LIVE WEBINAR

EXPLORING UNIVERSAL HEALTH COVERAGE FUNDING AND PAYMENT REFORMS FOR PRIMARY HEALTH CARE IN AFRICA.

WELCOME!!!!

SPARC
STRATEGIC PURCHASING AFRICA RESOURCE CENTER

AfroPHC
AFRICAN FORUM FOR PRIMARY HEALTH CARE

#SPARCandAfroPHC

Exploring UHC Funding And Payment Reforms for PHC in Africa

Dr Nkechi Olalere

Executive Director, SPARC

SPARC's Pillars:

CONNECT

Coaching & Mentoring

Build and coach a regional cadre of experts to serve as the go-to source of strategic purchasing technical support.

MATCH

Country Engagement

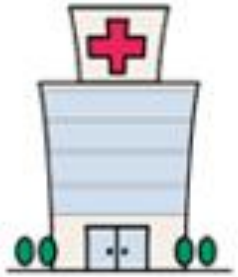
Match countries implementing strategic purchasing approaches with regional experts who understand local contexts.

SHARE

Knowledge Management & Joint Learning

Serve as a resource and knowledge hub for practical tools and best practices on strategic purchasing.

Why The Interest In PHC?



WHO asserts that a strategic purchaser prioritizes PHC and protects funding for those services. In the wake of COVID-19, it appeared that PHC services were taking a back seat as countries mounted an appropriate response to COVID-19.

WHO also describes Primary health as the programmatic engine for UHC most contexts, if not all.

It reflects the right priorities and is a critical milestone along the road to achieving UHC targets.

And it remains the most cost-effective way to address comprehensive health needs close to people's homes and communities.

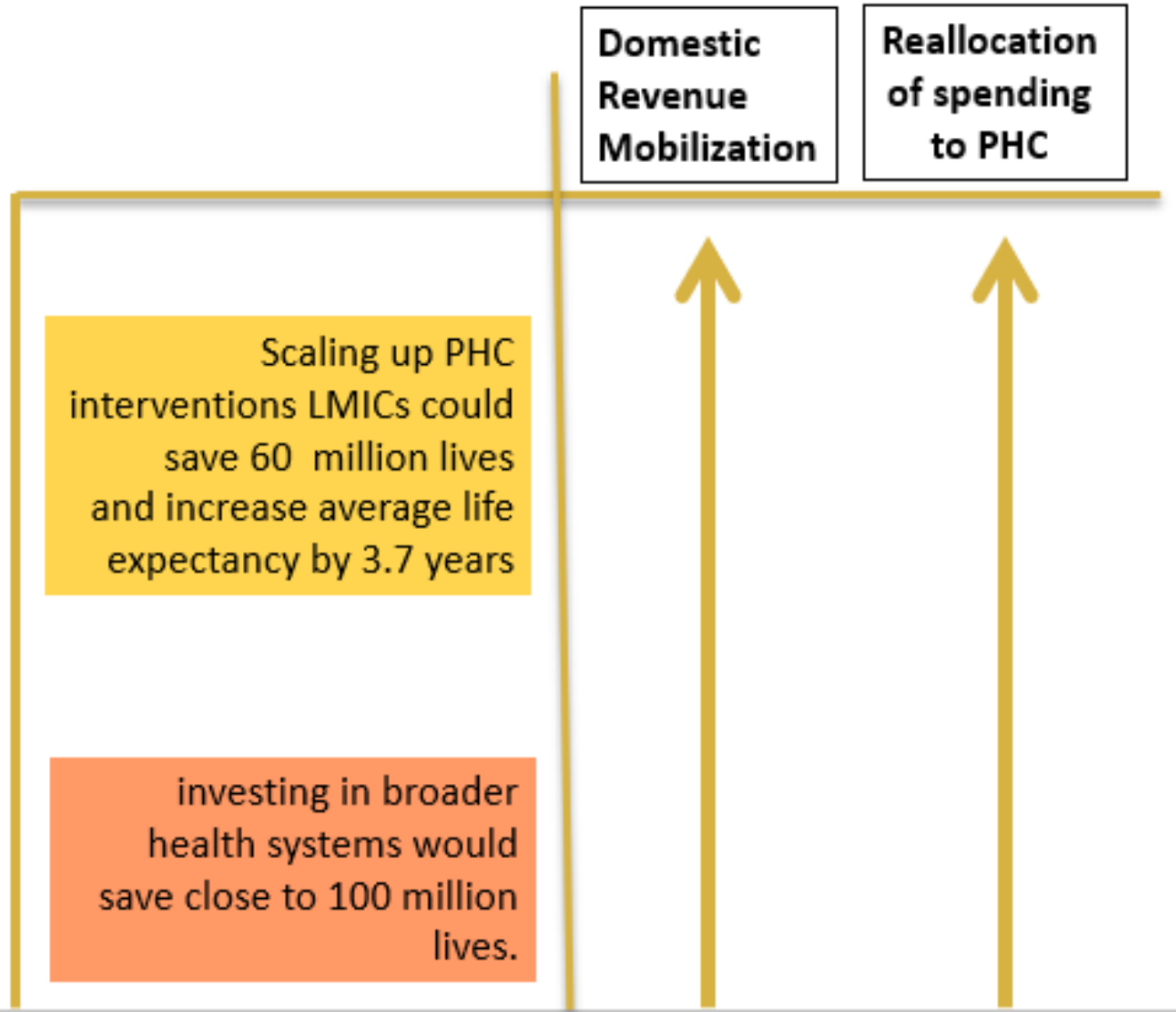
PHC funding is critical because it is widely accepted that if the health targets of the 2030 Agenda for Sustainable Development Goals (SDGs) are to be met, low-and-middle-income countries (LMICs) need to increase their allocated spending on primary health care (PHC).

PHC Is Critical To Achieve UHC

To achieve the targets for primary health care requires an additional investment of around US$ 200 billion a year.

to achieve UHC requires another US$ 170 billion a year for a more comprehensive package"

These amounts may appear significant, but they would represent only about a 5% increase beyond the US$ 7.5 trillion already spent on health globally each year.



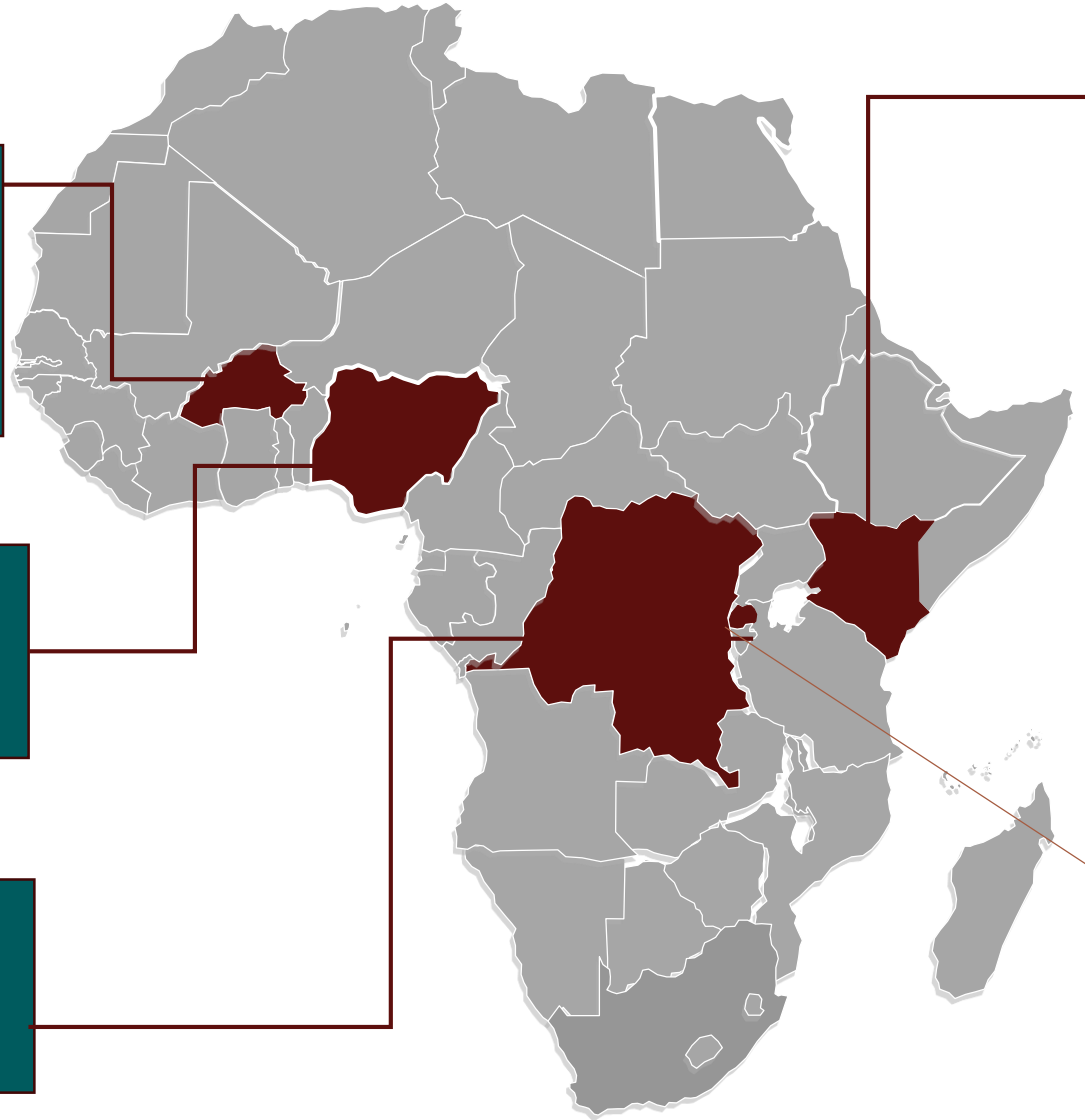
https://www.who.int/docs/default-source/documents/2019-uhc-report-executive-summary

How Are Countries Improving The Delivery And Funding Of PHC?

