

Study on the linkages between formal social security schemes and community-based social protection mechanisms

Part I: Risk of illness and maternity

1. Short introduction to the social protection system in Rwanda

Social protection is still a fairly new sector in Rwanda but has grown in importance. A national social protection policy has been established in 2005 providing an orientation on how to improve the well being of the Rwandan population. The main elements of the policy are transfers to the poor and vulnerable, protection against welfare risks through risk pooling and social insurance schemes as well as the improvement of social status and rights. It recognizes the necessity for a shift from a mere assistance-typed system to the prevention of risks and a social risk management. The vision is to extend social policy coherence and the idea of solidarity in order to reduce the vulnerability of the poor and marginalized people. The challenge is to unite the diverse and unconnected activities under one strategy and possibly one fund.

In the current review of the economic development and poverty reduction paper (EDPRS) the government lays out its roadmap for a sustainable economic growth and social development. Major interventions aim at the increase of people graduating from social assistance to self-sustained livelihoods and who benefit from social insurance schemes as well as institutional strengthening of decentralized structures.

Total government spending for social protection was 6.5% in 2005, together with donor spending it made up 4 % of GDP.

The Social Security Fund of Rwanda (*Caisse Sociale*) is in charge of the social insurance covering occupational hazards (including accidents at the workplace) and pension of people employed in the formal sector. Contributors to the fund make up about 2% of the Rwandan population (182.962, 2006). Contributions are compulsory for all salaried workers and political representatives. They are made up of 2% of employee's base salary for occupational hazards and 6% for pensions of which 3% each come from the employee and the employer.

The Ministry of Local Administration (MINALOC) is in charge of social protection programmes for households and individuals. They manage around 80% of the total expenditure, which is spent mainly for the genocide survivors support programme (FARG), the community based support programme for the poor (*Ubudehe* approach) and the labour intensive public works programme (PDL-HIMO). *Ubudehe* is a traditional approach to identify and support the most vulnerable households in the community. The Government is especially interested in targeting the beneficiary households for their programmes through *Ubudehe*. Activities concentrate mainly on income earning projects. It is now part of the Government's Community Development Fund (CDF) and financed by the European Union (EU).

Despite recent efforts to strengthen the district roles they only manage around 11% of funds mainly on support to orphans, the health insurance system and to the *indigents* (the poorest). A great part of the funds for social protection is provided by development partners namely the EU and the World Bank (WB) most of it outside the Rwandan budget.

Other programmes include refugees and returnee support by UNHCR and WFP, demobilisation of ex-combatants with substantial WB support and support to people infected or affected by HIV and AIDS (PLWHA), PEPFAR and UNICEF.

a. Legal systems of social security

i. REGIME D'ASSURANCE MALADIE DES AGENTS DE L'ETAT/Rwanda Medical Insurance Scheme (RAMA)

RAMA was founded in 2001 (law n°24/2001) following the Rwandan government's intention to cover health related risks of its employees. It is a legal entity with financial autonomy. RAMA is mainly financed by monthly contributions composed of 15% of their member's base salary whereby the employees pay 7, 5% and employers add the same percentage. RAMA has signed contracts with all existing public health centres (including those run by churches), district as well as reference hospitals, 16 private and 2 special institutions for mental and psychosocial services. Further, it has contracts with all pharmacies at health centre and hospital level, 8 private as well as 11 pharmacies run by RAMA itself. This allows total freedom of choice to members in choosing their health facilities. In practice it also means that private facilities are often preferred and that care can be and often is sought directly at hospital level without referral from health centres.

The benefit package covers all preventive and curative services including dental services, hospitalisation and surgery as well as radiology and laboratory costs, approved generic pharmaceuticals and glasses. Not included are prosthesis and plastic surgery. Health care providers are paid on a fee for service base at the end of each month. RAMA reimburses 85% of the total costs of medical services and pharmaceutical products whereas the remaining 15% are paid by the beneficiaries in the form of direct co-payments.

Since 2003 RAMA also accepts employees from the private sector as well as other public sector employees to enlarge their member base. In October 2006 a total of 196827 people benefited from RAMA which represents 2.2% of the Rwandan population. The average household size of RAMA members in 2006 amounts to 2.2 persons and contrasts with the national average of 5 (DHS, 2005).

