Rwanda innovates to sustain universal health-care coverage

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Photo: Bill & Melinda Gates Foundation

Rwanda is known for its remarkable success story in extending access to health care to its entire population. This process took an important further step in July 2011 with the introduction of measures to improve the health-care system's financial sustainability.

While it has been relatively easy to cover Rwanda's formal sector (5 per cent of the population), the government has risen to the challenge of extending coverage to those in informal and rural economies. To move towards universal coverage, Community Based Health Insurance (CBHI) has been identified as an instrument to ensure financial protection and access to health care for the majority of the population. By exploiting concepts of community solidarity and participation, it has allowed the most vulnerable and poorest segments of the population to be fully integrated into the health insurance system.
Table 1 shows the rapid expansion of CBHI coverage and utilization of services by the population for the period 2003-2010.

Table 1. CBHI coverage and utilization (percentage of population), 2003-2010

	2003	2004	2005	2006	2007	2008	2009	2010
Enrollment in CBHI	7	27	44.10	73	75	85	86	91
Utilization rate	31	39	47	61	72	83	86	95

Source: Rwandan Ministry of Health Mid-Term Review, 2011.

CBHI schemes started as pilots in three districts in 1999, with premiums set at RWF 2,500 – RWF 3,500 per household, and following good results were rolled-out in all districts in 2005. From 2005 to June 2011, the premium was RWF 1,000. The table below shows the gradual progress in implementation over the years.

Table 2: Progress in implementation of CBHI

Year	Premium Contribution	Stage of Implementation	Remarks
1999	RWF2,500 – 3,500 per household	Feasibility/Pilot	Implementation in selected districts as basis for policy
2005	RWF1,000 per person; government provides a subsidy of RWF1,000 per member	Roll-out and scaling up	Nationwide implementation
2011	Premium based on 3 categories (see table on premium rates)	Consolidation	Reforming the system to address the challenges

However, the rapid expansion of coverage and the low, subsidized, premium contribution of 1,000 Rwanda Francs (RWF) (approx. USD 1.67) per member per year led to a financially unsustainable situation. The revenues generated from contributions proved to be insufficient and led to debts to district hospitals accumulating for the services delivered to CBHI members.

To define a policy response to the weaknesses of the CBHI system, the 2008 Rwanda Health Financing Systems Review: Options for Universal Coverage prepared by the Ministry of Health (MoH) and the World Health Organization provided guidance.

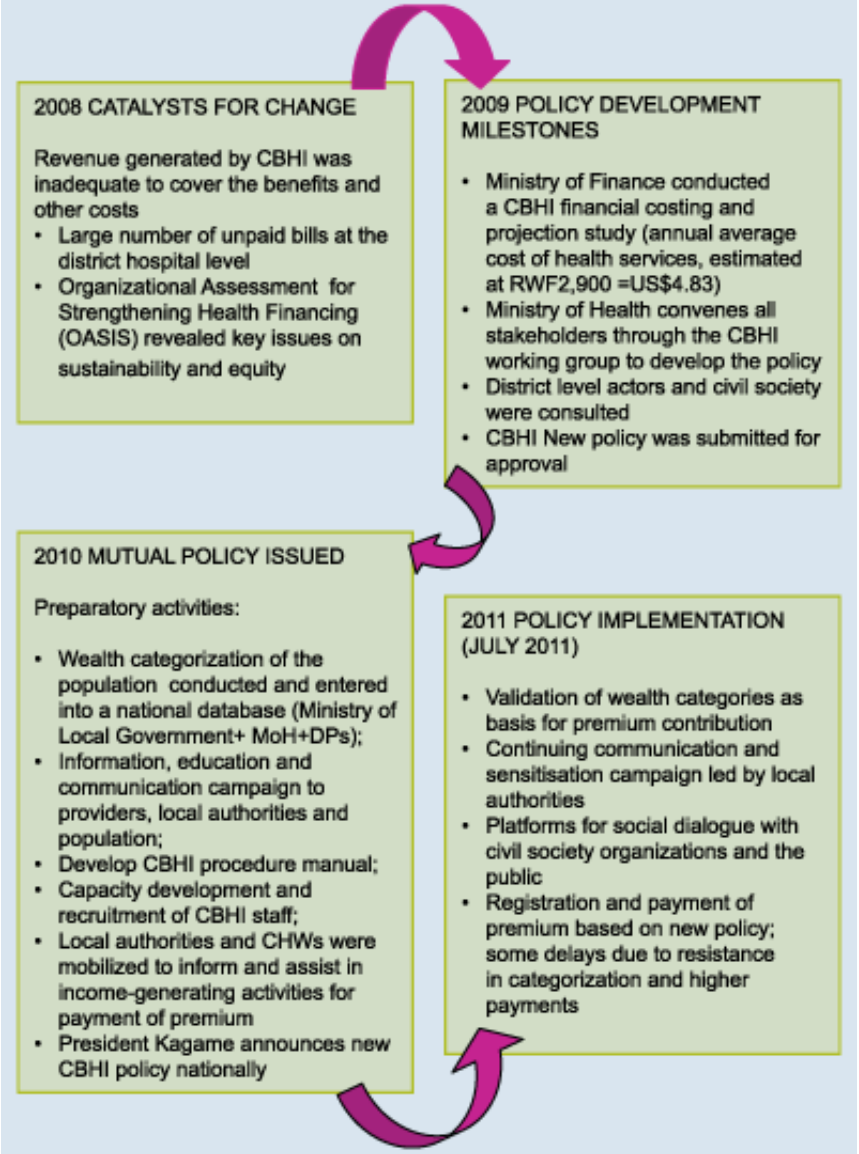
The challenges highlighted in the review can be summarized as: insufficient funds at both district and national risk pooling levels; weak pooling mechanisms; insufficient staff; limited management capabilities; possible abuse at different levels in the system (beneficiaries and providers); and large numbers of people in the informal sector with limited capacity to make contributions and who are difficult to identify. These challenges needed to be addressed if CBHI was to become sustainable.