Burkina Faso
Tax-financed subsidies cover user fees for free primary and hospital care for these priority population groups at public health facilities and some accredited private facilities

Nigeria
NHIS and SHISs pay providers using capitation for primary care and fee-for-service for hospital care.

Uganda
PHC grants with allocation formulas based on catchment population attributes and administrative roles



Kenya
The MOH and CDOHs are testing new primary care networks as contracting units, in which the county hospital acts as the clinical and administrative hub for a geographically defined set of primary care providers, regardless of ownership type. The primary care networks aim to increase the focus on primary care and more integrated care.

Rwanda
Pyramid shaped health system with CHWs, HCs and HPs providing PHC
Mandate to locate HP in every cell without a HC (1hr or 5km) – complemented by virtual clinic (on CBHI's provider network)
Plan for capitation to increase PHC funding

For more details: https://sparc.africa/changing-the-conversation/a-theory-of-change-and-practical-steps/policy-briefs/

Ghana's Overall Experiences Towards Achieving Universal Health Coverage Funding and Payment Reforms for Primary Health Care

Dr. Ama P. Fenny

ISSER, University of Ghana

Outline

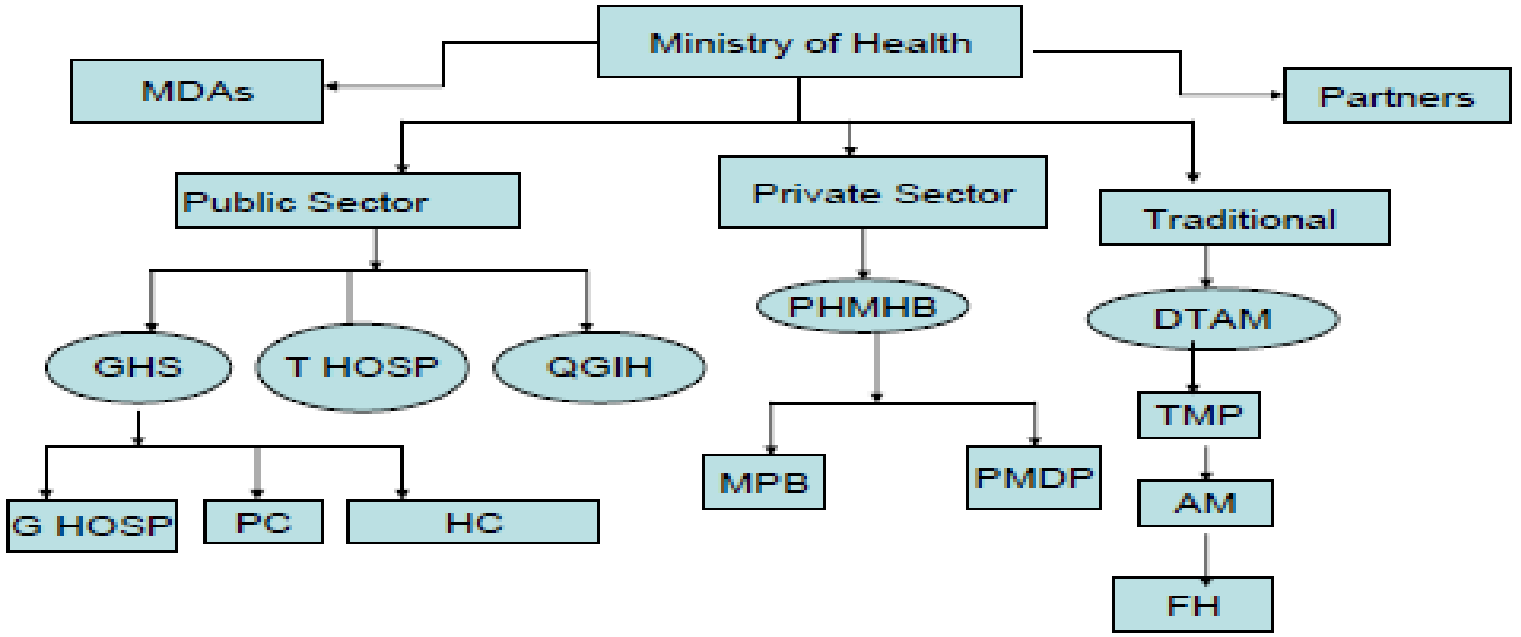
- Country context and health system structure and institutions
- Some key service delivery challenges and reforms
- Primary Health financing context, reforms and milestones over time
- UHC road map as means of improving health care system performance
- Reflections

Country context

	Ghana	South Africa	Kenya	Nigeria
Total population (million)	31 (2020)	59	53	206
GDP per capita, PPP (constant 2017 international $)	5,413 (2019)	13009	4513	5353
Gross Domestic Product Growth	6.5(2019)/ 0.9 (2020)	0.15 -7	5.3 -0.3	2.2 -1.8
Inflation (%)	7.2 (2019)	4.1	5.2	11.4
Life Expectancy at Birth	64 (2018)	64	67	55
Infant Mortality (deaths per 1,000 live births)	34 (2019)	28	32	74
Under 5 Mortality Rate (deaths per 1,000 live births)[6]	46 (2019)	35	43	117
Maternal Mortality Rate (Per 100,000) [UNICEF Database, 2017]	308	119	342	917
Out-of-pocket expenditure as % of THE in 2018	38	8	24	77

Health System Organisation

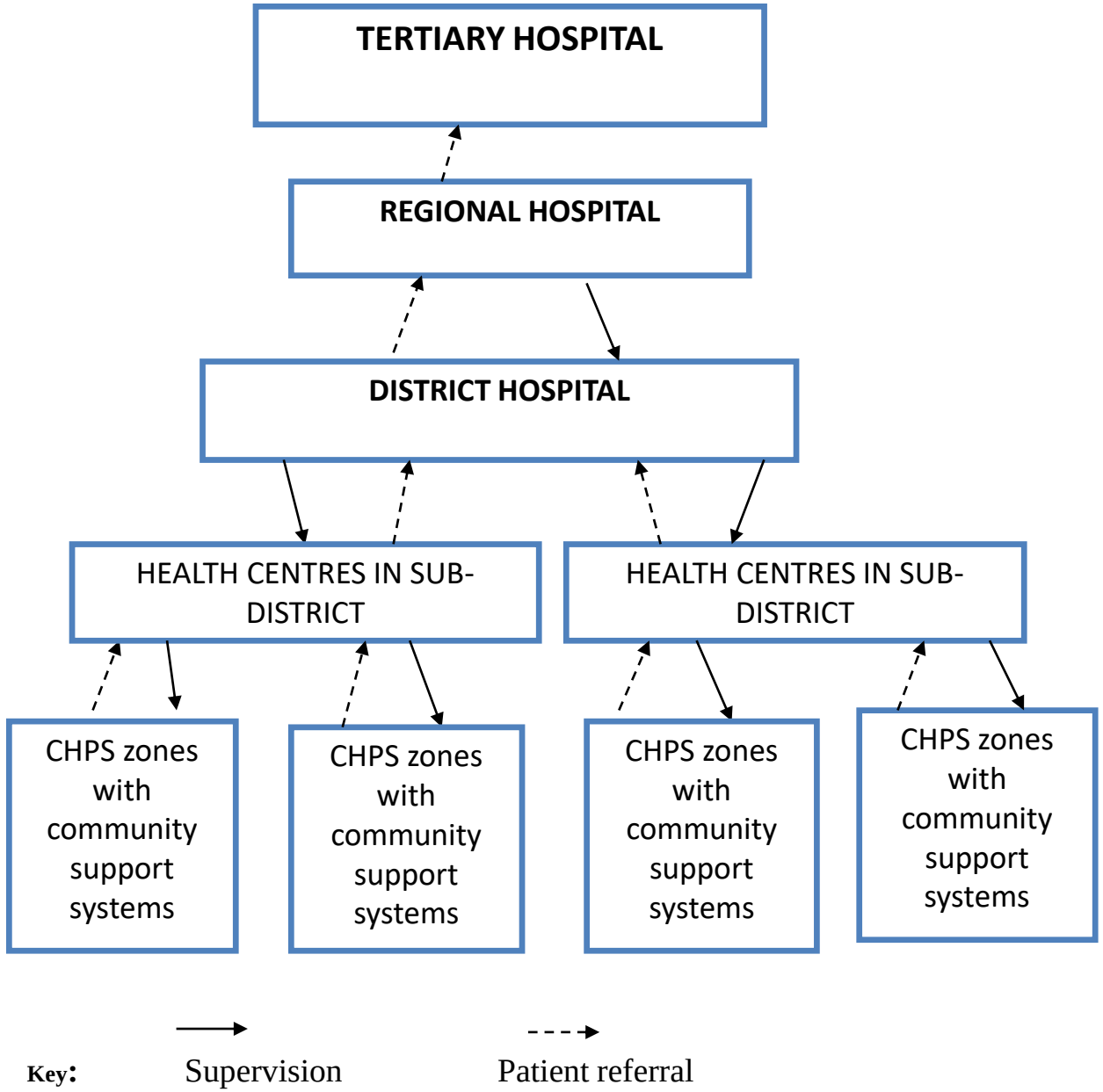
Ghana's pluralistic health sector is structured using a decentralized method