Year	2001	2002	2003	2004	2005	2006
Affiliates	34883	42346	49283	54970	58078	62287
Dependents	74649	90797	106111	118185	125451	134540
Total of beneficiaries	109532	133143	155394	173155	183530	196827

Table 1: Evolution of RAMA membership since 2001

Membership is granted on group basis only and without any previous medical check-up. Public or private companies or associations need to be affiliated with the Social Security Fund (SSFR) in order to become a member of RAMA. From the point of inscription a probation period of 3 months is observed. The insurance coverage extends from members to their legitimate spouses and children up to the age of 18 if they are unmarried and without income, up to 25 if they are still enrolled in school or university and indefinitely for children who are unable to care for themselves as a result of a disability. There are no elements of financial redistribution within RAMA, surplus is invested in property. The law regarding RAMA is currently under revision.

ii. Military Medical Insurance (MMI)

MMI was founded in 2005 (law n° 14/2004) after an unsuccessful attempt to integrate the military personnel into RAMA which was mainly due to concerns about the financial consequences of their higher risk. To cover this risk MMI receives 22, 5 % of their member's base salary of which the affiliates themselves pay 5% and the Government adds 17, 5 %. On top of that beneficiaries contribute 15% direct co-payment for services and pharmaceuticals.

MMI is also an autonomous body and is financed by member's contributions. MMI has signed contracts with all public health centres (including church-run), district and reference hospitals including the military hospital of Kanombe as well as all 15 private clinics. It also has contracts with 13 pharmacies and signed conventions with all pharmacies operated by RAMA. The benefit package of MMI is the same as RAMAs with the difference that prostheses are covered. Excluded are contact lenses and braces as well as plastic surgery for purely aesthetical reasons. In the law it is envisaged that accidents happening during or

illnesses caused by work will be covered by the Social Security Fund (SSFR) but no convention has been signed as financing agreements have not been settled yet. All service providers are paid on a fee for service base at the end of the month. Members are accepted on the basis of their employment in Rwanda's Military Services however, membership beyond the military personnel is envisaged in the future.

All legitimate family members of MMI affiliates are covered under the assurance with the same conditions regarding children applied as in RAMA. The exact number of adherents and beneficiaries could not be obtained due to national security issues but an estimated figure of 100.000 was given (1.1 % of the total Rwandan population).

Like RAMA there are currently no elements of financial redistribution within MMI, surplus is invested.

b) Community based social protection schemes in health

i. Mutuelles de Santé

Community-based health insurance schemes – *Mutuelles de Santé* - were introduced (or reintroduced as small scale schemes had existed before) in 1999. They differed from similar schemes in Africa mainly due to a strong government involvement and commitment. The first pilot schemes were established in a participatory process led by the Rwandan Ministry of Health (MoH) in the former Byumba, Kabutare and Kabgayi health districts. The major institutional and technical questions were developed by MoH and partners and discussed with community representatives in the concerned districts. Bylaws and contracts with the health providers were elaborated in community workshops.

The initial pilot phase was followed by an adaptation phase beginning in 2001 whereby the Government strengthened its support to the development of the *Mutuelles*. A special unit for the *Mutuelles* situated at the Ministry of Health (*Cellule technique d'appui au Mutuelles de Santé*, CTAMS) was set up in 2005. They were responsible for elaborating a legal framework and a strategic plan, monitoring and evaluation as well as capacity building and became a major driving force in extending health insurance coverage.

Membership rates grew slowly in the beginning and reached 9% in 2003. From 2004 onwards rates began to climb faster from 27% that year to 44% in 2005 to currently 73% of the total Rwandan population. This was mainly due to the implication of administrative and health districts in setting up and developing *Mutuelles*. Another important factor was the extension of the benefit package. *Mutuelle* sections are now installed in all 410 health centres in Rwanda.

The *Mutuelles* are based on district level but a section of the *Mutuelle* is present in every health centre at sectoral level. The members of one section finance a person who is responsible for the financial and administrative management of that section. He or she receives and registers members, manages their files and together with a management committee reviews and settles the monthly accounts. The committee consists of a delegate from the health centre and community members who are elected by *Mutuelle* committees at the smallest *cellule* level. They are also responsible to sensitize their community to adhere to the *Mutuelle*.

