Rwanda Innovates To Sustain Universal Coverage

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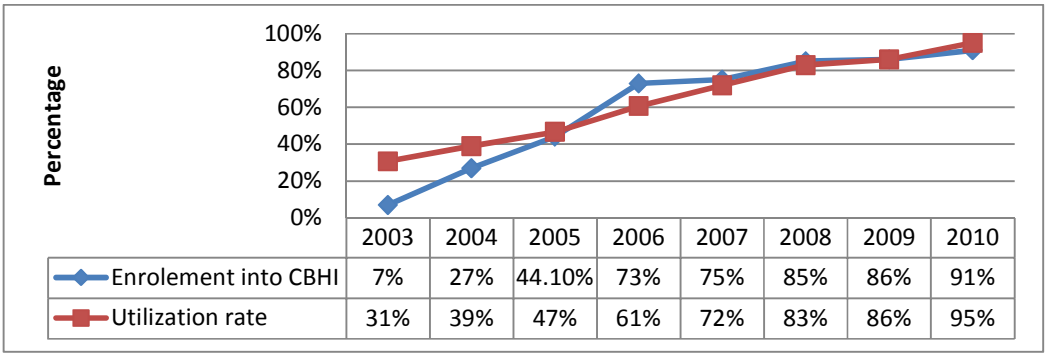
1) Background and Evolution

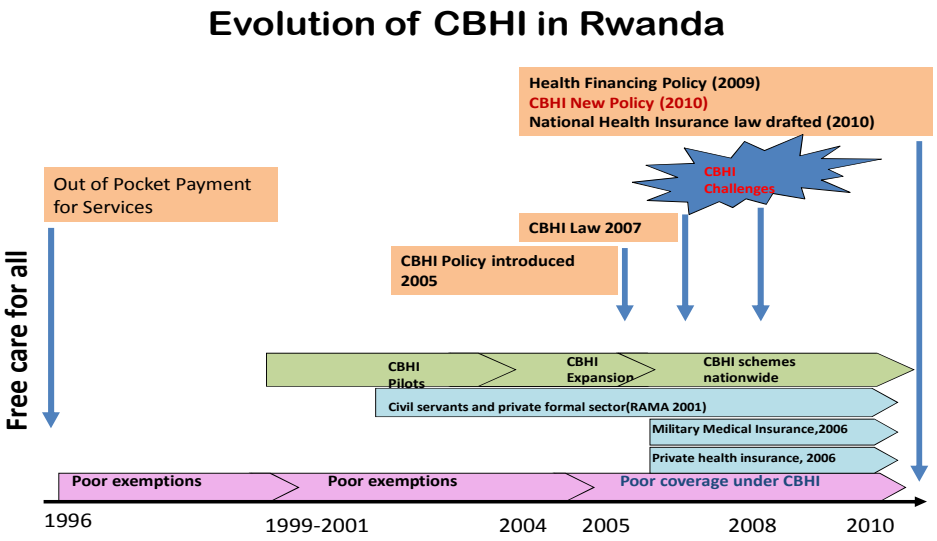
Rwanda is known for its best practices and innovations in health financing[i]. While it is relatively easy to cover the formal sector (5% of the population), the government has risen to the challenge of providing coverage to the informal sector in order to move towards universal coverage. Community Based Health Insurance (CBHI) in particular has been identified as an instrument to achieve ensure financial protection and health care access to 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 in the health insurance system. The table below shows the rapid expansion of CBHI coverage and utilisation of services by the population.

Table XXX: CBHI Coverage/Utilisation



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

(Source: MTR HSSP2, MOH[ii])



CBHI schemes have started as pilots in three districts in 1999 and with the good results; it was rolled-out in all the districts in 2005. The table below shows the gradual progress in implementation over the years.

Year	Premium Contribution	Stage of Implementation	Remarks
1999	2,500 – 3,500 Rwf/household	Feasibility/Pilot	Implementation in selected districts as basis for policy
2005	1,000 Rwf per person; government provides a subsidy of 1,000 Rwf 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

The rapid expansion of coverage and low, subsidised premium contribution (1,000 Rfw = $1.7 per member per year) however led to a financially unsustainable situation. The revenues generated from the premium contributions proved to be insufficient to cover the package at the district hospital and health centre that was decreed by the MoH in a sustainable manner. This led to an accumulation of debts to district hospitals for the services delivered to CBHI members.