Legend

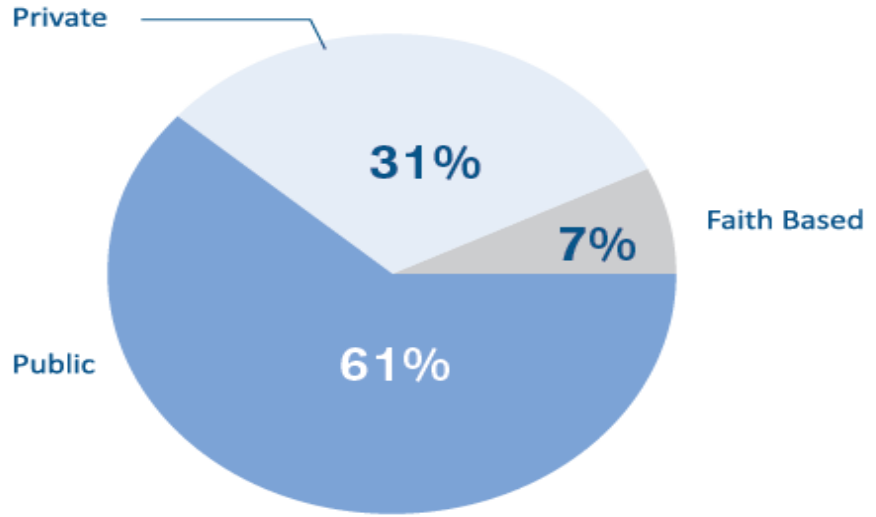
MDAs - Ministries Departments and Agencies
GHS - Ghana Health Service
T HOSP - Teaching Hospitals
QGIH - Quasi Government Institution Hospitals
PHMHB - Private Hospitals and Maternity Homes Board
DTAM - Department of Traditional and Alternate Medicine
GHSP - Government Hospitals
PC – Poly-Clinics
HC - Health Centres
MBP – Mission-Based Providers
PMDP - Private Medical and Dental Practitioners
TMP - Traditional Medical Providers
AM - Alternative Medicine
FH - Faith Healers

Ghana has a decentralised, multi-level health system



Source: MOH 2009

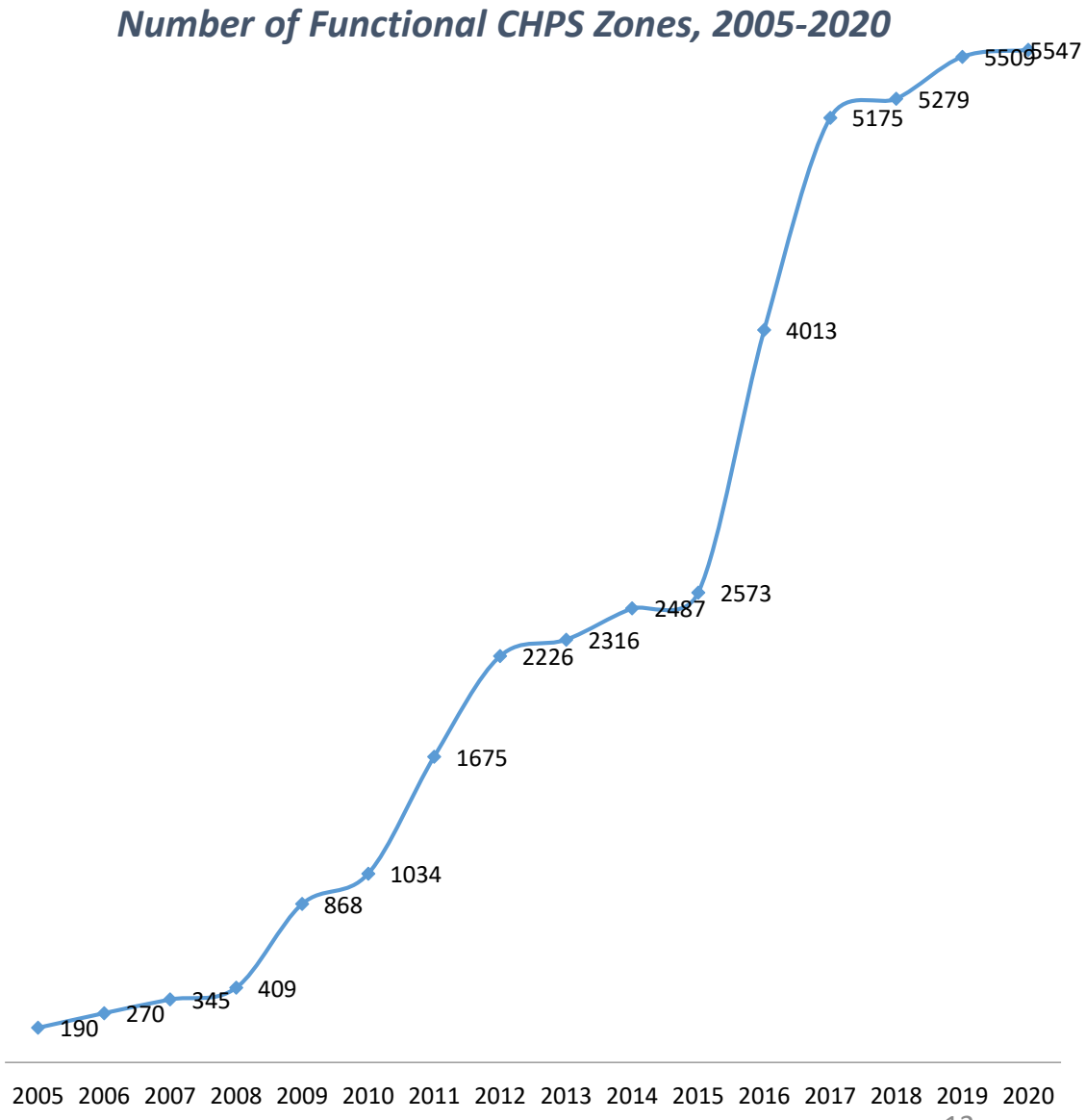
- Primary (health centre)
- Secondary (district hospital)
  - Districts divided into sub-districts which are further divided into Community Health Planning & Services (CHPS) zones
  - Integrated decentralized health service run from the district level
- Tertiary levels (specialist and teaching hospitals)
- A district with a population of 100,000 typically has one hospital, five health centres and 10-15 CHPS zones.



http://data.gov.gh/dataset/health-facilities, 2016

Community-Based Health Planning and Services (CHPS)

- CHPS program was designed to reduce health inequalities and promote equity of health by bringing care closer to communities and reducing Geographic barriers (MOH, 2009).
- Community Health Officers (CHOs) are engaged to live in compounds provided by the community or the District Assembly.
- CHOs deliver basic healthcare to the doorsteps of individuals within the selected communities, in addition to making prompt referrals, when necessary.
- The number of functional CHPS increased from 190 zones in 2005 to 5,547 zones in 2020.
- In practice, CHPS and Health Centers face significant barriers to effectively deliver essential PHC services (Awonoor-Williams et al., 2013)
- **Key Challenges**: Negative attitude, high attrition, inadequacy and unavailability of health professionals, non-availability of essential logistics, distance of CHPS compounds from communities, and inadequate funding (Kweku et al, 2020).