Membership can only be obtained on a family basis mainly to increase coverage but also to avoid fraud that could arrive when couples only register part of their children. Contributions however, are made on an individual basis and stands at FRW 1000 per person annually which has been harmonised throughout the country in January 2007. As about 60% of the Rwandan population is considered poor a great proportion cannot spare this seemingly minimal contribution. Hence, different donors and government's programmes support the *Mutuelles* by paying the fees for certain groups of people. The Global Fund to fight against HIV and AIDS, Tuberculosis and Malaria (GF) is currently paying for around 800.000 of the poorest. Other supporting mechanisms comprise the Fund for Genocide victims (FARG), for

people employed in the GACACA courts and the support to PLWHA by the initiative founded by the Rwanda's First Lady "Protection and Care for Families against HIV/AIDS" (PACFA).

Mutuelle sections have signed contracts with their respective health centre and surrounding hospitals but under the new law and harmonised tariffs it is possible to seek health care in all health centres of the country. This however, has not been realized in practice yet as capacities to transfer bills and funds are still limited. At the end of the month health centres send their bills to the *Mutuelle* section and they get reimbursed 90% of the overall cost. 10% is paid as co-payment by the insured patients at the point of service. Bills of patients who are members of a different *Mutuelle* section are directly sent there.

At district level a district agent is responsible for monitoring and supervision of the different sections as well as the management of the district level solidarity fund, the so called *pooling risk*, that was set up to cover the *Mutuelles* costs at the district hospital level. He or she is under direct supervision of the health unit director and the administrative council of the *Mutuelles*. This council consists of elected members of all sections management committees its major tasks being budget approval.

At the national level CTAMS is responsible for managing the national *pooling risk* fund to cover the health costs at reference hospital level.

The *pooling risk* was set up to financially support a comprehensive health care benefit package at secondary and tertiary level. Additionally to the 1000 FRW paid by beneficiaries which is used to cover their primary health care costs at the health centre level the government pays another 1000 FRW to cover higher risks at district and reference hospital level. However, as the current Rwandan health insurance mechanism is heavily dependent on external subsidies further funding needed to be obtained.

For the national *pooling risk* the government's contribution are joined by funds from the other public and private health insurances in Rwanda who will be contributing a certain percentage of their revenues to this fund; exact figures have yet to be agreed. For the district fund a certain percentage of the national fund is joined with contributions from the GF who has granted Rwanda the sum of \$ 34 Mill over 5 years (until 2010) in support health system strengthening, districts and 10% of revenues of the each *Mutuelles* section of the respective district. The exact set up of this mechanism is still subject to negotiation and will be finalised in the new law.

c) Private insurances

i. Société Rwandaise d'Assurance (SORAS)

SORAS is the oldest Rwandan insurance provider founded in 1982. However, their health insurance scheme only started in 2006. They currently have 1100 adherents and 3600 beneficiaries. Membership is granted on a group base of minimum 10 persons and the majority of their members are private companies, international organisations or other associations. Beneficiaries are apart from employees of inscribed groups their legitimate spouses and children up to the age of 25. SORAS offers different service categories that all have the same comprehensive benefit package but don't apply to the same range of health facilities. The most expensive one for \$436 per year allows access to all private and public facilities SORAS has signed contracts with whereas at the other end for \$109 per year only public health services can be consulted. On top of contributions all beneficiaries pay a direct co-payment of 10% of the total bill. SORAS refunds all pharmaceuticals officially registered in Rwanda. They are reassured by Munich Re.

ii. Compagnie Rwandaise d'Assurance et de Réassurance (CORAR)

CORARs health insurance schemes only started very recently in January 2007. Their total number of beneficiaries stands at 814 with only 414 affiliates. The majority of their current affiliates are priests which explains the low number of dependents. CORAR offers 4 different

categories of benefit packages from \$727 to \$264 per year to groups as well as to individuals. Individuals have to undergo prior medical check-up and they are placed into one category based on individual risk, groups however, make their own choice. The difference between the categories is the percentage of direct co-payment which rises with lower annual contribution. Beneficiaries of CORAR health insurances are apart from legitimate spouses all legitimate children up to the age of 21 who are still dependents of the household.

CORAR has reinsurance from several insurers including Africa Re, et Avenir Re.

iii. Africa Air Rescue (AAR)

AAR is a Health Management Organisation operating in the East African Region since 1984, in Rwanda they have been active since August 2005. Their current membership base comprises around 3000 beneficiaries including individuals, families and groups. Main areas of health care coverage are emergency services and hospital care including air rescue as well as funeral and rehabilitation services. Benefits are divided into 3 packages whereby all services up to a certain sum are covered without any further co-payment (not even for pharmaceuticals) according to the chosen package. Information on precise amounts of contributions could not be obtained as they are subject to different individual factors.