A 2008 review of the health financing system by the Ministry of Health and the WHO (OASIS[iii], 2008) also provided guidance on how to address the current weaknesses of the CBHI system. The challenges highlighted can be summarised as: insufficient funds at both district and national risk pooling level, weak pooling mechanisms, insufficient staff and limited management capabilities, possible abuse at different levels in the system (beneficiaries and providers), large numbers of people in the informal sector with limited capacity to make contributions and who are difficult to

identify. These challenges need to be addressed to get out of the vicious cycle that works against sustainability in any CBHI scheme.

2) CBHI Reform Process

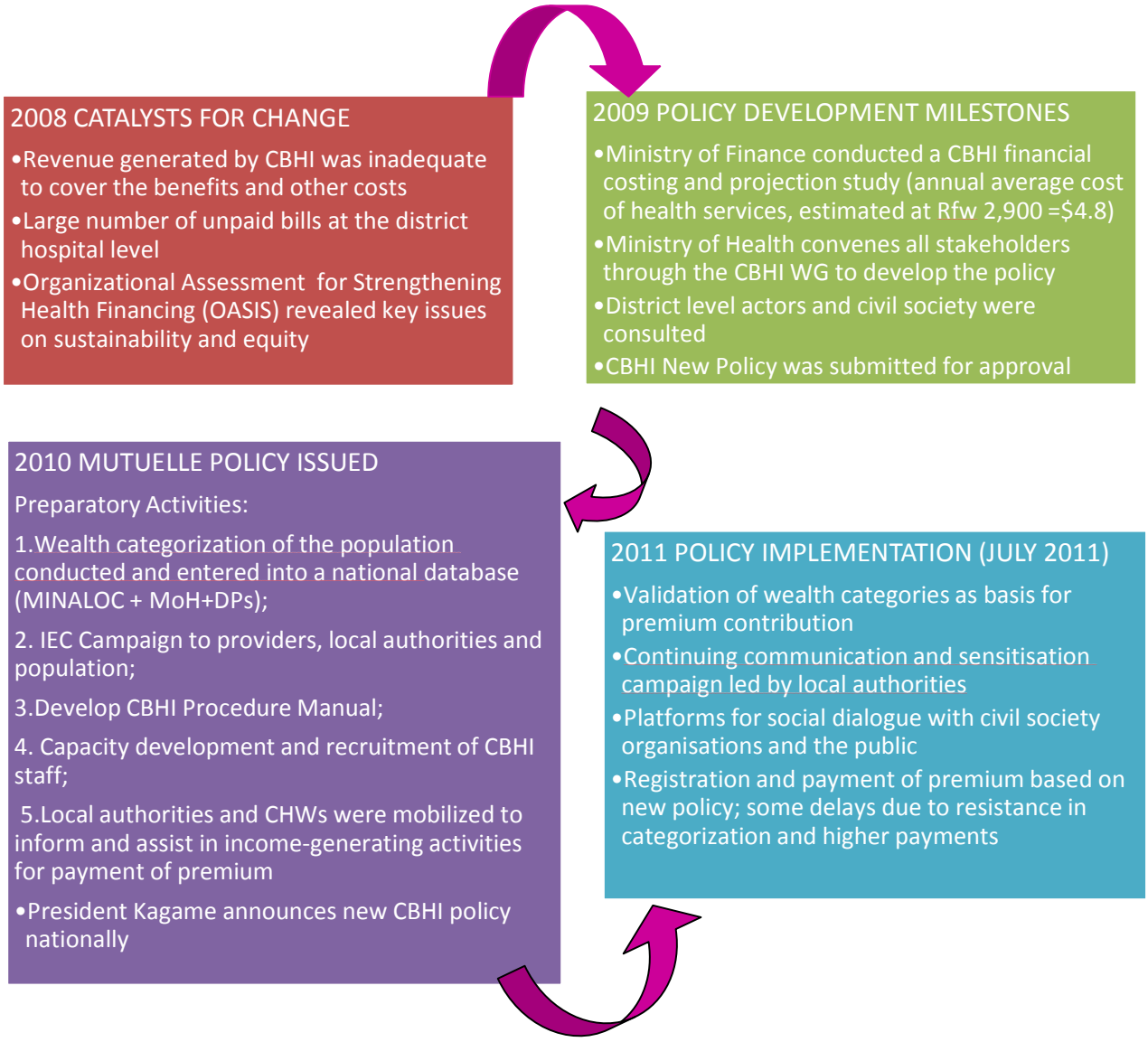
- *MoH-led policy development in collaboration with the CBHI Working Group*: To lead the reform process, the MoH convened the CBHI extended team, which brought together policy makers and development partners. The extended team was led by the MoH CBHI team and all partners in health financing, including representatives of DPs working in all the 30 districts. The civil society and local government were 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 at 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 2,900 Rfw was used as the basis of the reform design and new premium contribution after taking into account inflation, an increase in 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 socio-economic status of the population and from the villager's opinions. The categorisation system has traditionally been used for socio-economic opportunity distribution. As this is the first time that it is linked to "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 the President Paul Kagame announced the new policy publicly, demonstrating a strong political support for this policy from the highest possible level. At the same time, the new policy[iv] had been finalised and the date for implementation was set for July 2011. Preparation for implementation began in January 2011.