Source: Ghana Health Service and Ministry of Health, 2021.

Defining PHC

- *A whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment.*

Progress

- Ghana has made significant progress in expanding primary health care coverage.
- However, access to services by the population is largely uneven.
- Maternal, child health and communicable diseases are responsible for nearly half of the country's mortality levels.
- The increasing burden of non-communicable diseases now accounts of 43 percent of all deaths — due to cardiovascular diseases.

Key Reforms

- **1957** • Free health care policy implemented
- **1970s** • Ghana experienced economic shocks and began structural adjustment programs (SAP). Nominal payments for health services introduced
- **1985** • User fees (Cash & Carry) was introduced. This policy excluded majority of people from access to healthcare
- **1990s** • Community-based mutual health insurance schemes were introduced
- **2000** • High Out-of-Pocket expenditure on health and very low utilization of health services
- **2003** • National Health Insurance introduced
- **2016** • **Review of the NHIS**
- **2019** • **Development of the UHC Road map**

Era of User Fees or ”Cash and Carry’ system

- Since the 1980s user charges dominated policy debates

- Broad strategy in many developing countries:
  - reduce government spending on the health sector
  - curb shortages of essential medicines and medical supplies (World Bank, 1993)

- But, increasing user fees without improving the quality of services provided resulted in reduced use of health facilities (Nyonator & Kutzin, 1999; Sahn and Bernier, 1995; Waddington & Enyimayew, 1990).

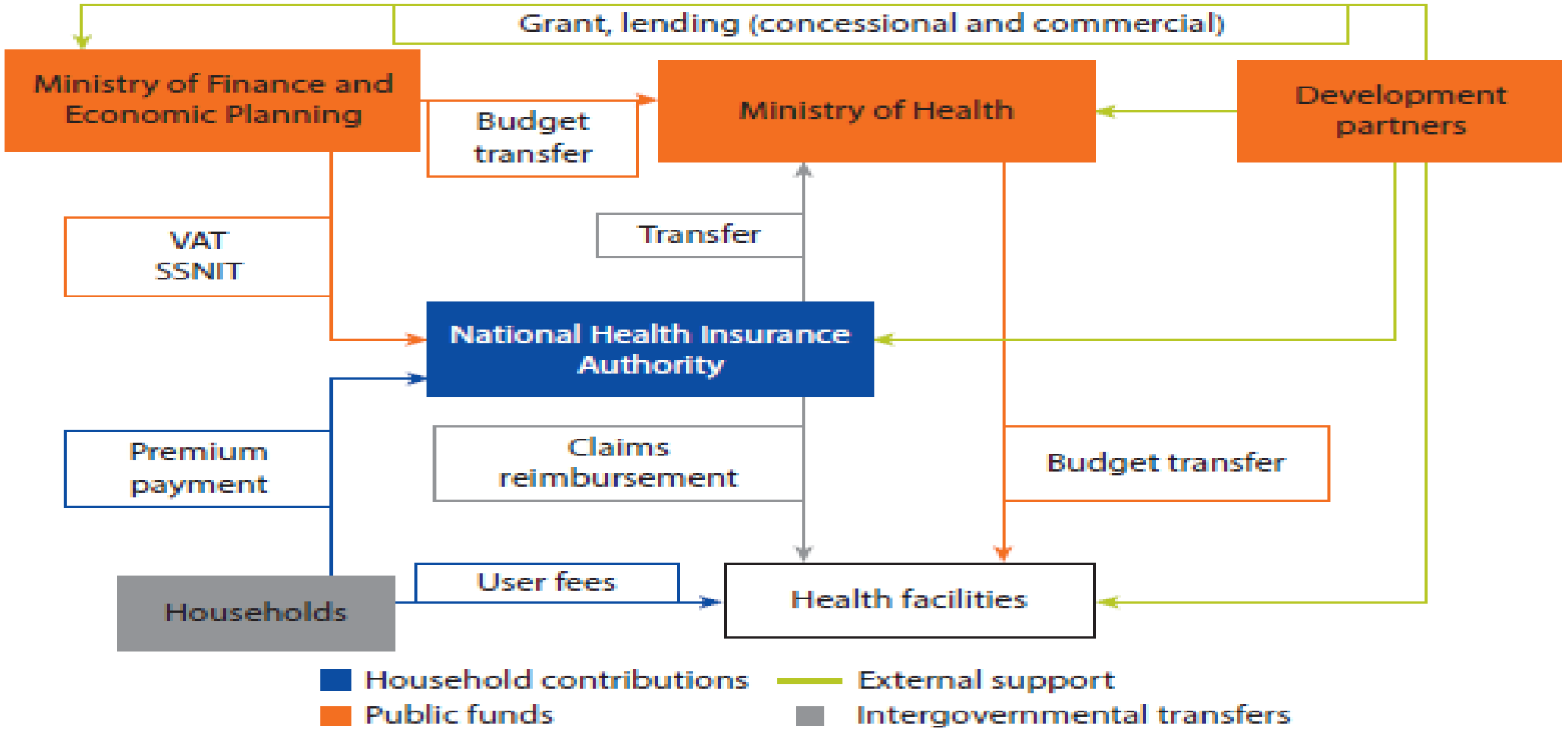
- According to Nyonator & Kutzin (1999), absolute levels of facility utilization were low between 1993-1996, consistent with the pattern generally found throughout Ghana

- Key debate –
  - **move away from excessive reliance on the direct payment of health services to pre-payment and risk-sharing** (World Health Report, 2010)

SPARC
STRATEGIC PURCHASING AFRICA RESOURCE CENTER

AfroPHC
AFRICAN FORUM FOR PRIMARY HEALTH CARE

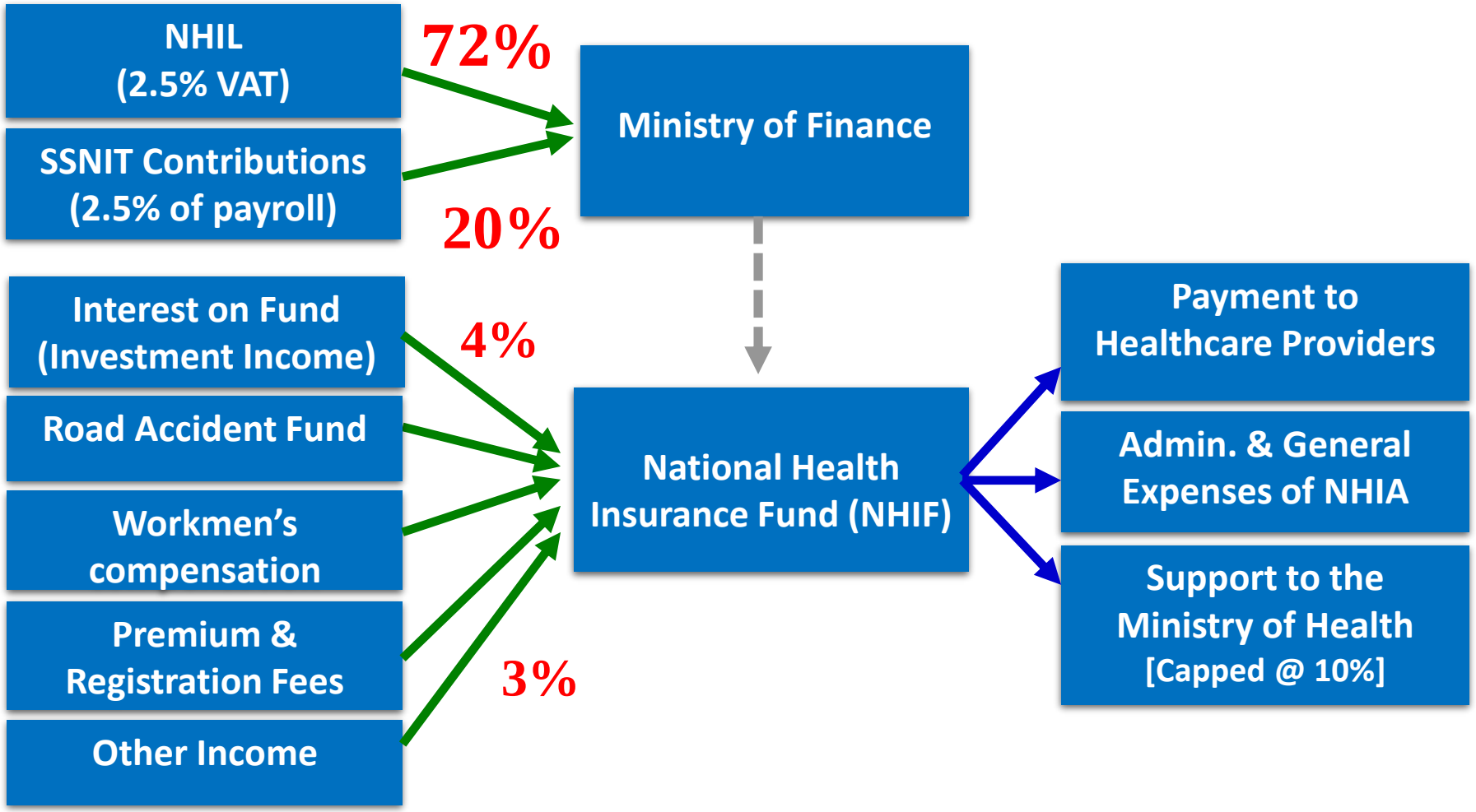
Flow of funds in Ghanaian health system



Ghana National Health Insurance Scheme • http://dx.doi.org/10.1596/978-1-4648-1117-3

Source: Huihui Wang, Nathaniel Otoo, and Lydia Dsane-Selby. 2017. Ghana National Health Insurance Scheme: Improving Financial Sustainability Based on Expenditure Review. World Bank, DC.