The CBHI reform process

The objective of the CBHI reform was the development and strengthening of the Rwandan CBHI system, with the larger goal of improving the financial accessibility to health care for the population, protecting households against the financial risks associated with diseases, and strengthening social inclusion in the health sector.
The process included a number of essential interconnected steps:

- *MoH-led policy development in collaboration with the CBHI Working Group* : To lead the reform process, the MoH convened the CBHI extended team, which brought together policy-makers and development partners. The extended team was led by the MoH CBHI team and all partners in health financing, including representatives of development partners (DPs) working in all 30 districts of the country. Civil society and local government representatives were also consulted during meetings.
- *Stop-gap measures to address the current problem* : To mitigate the increasing problem of CBHI debt, the Ministry of Finance (MoF) carried out an audit of the financial situation in each district and paid all verified and outstanding debts from government revenues. Intensive training of staff and recruitment of new staff for CBHI were also undertaken.
- *Use of historical data and evidence-based policy process* : The MoF also conducted a study to estimate the per capita annual cost of services in 2008; the finding of RWF 2,900 was used as the basis of the reform design and new premium contribution after taking into account inflation, an increase in the benefit package and “patient roaming”.
- *Development of a nationwide Ubudehe database* : *Ubudehe* is a home-grown initiative aiming to nurture citizen participation in development through collective action. The nationwide categorization of households was developed by collecting information on the socio-economic status of the population and from the villager’s opinions. The categorization system has traditionally been used for socio-economic opportunity distribution. As this was the first time that it had been linked to “contribution payment” rather than “benefits”, a careful validation and quality check was done to ensure its accuracy.
- *Public information and political support for the new policy* : In December 2010, President Paul Kagame announced the new policy publicly, demonstrating strong political support from the highest possible level. At the same time, the new policy (Rwanda Community Based Health Insurance Policy, 2010) was finalized and preparation began for its implementation from July 2011.

Figure 1: Overview of the reform and implementation process



The policy content

The main objective of the new policy was the development and strengthening of the CBHI system in Rwanda, with the larger goal of improving the accessibility to health care, protecting households against the financial risks associated with illness, and strengthening social inclusion in the health sector.

The policy outlines eleven strategic interventions designed to assist in achieving this objective. They are linked to the challenges identified from the original policy and are being addressed by a number of implementation initiatives which characterize the new policy.

Table 3 presents an overview of the challenges that the reform sought to address, and the strategic interventions and initiatives adopted to respond to these. Many of these challenges were related to the day-to-day management of the CBHI system: improving processes and strengthening the capacity of the system at all levels.

Table 3. Challenges addressed with strategic interventions and initiatives

Challenges	Policy strategy	Implementation initiative
1. Insufficient funds at both district and national pools	Strengthen the financial sustainability, equity and fairness of the CBHI system	From fixed rate premium contribution to stratified premium based on wealth category
2. Weak pooling mechanisms	Strengthen pooling mechanisms	Defined allocation of revenues from the section level to the district and national risk pools
3. Insufficient number of staff and limited management capabilities	Strengthen management of CBHI system	Recruitment of required staff, availability and use of new CBHI procedure manual after training for staff
4. Possible abuse at different levels in the system (beneficiaries and providers)	Strengthen a dialogue framework between CBHI actors and health facilities Strengthen community participation and ownership Intensification of sensitization and information	Local authorities are made responsible for implementation of CBHI in their districts under the decentralized context; performance contracts of Mayors; CBHI management committees established; regular coordination and accountability meetings
5. Large numbers of people in the informal sector with limited capacity to make contributions who are difficult to identify	Strengthen the financial sustainability, equity and fairness of the CBHI system	Local authorities conduct wealth categorization, which includes poverty identification, to ensure free CBHI coverage of the poorest (*Ubudehe* database); districts organize and mobilize the population to join income-generating activities and cooperatives
6. Moral hazard exhibited by beneficiaries	Strengthen the monitoring and evaluation system Participation of CBHI in the promotion of prevention activities Strengthen the management of patient roaming	CBHI Unit in the MoH is strengthened to fulfil its role in monitoring and evaluation and supervision