3) The Policy Content

Objective: The development and strengthening of the CBHI system in Rwanda, with the larger goal of improving the financial accessibility of populations to health care, protecting households against the financial risks associated with diseases, 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 characterise the new policy

Figure XXX: Overview of the reform and implementation process



. **Figure XXX: 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		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[v] 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 sensitisation and information	Local authorities are made responsible for implementation of CBHI in their districts under the decentralised 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 categorisation, which includes poverty identification, to ensure free CBHI coverage of the poorest(Ubudehe database); districts organise and mobilise the population to join income-generating activities and cooperatives
6. Moral hazard exhibited by beneficiaries	Strengthen the M&E system Participation of CBHI in the promotion of prevention activities Strengthen the management of patient roaming	CBHI Unit in the MoH is strengthened to fulfill its role in M&E and supervision;

Many of these reforms are related to the day to day management of the CBHI scheme; improving processes and strengthening the capacity of the system at all levels. The reforms which most immediately affected the population are: (1)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, premium contribution was a flat rate of Rfw 1,000 ($1.6) with a subsidy of the same amount from the government. Indigents were covered by a combination of government and donor support. The table below shows the new contribution rates and the proportion of the population under each category:

New Stratified Premium Contribution (effective 01 July 2011)

CBHI Category	Premium Contribution per person/ per year
Group1- Indigents (Ubudehe category 1&2) Est.24.8% of popn	2000 RWF, fully supported by the government; this group is exempted from paying; No co-payments
Group 2- People who can afford to pay (Ubudehe category 3&4) Est. 68.8%	3000 RWF paid by themselves With co-payments: 10% at DH/RH and 200 RwF at health centres
Group 3- People who are rich (Ubudehe category 5&6) Est. 2.17%	7000 RWF paid by themselves With co-payments: 10% at DH/RH and 200 RwF at health centres

4) Implementing Challenges

- *Development and Validation of Wealth Categorisation Database*: As basis for fair contribution rates in a country with a huge informal sector, the database is a prerequisite for the implementation of the policy. Although it was developed almost a year ahead, 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 the 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 card. MoH informed the population and instructed the providers to ensure that there is 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 speculations and some people adopted a wait and see attitude. Many did not immediately renew their membership with the new premium rates while others need to wait 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. Thanks to the intensified sensitisation campaign and commitment of local authorities, the coverage rate bounced back to 85% at the end of the year.
- *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 done . The number of required local staff was also monitored to ensure efficient service to members.

5) Lessons Learnt from the reform process

- ***Strong leadership and good governance*** from the highest political level are essential to ensure the successful implementation of such a policy. Likewise, good cooperation among agencies within the government.
- ***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 air their opinions or concerns.
- ***Decentralised 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, informational 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 categorisation 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 change process.
- ***Policy change is a complex process*** that needs to be carefully planned and managed to ensure transition effects are minimised, if not avoided. The implementers should analyse the implications of the policy and plan mitigation strategies for potential negative consequences

and mobilise multi-stakeholder support to the policy. A well-developed change management strategy is therefore essential to the process.

6) Where are we now?

After the initial slow uptake of CBHI membership and some birthing pains upon introduction of the policy, coverage has increased to 91 percent (CTAMS, MOH 2012) bringing the national health insurance coverage to 96%. The recently developed Health Sector Strategic Plan III for Rwanda 2013-2017[vi] focuses heavily on reviewing the benefit package to make it more responsive and sustainable and building health financing institutional capacity to further consolidate the successes of CBHI within a national system.

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[i] Rwanda Health Financing Policy, 2009
[ii] Ministry of Health Mid-Term Review, 2011
[iii] Rwanda Health Financing Systems Review, Options for Universal Coverage, 2008
[iv] Rwanda Community Based Health Insurance Policy, 2010
[v] Rwanda Health Insurance Procedure Manual, 2011
[vi] Rwanda Health Sector Strategic Plan III, 2013-2017