Revenue Sources & Allocation (Act 852)



16

National Health Insurance Scheme (NHIS)

One of the main objectives is to promote access to good quality health services and ultimately improve the health of its population

Structure of NHIS

NHI law allows the concurrent operation of three types of health insurance schemes:

- District-Wide (Public) Mutual Health Insurance schemes (DMHIS)
- Private Mutual Health Insurance schemes
- Private Commercial Health Insurance schemes

District Mutual Health Insurance Scheme (DMHIS)

- State funded; operating under the National Health Insurance Authority (NHIA)
- Operational in all districts across the country and therefore widely accessible

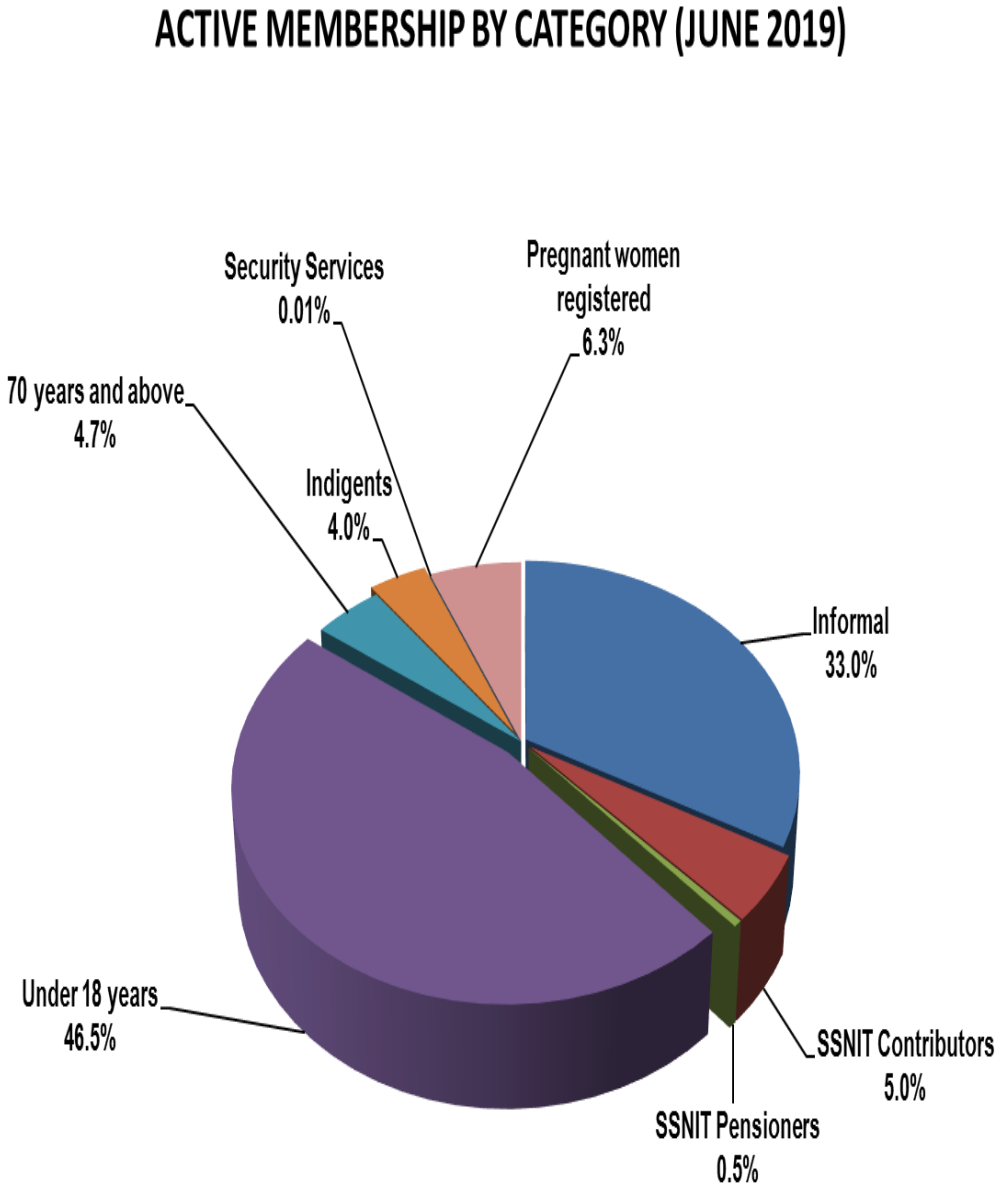
All residents of Ghana can enrol in one of three schemes, no provision was made for the enforcement of enrolment as it pertained in the law

Private Health Insurance Schemes (PHIS) involve very small shares of the population

NHIS (2)

- **Exemption groups:**
  - children under the age of 18 years, the elderly (70 years and above) and the indigent (poor)
  - from July 2008, expectant mothers were exempted from paying premiums

- **Payment structure**
  - Public and private formal sector workers – 2.5% of salary deducted at source
  - Adults in the informal sector -pay premium (US$4.8 - US$32)
  - All members – pay registration fee (US$4.8) with exception of the poor (indigents) and pregnant women
  - Registration fee is one-time payment
  - Premiums are paid annually to remain valid



Source: NHIA 2019 Mid-term report

Benefit package

- 95 percent of health conditions affecting the population
  - Outpatient services
  - Inpatient services
  - Oral health
  - Eye care
  - Maternity
  - Emergencies

Service coverage index: **47%** (2017)

Source: World Health Organization. [Internet] Global Health Expenditure DatabaseURL: https://apps.who.int/nha/database

Exclusions

- Cosmetic surgery and aesthetic care
- HIV retroviral drugs
- Assisted Reproduction e.g. Artificial insemination and gynecological hormone replacement therapy
- Echocardiography
- Angiography
- Dialysis for chronic renal failure
- Heart and Brain surgery other than those resulting from accidents.
- Cancer treatment other than cervical and breast cancer
- Organ transplanting
- Diagnosis and treatment abroad

NHIS (3)

- Service providers
  - reimbursed retrospectively on a Fee-for-service (FFS) basis and DRGs
  - compile a schedule of the total cost of service, supplies and medicines
  - claims form are sent to the District Scheme Office for payment
- Accreditation criteria [NHIA provides accreditation]*
  - All public health facilities are automatically accredited to the NHIS but regularly monitored
  - Private health facilities need to apply for accreditation to provide services under the scheme
  - Facilities are required to meet quality standards with regards to a specified number of qualified health personnel, availability and quality of utilities such as regular supply of water and electricity among others
- NHI law revised in 2012 to include mental health and family planning

*Current negotiations to transfer the accreditation function to the Health Facilities Regulatory Agency (HeFRA)

Provider Payment Mechanism

A mix of provider payment mechanisms:

- **FEE FOR SERVICE** → **Medicines**
- **G-DRG** → **Secondary & Tertiary care**
- **CAPITATION*** → **Primary care***

	Services	Medicines
2005	FFS	FFS
2008	Ghana-DRG for outpatient & inpatient services	FFS
2012	• Capitation for outpatient primary care [pilot in Ashanti] • G-DRG for inpatient, outpatient specialist and emergency care.	FFS

Ghana Diagnostic Related Groups (G-DRG)

Health Service Delivery Challenges

- Inequitable distribution of human resources

- There are large gaps in human resources capacity to deliver basic primary care

- A provider capacity mapping exercise was conducted in the Ashanti region in 2015, where 482 health facilities were mapped and surveyed:
  12% of all providers met the criteria to deliver the full capitation package,
  after relaxing the criteria, only 40% of all providers met the criteria

- In the Central region in 2015, where 415 health facilities were mapped and surveyed:
  6% of all providers met the criteria to deliver the full capitation package,
  after relaxing the criteria, only **46%** of all providers met the criteria

- The formation of PCP networks has been seen as a key step in improving access to high-quality primary care

  - Organizing primary care providers (PCPs) into network partnerships to deliver an essential package of prevention and primary care services

- CHPS (Community-Based Health Planning and Services) and PCP Networks have been two flagship reform policies aimed at addressing the service delivery challenges identified.

