available policy and strategy documents and other relevant official documentation, key informants, cooperating agencies, expert opinions, databases, search engines and websites of organizations with relevant information. The description, analysis, and comparison were made on basis of findings by focusing on the synergies and/or overlaps between the schemes on each feature.

Findings and discussion

The universal health coverage cube in Rwanda is not yet filled in terms of population coverage, services covered and costs covered. Rwanda has also commonalities and differences with Francophone African countries on the architecture of their respective health care financing systems. While these countries have in average 23 schemes ranging from 15 to 32, Rwanda has only 11. The dependence on external funding is common in all these countries including Rwanda. However, the Rwanda government's emphasis on cross-sector collaboration, decentralization and the sector-wide approach framework has promoted accountability for both government and donors, which might explain the lower number of schemes in Rwanda contrary to other countries and strict alignment of donor projects to national priorities. As it may not be surprising in low income countries, the better-off benefit more of the system than the worse-off by using both exemption schemes and insurance benefit. In targeting programmes, women and under five children are the main target groups of the schemes contrary to Rwanda where health insurance is compulsory to all residents. There is an appalling difference on out-of-pocket expenditure that was 11% in 2009/10 in Rwanda while the lowest was 65% in 2011 in Burundi. Pro-poor programmes are operational countrywide in Rwanda while not in those countries. Benefit package is also found partial in all countries including Rwanda but not to the same extent. There is a mixed use of provider payment mechanisms in all these countries proportional to the number of schemes.

Conclusions and recommendations

We wanted to investigate how health care financing schemes in Rwanda interact in terms of coherence and complementarity and hence contribute to build the cube of universal health coverage. Findings show that the Rwanda health system is fragmented because of a mix of health care financing schemes like in other 12 Francophone African countries. Rwanda health sector, like other low income countries, is highly dependent on external funding, with a large share of the Global Diseases Initiatives, and HIV spending is high when compared with other schemes. This study shows the importance of not only financing a health system to function but also of managing it. While progressively moving toward universal health coverage, countries need to make critical choices on which priority services to expand first, the people to include and how to reduce out-of-pocket payments within their respective institutional context.