The reforms which most immediately affected the population were: (1) the introduction of a tiered contribution scheme, based on ability to pay; and (2) patient roaming to use services in districts other than their registered district in emergency and justifiable cases.

Prior to the reform, the premium contribution was a flat rate of RWF 1,000 (US$1.67) with a subsidy of the same amount from the government. Indigents were covered by a combination of government and donor support. Table 4 below shows the new contribution rates and the proportion of the population under each category.

Table 4. New stratified premium contribution system (effective 1 July 2011)

CBHI category	Premium contribution, per person / per year
Group 1 – indigents (*Ubudehe* category 1 and 2) Coverage: approx. 24.8% of the population	RWF 2,000, fully supported by the government; this group is exempt from paying; no co-payments
Group 2 – people who can afford to pay (*Ubudehe* category 3 and 4) Coverage: approx. 68.8% of the population	RWF 3,000 premium contribution; with co-payments: 10% at district and regional hospitals and RWF 200 at health centres
Group 3 – people who are rich (*Ubudehe* category 5 and 6) Coverage: approx. 2.17% of the population	RWF 7,000 premium contribution; with co-payments: 10% at district and regional hospitals and RWF 200 at health centres

Implementation challenges

A number of important implementation challenges arose as the result of the reform process:

- *Development and validation of wealth categorization database* : As the basis for fair contribution rates in a country with a very small formal sector, the database is a prerequisite. Although it was developed almost a year ahead of schedule, there were constraints in data collection, data input, quality and validation that resulted in the delay of its use. Also, some adaptations of the old tool were required to fit new needs.
- *Ensuring continuity in delivery of health services during the transition* : The policy was implemented as planned with some stop-gap measures to allow people to be continuously treated using their old CBHI membership card. The MoH informed the population and instructed the providers to ensure that there was no break in service delivery.
- *Dip in coverage rates and slow registration of CBHI members* : During the 6-month transition to the new policy, there was a lot of speculation and some people adopted a wait and see attitude. Many did not immediately renew their membership at the new premium rates while others waited for the validated wealth categories, leading to very low coverage rates in all districts. The national pooling risk covered the financial gap during the process. Owing to the intensified sensitization campaign and commitment of local authorities, the coverage rate bounced back up to 85 per cent.
- *Limited capacity at the CBHI district level to implement the new policy* : To address this issue, training on the CBHI procedure manual for all CBHI staff, close supervision by the MoH CBHI Unit and recruitment were undertaken. The number of required local staff was also monitored to ensure efficient services to members.

Major lessons learned from the reform process

- *Strong leadership and good governance* at the highest political level plus good cooperation among agencies within the government are essential to ensure the successful implementation of such a policy.
- *Platforms for social dialogue* serve not only to enforce support for the new policy but also encourage social buy-in, community participation and ensure the availability of a venue for civil society to articulate their opinions or concerns.
- *Decentralized context and ownership of local leaders* are important elements contributing to the success of the new policy. The implementation is anchored on strong community networks, information flows, coordination and local authorities' commitment to support the change process. This context could also be used to allow more efficient and faster data collection for updating the wealth categorization of the district.
- *Strengthen capacities for the implementers to fulfil their role* both at the central and local level. The respective roles and tasks of the various stakeholders need to be clearly defined beforehand to ensure all areas are covered as planned. Flexibility and responsiveness of development partners in their technical and financial assistance is highly-valued in the change process.
- *Policy change is a complex process* that needs to be carefully planned and managed to ensure transitional effects are minimized, if not avoided. The implementers should analyse the implications of the policy and plan mitigation strategies for potentially negative consequences and mobilize multi-stakeholder support for the policy. A well-developed change management strategy is therefore essential to the process.

Where are we now?

After the initial slow uptake of CBHI membership and some teething pains upon the introduction of the policy, coverage has increased to 91 per cent, bringing the national health insurance coverage to 96 per cent. The recently developed Health Sector Strategic Plan III for Rwanda 2013-2017 focuses heavily on reviewing the benefit package to make it more responsive and sustainable and also to building health financing institutional capacity to further consolidate the successes of CBHI within the national system.

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