NHIS: Impact on PHC

- Most important by far is reduced fragmentation within the insurance system
  - Single pool and purchaser for the insurance benefit package
  - Publicly financed social health insurance, not individual premiums
  - Equitable benefit package for all members (cf. other African countries)
  - Strategic purchasing potential as evidenced by provider payment reforms
  - But 'single purchaser' undermined by fragmentation of wider health system financing
    - GoG financing is through 4 channels (Salaries, NHIF, goods and services, credits)
    - OOPs, donors, companies and communities are other financing sources

NHIS: Inequities

Is the entire population covered by NHIS? If not, are subgroups outside of NHI scheme at higher risk of catastrophic health payments?

Population, who is covered: 36% [2018 Holistic Assessment] to 52.6% [2021 Holistic Assessment report]

- OOPE (% of Current health expenditure) – **37.7** in 2018)

Service coverage index: **47**% (2017) Source: World Health Organization. [Internet] Global Health Expenditure Database

Will provider payment methods provide sufficient incentives for preventive health services or curative? The current emphasis on healthy lifestyles to curb expenditure on curative services must be promoted at the PHC level.

Priority interventions identified by UHC Roadmap

- Essential services for the population
- Management of clinical and public health emergencies
- Improve quality of care and information management
- Enhanced efficiency in HR performance
- Institutional reforms for sector effectiveness
- Health policy, financing and systems strengthening
  - working towards allocating an additional 1 (one) percent of GDP to primary health care
  - Reforming the NHIS to improve efficiency
  - Prioritise PHC and allocate at least 50% of its resources towards PHC expenditure

Source: MOH. 2020. Ghana's Roadmap for attaining Universal Health Coverage 2020 – 2030.

Framework shift is needed to deliver better health outcomes through people-centred health systems and UHC

Frameworks that rely on people-centred health systems, focused on prevention, primary care, and public health, and supported by clinical referral systems and quality tertiary care is required to move to the next stage of better health [Agyepong IA et al. 2017].

The health system strengthening efforts made in response to COVID-19 provide an opportunity for African countries to make comprehensive investments in health that will strengthen the foundation for UHC [Barasa E. et al, 2021]

PHC financing and Ghana's UHC agenda

- Financing of primary healthcare (PHC) must be integrated in countries' socio-economic and political conditions.
- The NHIS is becoming the main health financing avenue in Ghana. It contributes about 80% of healthcare providers financial resources
- However, the source of funding for the NHIS and the Ministry of Health is not sufficient to build a resilient health sector. The health sector budget support has reduced sharply within the last two decades, from 48% in 2004 to 9% in 2018.
- Given the current budget available for NHIS claims reimbursement, **it is unlikely that all primary care interventions can be covered**. In order to achieve universal health coverage at the primary care level, additional NHIS funding would be needed (Vheleen Vessekoop and Emmanuel Odame, 2018)
- Undoubtedly, the pandemic has revealed the frailties in the Ghanaian health infrastructure which has called for increased investment in the sector.
    - Investment in construction of new hospitals should be limited to underserved areas.

Reflections: Making PHC financing priority

- What would it take to ensure that families are unnecessarily burdened by catastrophic health payments?
- Can we adequately pay for quality services and products without escalating prices?
- Are our institutions equipped to judge when we have value for the money spent at the PHC level?
- Why are doctors and nurses reluctant to work in some of the PHC facilities – how do we incentivise our human resource workers through our payment mechanisms?
- Who else should be in the room – patient groups, private sector, CSOs, other sectors (transport, water, environment etc.)?

Primary Healthcare system Financing in Rwanda

Stella Matutina Umuhoza
Health Economist and Public Health Expert
University of Rwanda School of Public Health

Outline

- Introduction
- Organization of the Rwanda's health system (overview)
- Who are the primary healthcare (PHC) providers?
- How Community health workers (CHWs) are involved and paid in PHC system in Rwanda?
- What are different PHC provider payment methods ?
- What are the key challenges and lessons learnt in Rwanda?

Introduction : Overview of the health system in Rwanda

- **Policy Orientation**

- **Vision:**

  Improve the health of the people of Rwanda, through coordinated interventions by all stakeholders at all levels, thereby enhancing the general well-being of the population and contributing to the reduction of poverty.

- **Mission :**

- To provide and continually improve affordable promotive, preventive, curative and rehabilitative healthcare services of the highest quality, thereby contributing to the reduction of poverty and enhancing the general well-being of the population.

Overview of the health system in Rwanda

- **Overall policy objective**
  - To ensure universal accessibility (in geographical and financial terms) of equitable & affordable quality health services (preventative, curative, rehabilitative and promotional services) for all Rwandans.

- General objective for key health programs
  - **Improve demand, access and quality of essential health services** : Maternal, Neonatal and Child Health; Family Planning and Reproductive Health; Nutrition Services; Communicable Diseases AIDS, TB, Malaria), IDSR and Disaster Preparedness and Response (DP&R); Non communicable Diseases; Health Promotion.
  - **Strengthen policies, resources and management mechanisms of** health support systems **to** ensure optimal performance of the health programs: Governance, Medical products, HRH, Health Financing, Health services delivery, Health information system.
  - **Strengthen policies, resources and management mechanisms of** health services delivery systems to ensure optimal performance of the health programs : Community, Health centers, District health system, Referral hospitals, Pre-hospitalization medical services
  - **Strengthen the Health Sector** Governance mechanisms (decentralization, partnership, aid effectiveness, and financial management) to ensure optimal performance of the health sub-programs

Key health reforms elements

1. **Decentralization of health services** at each administrative level (to promote Autonomy & accountability

2. **Introduction Health insurances** (most importantly the Community Based Health insurance with a coverage of 85% last year) to increase the financial accessibility

3. Introduction of **Performance based financing** (PBF in 2007) system to improve the quality of health care delivery and motivate health professionals

4. **Sector Wide Approach** (SWAP in 2007): Alignment of interventions and resources to one plan (Vision 2020, 7 Years Government Plan, Economic Development and Poverty Reduction Strategy, Health Sector Strategic Plan, District Development Plan, District Health Strategic Plan) through various consultations at each level

Rwanda's Health Structure

Admin structure and responsibilities	Health care delivery system	No. of public facilities / CHWs	Av. Catchment area pop	Type of service offered
National (Parliament, Cabinet, Social Cluster..)			Country wide	Legal, Policy & Regulatory Oversight; Approval of Plans & Budgets; Performance; Monitoring: Oversight
MoH: ***Policy, Regulation, M&E, Allocation, Capacity Building…***	MoH			Policies; Regulations; Resource Mobilization, Allocation; M&E, coordination, Capacity Building
Referral Hospitals: ***Supervision / Monitoring of District Health ,Services, Mentorship***	Teaching and Tertiary hospitals	8	National (~12 m)	• Specialized hospitals serving the entire country • Medical training • Mentorship, supervision of health services
	Provincial Hospitals	4	Provinces	
District (30): ***Planning & Budgeting; Performance ; Coordination Implementation; M&E of health systems***	District hospitals	36	~ 255, 000	• Provide government defined "Complementary package of activities (CPA) (C-section, treatment of complicated cases,.. • Provide care to patients referred by the primary health centers • Carry out planning activities for the health district and supervise district health personnel
Sector (416): ***Planning, Budgeting Performance , Monitoring: HC, HP & CHWs***	Health centers	499	~ 23 000	• Provide government defined "minimum package of activities at the peripheral level (MPA) • This includes complete and integrated services such as curative, preventive, promotional, and rehabilitation services • Supervise health posts and CHWs operating in their catchment area
Cell (2148): ***Advise/ Enforce Adoption of Positive Health Behaviors; Follow up hygiene and sanitation, CHWs activities***	Health posts	470		• Services provided are similar, albeit reduced from, that by Health Centers. • Established in areas which are far from health centers, • Services include curative out-patient care, certain diagnostic tests, child immunization, growth monitoring for children under five years, antenatal consultation, family planning, and health education
Village (14,837) ***Advise the community Enforce Adoption of Positive Health Behaviors***	Community Health Workers	45,516	~ 250	**Community-based** : • Prevention, screening and treatment of malnutrition • Integrated Management of Child Illness (CB-IMCI) • Provision of family planning • Maternal Newborn Health (C-MNH) • DOT HIV, TB and other chronic illnesses • Behavior change and communication
Household ***Adoption of Positive Health Behaviors; Report health events to CHWs***				

Overview of the PHC in Rwanda

Primary Health care is the cornerstone of the healthcare system to address geographical inequalities and improve health outcomes;