d) Percentage of covered population by different health insurance mechanisms

Public insurances (RAMA, MMI): 3.3%

Community based insurance: 73%

Private insurance: less than 1%

e) Legal framework for community based social protection mechanisms

The law on the community-based health insurance in Rwanda is currently in the process to pass national legislation. It will be the first legislation of this kind as the only other existing law on mutual benefit organisations stems from 1958, which was not health specific. In many ways the law will confirm existing practice like the new decentralised organisational structure, the nationally harmonised contribution fees and the obligatory character of membership in a health insurance. Further, it will clarify the status and responsibilities of personnel at district and section level. Some government agents had already been employed and paid since 2006 but their position had no legal grounding.

f) Legal framework for the informal sector

Only a minority of approximately 5% of the Rwandan population is employed in the formal sector and hence benefits from the existing social security system. The great majority depends on communal schemes and other government or donor support. However, given that some sort of health insurance is obligatory in Rwanda and the great effort put into the *Mutuelles* in theory, no one is excluded from health insurance. In practice, a considerable part of the - mostly - rural population cannot afford the premium and does not benefit from financial support though, verification on the exact number is difficult to obtain.

The targeting process of beneficiaries for different government or donor supported programs is led by the communities who identify the most vulnerable among them. Hence, people living outside these community ties are often excluded from these processes, most notably the pygmy minority of Rwanda. Other vulnerable groups like orphans and PLWHA are taken care of by vertical programs like PEPFAR and other organisations who pay their *Mutuelle* contribution and for ARV.

g) Major reforms and political will

Improving access to and the overall quality of health care through community-based health insurance for the informal sector has been a major concern of the Rwandan Government and

therefore features prominently in national policy documents like the poverty reduction strategy (PRSP 2002 and current EDPRS), the Health Sector Policy as well as the Health Sector Strategic Plan (2005-2009).

With the support of development partners the government has initiated the setting-up of community-based health insurance in Rwanda in 1999 and has been strongly implicated in their further development.

In 2004 a working group on the *Mutuelles* has been set up under the umbrella of the Health Sector Cluster Group, uniting the MoH and development partners in the health sector of Rwanda to coordinate and harmonise their activities. The working group advises the Ministry on policy issues and provides technical support to districts and *Mutuelle* sections.

With increasing decentralisation more responsibility had been delegated to local and regional authorities, which spurred the expansion of *Mutuelles* schemes throughout the country. Targets set by the government and intensive sensibilisation and mobilisation campaigns enforced this process. Subsequent to the administrative reform in January 2006 the organisation of the CBHIs was restructured by redirecting their management to district level. There is now one *Mutuelle* in each of the 30 new districts and sections of that *Mutuelle* at health centre level (in general there is one health centre in every sector of which there are on average 14 per district).

Similarly strong is the political will regarding the expansion of overall social protection mechanisms as shown in the first paragraph. However, dependence on external funding is and will be substantial for a while in the absence of significant formal sector development and economical growth.

2. Articulations

There is limited articulation between the public, private and community-based health insurance in Rwanda. However, improved access to health care service through universal health insurance coverage is important to the Rwandan Government in their overall poverty reduction strategy. As described above, initiatives to increase interaction and distribution of funds exist, especially in the form of a national solidarity fund (*pooling risk*) to support the *Mutuelles*. In February 2007 a conference with the participation of all health insurers and Belgian health insurance institutions has taken place to share experiences, discuss issues of universal and comprehensive health insurance in Rwanda and how to reach that goal. The development of a legal framework for all health insurances in Rwanda is in the process of discussion but no specific action has been taken yet. At the moment the law on the *Mutuelles* is in its final phase of negotiation.

3. Impact of existing interactions and future perspectives

The setting up of the solidarity fund happened mainly in view of securing the financial stability and hence, had no direct influence on the extension of coverage. However, viability of the health insurance system is crucial in order to keep people adhering and gaining trust in the system. Failing to pay bills and possible subsequent refusal of insured members by service providers could have disastrous consequences for the insurance system and the objective of universal coverage. The new law will regulate financial distribution from other public and private insurances into the *Mutuelles* to strengthen their viability.

4. Other systems

Not relevant

5. Contractualisation with health care providers

From the beginning each *Mutuelle* section had its own contract with its respective health centre. The districts have signed contracts with the district hospitals and CTAMS at national level with all reference hospitals. There is no legal framework yet as that will be regulated in the new law. Contracts are the same for all *Mutuelle* sections and districts. Contracts with pharmacies will soon follow.