- The Government of Rwanda **has scaled up the construction of health facilities** in all parts of the country in line with the Decentralization of health service delivery
  - Health infrastructure have been established at **every administrative level of the national structure**: National, Provincial, Sector and cell levels
  - PHC is composed of a network of Health centres (510), Health posts (1094) and Community Health Workers (about 45,000)
  - Health Centres are located at the level of administrative sector. Each HC covers about 20,000 people while **Health posts are located at the level of administrative Cells**

Overview of the PHC in Rwanda

- The healthcare packages have been defined for each level, down from the community level up to the referral level.
  - Health posts (HPs) and health centers (HCs) provide similar services , albeit reduced from , that by health centres .
  - They deal with more than 90% of all outpatients (OPD) visits in the Health system

- Over the last five years, the Government of Rwanda has decided to further decentralize the healthcare services and improve geographical accessibility to health facilities.
  - MOH and local authorities were mandated and given new targets on having at least a health post in every cell by 2024 (**Rwanda has 2148 cells)**
    - People should not walk more than 5km or 1 hour to access care
    - Generally constructed in partnership with the Local Government authorities, private sector and the community)
  - Recently , digital health care services (using mobile phone) was introduced to improve **health-care service** delivery processes with a focus on PHC package

Organizational structure of the health system

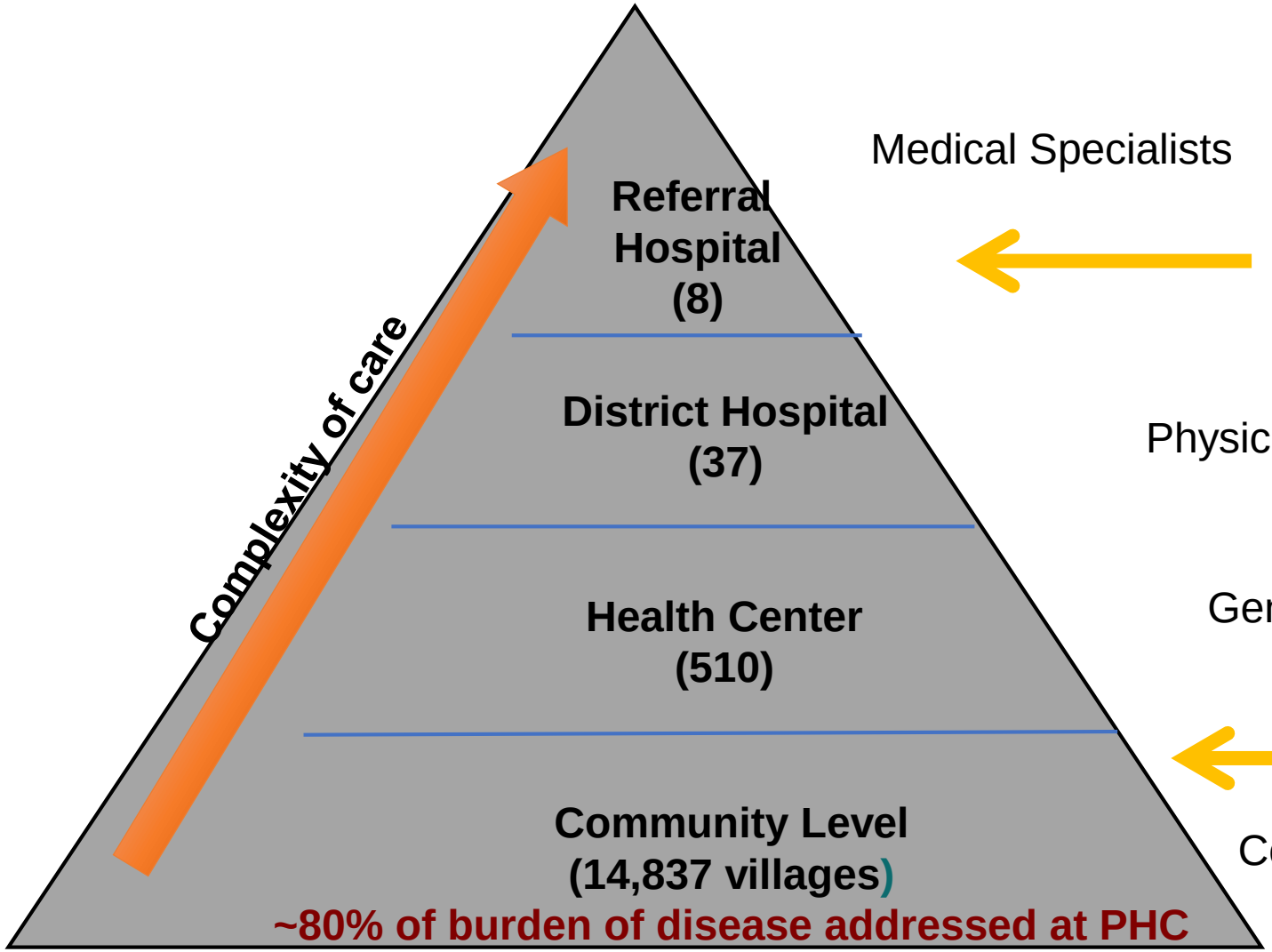
Trends in the availability of healthcare facilities in Rwanda between 2016-2020

Heath Facility type	2016	2017	2018	2019	(June 2020)
National Referral Hospital	8	8	8	8	8
Provincial Hospital	4	4	4	4	4
District Hospital	36	36	36	36	37
Health Center	499	503	504	509	510
Prison Clinic	14	13	13	13	13
Health Post	471	505	703	885	1094
Private Dispensary	125	130	130	123	122
Private Clinics and polyclinic	123	128	128	149	158
Private Hospital	5	5	8	8	8
Total	1285	1332	1534	1735	1954

Majority of new health infrastructure has been put at the lower levels of the healthcare system in partnership with local government, private sector and involving community participation.

Health System Structure and HR categories

HPs are mainly run by nurses and this part of the strategy to maximize the use of minimal HRH by task shifting



Medical Specialists

New 2016 : 4 Provincial

Physicians GPs

General Nurses

1094 Health posts (HPs) managed by nurses

Community Health Workers (45,011)

CCommon PHC providers in Rwanda

- Public PHC providers
- Faith – Based providers
- Private for- profit PHC providers , mainly health posts under **Public Private Community Partnership (PPP) model** (e.g health posts)

Note:

- Patients **are not required** to register with a specific public PHC provider
- However there is a strong gatekeeping mechanism in place (especially for beneficiaries of CBHI Scheme)
- **The health centres serve as gatekeepers** to mitigate moral hazard at the hospitals.
  - Patients need to be referred by a public PHC provider in order to access secondary care or specialists
  - Patient roaming system is allowed for CBHI beneficiaries to access care anywhere in the country
- The referral system is mandatory with exceptions for accidents and medical emergency cases

Common PHC providers in Rwanda
Private sector engagement

- Private sector involvement the PHC is one of the key priorities to achieve UHC in Rwanda.
  a. services delivery ,
  b. supply of medicines and equipment
  c. Development of health infrastructure
  d. Financing

❖ Majority of health posts (HPs) are closer to the community than health centers, and in a walkable distance, people would have preferred to visits health posts than travelling to health centers.

❖ Health posts under PPP model are located across the country (peri-urban, rural and remote areas) and managed by a licensed providers (e.g. experienced nurses)

a. They have a budgetary and other decision making autonomy (e.g. hire and fire staff,)
b. They are allowed to procure/ obtain drugs and health commodities in the national system (in the District pharmacies) at affordable price

Common PHC in Rwanda
Role of Community Health Workers (CHWs)

- CHWs play interface between the PHC and community;
- Community Health program was introduced in 2007
- Community performance-based financing (cPBF) in 2010 to sustain community work system
  - Community PBF (C_PBF) is implemented at the village level through the trained community health workers (CHW) operational within each community;

- **Rwanda counts about 45,000 CHWs are trained countrywide** to give health interventions in the community especially maternal and child health interventions;
  - **CHWs** receive financial compensation **through performance based** financing, or **PBF**, for delivering a certain **number** of health **services.**

- CHWs are provided incentives (financial compensation) through their cooperatives **based on reporting and performance** (quantity and quality of services rendered) on predetermined indicators.

Introduction : PHC Benefit package

- HCs offer " a Minimum Package of Activities (MPA)
- Primary healthcare services include
  - Promotional activities
  - Curative services; including consultations, management of chronically ill patients,
  - Preventative health services; including premarital consultation, ANC,
  - Maternal, new born and child health services;
  - Reproductive health services (e.g Family planning)
  - Communicable disease- specific health services
  - Non-communicable disease
  - Pharmacy and laboratory services
- Currently, majority of HCs offer some Specialized services such eye care services; and dental services
- HCs have no medical doctors. However outreach campaigns are common at PHC
- The referral system is mandatory with exceptions for accidents and other emergency cases
- CHWs play important roles in primary health care delivery:
  - Four trained CHWs in every village , widely respected by beneficiaries
  - 45,000 CHWs countrywide to give health interventions in the community,
  - They have been *supplied with mobile phones for RapidSMS* reporting, calling ambulance at HCs, etc

PHC governance and accountability mechanisms

- In Rwanda, HCs are supervised by District Hospitals;

- Each district hospital conduct regular supervision visits to HCs in that district
- External supervision include two categories of supervision visits by competent supervisor:
  - **Evaluative supervisions** : very predominant, at least once month
    - Focus on performance evaluations and marking for Performance Based Financing (PBF),
  - **Formative supervisions :** aiming to provide useful feedback and to build capacity of staff capacity in various services.

- External supervisors are part of the District Health Management Team (DHMT)

- Both supervisions are often combined, conducted by the same team of supervisor to maximize efficiency use of time and resources

- Each HC Head/Manager signs a **performance contract (imihigo) with the local entity** (administrative sector) and district hospital for improving service delivery, enhancing service utilization and improving CBHI uptake and the lives of individuals living in the catchment area
  - In turn, each individual staff in the HC signs a performance contract (imihigo) with the HC manager/ Head (titulaire)

Key Health Financing indicators in Rwanda

Indicators	Results	Source of information
Total Population of the country	13,2 Million	National Institute of Statistics of Rwanda , 2021
Distribution of population (rural/ urban)	67% versus 33%	National Institute of Statistics of Rwanda , 2021
Life expectancy at birth	67.8 years	National Institute of Statistics of Rwanda , 2021
Total Health expenditures as		
Total Health expenditure as % of GDP	6.2%	MOH , HRTT report , 2020
Government budget on Health as a share of Total Government budget	15.8 %	MOH , HRTT report , 2020
PHC expenditure as % of total health expenditure	38.098	World Bank & MOH , HRTT report , 2020
Per capita public sector expenditure on PHC	U$ 52	World Bank & MOH , HRTT report , 2020
Out-of-pocket payments as proportion of total health expenditure	9%	MOH , HRTT report , 2020

PHC Financing in Rwanda:
Public PHC provider payment methods

FIVE main payment methods:

- **Government budget** : Line-item budget to cover Salaries and facility maintenance;
- **Performance based financing (PBF)** : disbursed on quarterly basis based on HC performance
  - PBF Monthly and quarterly evaluations are conducted focusing on both quantitative ad qualitative indicators
  - **Only used to top up staff salaries to increase motivation and retention**
- **Reimbursement from Health insurance schemes ,** mainly from CBHI scheme covering about 85% of the target group in FY 2020/2021.
  - All Public PHC providers are automatically contracted by the CBHI scheme;
  - Payment to PHC providers in Rwanda is based on fee-for-service across all the schemes
  - Funds are generally used to purchase health commodities, buy consumables and utilities , pay contractual staff, etc
- **Donor funding** that targets specific health services and indicators (eg. **HIV/AIDS** and reproductive health services)
- **Households' out of pocket payments:**
  - **Flat co-payment fee** at health centres and health posts (relatively very little)
    - CBHI Members pay Rwf 200 co-payment at each health centre visit,
    - **15%** cost-sharing upon treatment (15% for beneficiaries of other medical schemes. E.g. MMI/RSSB medical scheme)
    - Uninsured patient bears the full burden of health care costs.
  - The "poorest" households (Ubudehe category I) are entitled to free care and fully subsidized by government and external resources.
  - **Prisoners and refugees** are **entitled** to **free health care**.

Key achievements and lessons learnt

- PHC system in Rwanda has improved access and use of essential health services and thereby contributed to household financial protection and UHC;
    - 80% of burden of disease addressed at this PHC level
    - **They deal with more than 90% of all outpatients (OPD) visits in the Health system;**

- The Rwanda PHC has greatly contributed to the achievement of health-related MDG targets due to high commitment of the leadership and consistent implementation of critical interventions
    - Reduced premature mortality:
    - Decline in Childhood mortality from , 2000 to 2019-20
    - assisted health facility delivery increased and stood 92.1% In 2021

- The functioning of PHC system is based on a partnership between the national and local governments and the communities.

Trends of Key health indicators (2000-2020)

Indicators	2000	2010	2020
Infant mortality	107 deaths per 1,000 live births	50 deaths per 1,000 live births	33 deaths per 1,000 live births
Under-5 mortality	196 deaths per 1,000 live births	76 deaths per 1,000 live births	45 deaths per 1,000 live births
Childhood vaccination (Percentage of children have received all basic vaccinations)	76%	90%	96%
ANC care coverage (at least 1 ANC visit and more for the most recent live birth)		98%	97.7%
Percentage of women delivered by a skilled provider		69%	94.3%
Maternal mortality ratios	1071 deaths per 100,000 live births	476 deaths per 100,000 live births	203 deaths per 100,000 live births
Family planning (modern contraceptive method)	17%	45%	58%
Unmeet need for Family planning		21%	14%

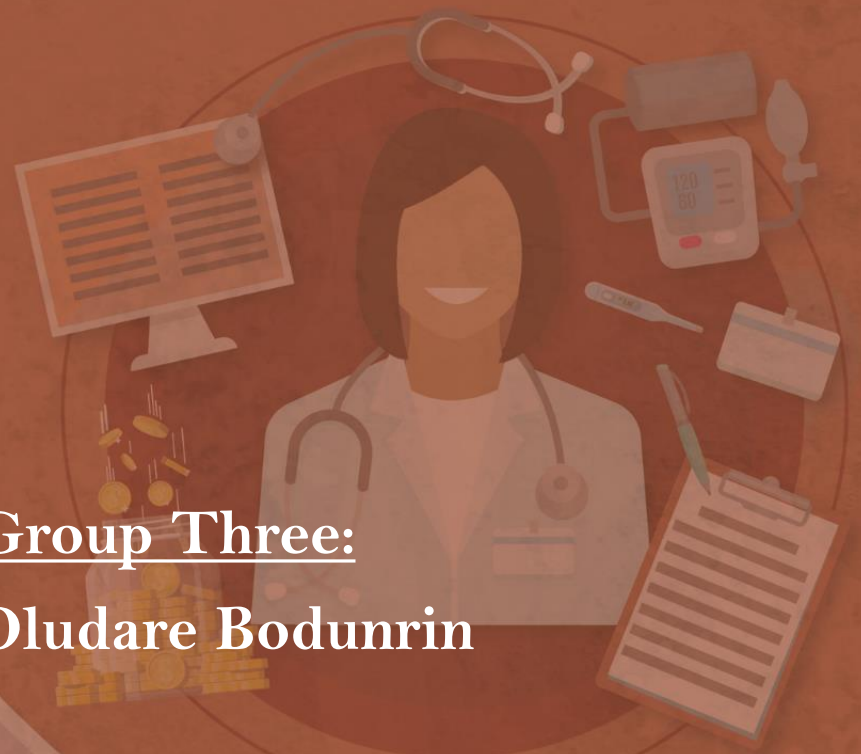
Key challenges

- Turnover of PHC providers in rural and remote areas;
- Significant reduction in external financing for the health sector
- Decrease in the Performance – based Financing –related funds received by health facilities due to decline in funding
- Delayed reimbursement of CBHI bills due to long verification processes and financial difficulties faced by the scheme;
- Epidemiological profile shift and increase in the cost of care due to a double burden of disease dominated by an increase in non- communicable diseases (NCDs).
- Ongoing COVID-19 pandemic has also put immense pressure on the PHC due to increase in number of cases and deaths

Lessons learnt

- Increasing government allocations to the PHC level is very important to improve the quality of healthcare services;
- Stakeholder and community engagement is very critical to adequately finance the PHC providers
- Increasing synergies and role of the private sector in Financing the PHC
  - strengthen private sector collaboration through, for example, Public Private Community Partnership (PPCP) for sustainable PHC service delivery and financing
- Clarity of roles and accountability mechanisms is very important to ensure proper functioning of the PHC system
- Trust in public PHC is vital is key to move towards UHC
- PHC is vehicle to improve financial protection of citizens and achieve UHC targets

Group Discussion: Breakaway Groups



Group One:

Stella Umuhoza

Group Two:

Dr Ama Fenny

Group Three:

Oludare Bodunrin

LIVE WEBINAR

EXPLORING UNIVERSAL HEALTH COVERAGE FUNDING AND PAYMENT REFORMS FOR PRIMARY HEALTH CARE IN AFRICA.

Thank You

SPARC
STRATEGIC PURCHASING AFRICA RESOURCE CENTER

AfroPHC
AFRICAN FORUM FOR PRIMARY HEALTH CARE

#SPARCandAfroPHC