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Volume 2: National Cases

For the research framework, the analysis of the national cases, and other research components, including a description of the research team members, refer to Volume 1: Report.

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RWANDA

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HEALTH SYSTEM[1]

The 1994 genocide in Rwanda destroyed much of the socioeconomic fabric of the country as well as its health infrastructure. The health care system is still suffering in the aftermath. Although the health status of the Rwandan population has improved significantly in recent years, it remains inadequate. Training health workers to advanced levels has taken time and has not been rapid enough to meet the needs of the Rwandan population.

In 2000, the Rwandan government adopted a plan, Vision 2020. The key idea was to transition into a middle-income country over the next two decades. The cornerstone of this development was to be health. As Rwanda's Minister of Health, Dr. Agnes Binagwaho, explained, "health is a key pillar of our development" and without improving health, they will never alleviate the country's poverty.[2]

The health system in Rwanda is a decentralized, multi-tiered system. It is composed of the following tiers and associated packages of health services: 18 dispensaries (primary health care, outpatient, referral); 16 prison dispensaries; 34 health posts (outreach activities – immunizations, prenatal care, family planning); 430+ health centres (prevention, primary health care, inpatient, maternity); 39 district hospitals (inpatient and outpatient); and 4 national referral hospitals (specialized inpatient and outpatient). The 4 referral hospitals are: Centre Hospitalier Universitaire de Kigali, Centre Hospitalier Universitaire de Butare, King Faisal Hospital, and the Kanombe Military Hospital.

Population (in thousands): 11,458

Population median age (years): 18.05

Population under 15 (%): 43.56

Population over 60 (%): 3.94

Total expenditure on health as a % of Gross Domestic Product: 10.7

General government expenditure on health as a % of total government expenditure: 22.1

Private expenditure on health as a % of total expenditure: 42.7

Rwanda's health system is financed both by state funds and by individuals' contributions through health insurance and direct fees for services. Health insurance is provided through a variety of programmes. The largest is the Community-Based Health Insurance Scheme which is primarily comprised of the social health insurance programme Mutuelles de Santé. Members pay annual premiums of approximately $6 USD per family member (increased in 2011 from $2 USD per person) with a 10% service fee paid for each visit to a health centre or hospital.

Membership is voluntary and payment of premiums is based on economic status. The program was first introduced in 2004. By 2010, 91% of the Rwanda population was insured through Mutuelles de Santé. Rwandans can access health care at all public and non-profit health centres in Rwanda. The Mutuelles de Santé member's package does not include coverage at private health centres, however.

Rwanda's experience illustrates the value of universal health insurance. In the view of Peter Drobac, the director in Rwanda for Boston-based Partners in Health, "Its health gains in the last decade are among the most dramatic the world has seen in the last 50 years."[3]

MUTUAL HEALTH ORGANIZATIONS

With Law No. 62/2007 of December 30, 2007, membership in a health insurance plan is mandatory for every Rwandan citizen.[4] Rwanda has pioneered major programmatic, organizational, and health financing reforms aimed at improving the quality of care and, ultimately, the health status of the population with a particular focus on its most vulnerable segments. From only one initiative in 1998, these schemes have expanded to cover virtually the entire country. MHO schemes are part of the national programme for the promotion of access to health care.

MHOs in Rwanda are autonomous organizations, administered freely by their members. MHOs determine their benefit packages, annual premiums, and periodicity of the subscriptions. They establish conventions on care and health services, service providers, and reimbursement modalities, according to the terms of the contract. In addition, they sensitize the population and ensure the recruitment as well as development of customer loyalty among members. MHOs ensure the day-to-day management of the resources they collect and maintain transparency and traceability in their various bank and cash operations.[5]

Following the reintroduction of the policy for health care payment in 1996, multiple pilot initiatives for the implementation of MHOs have been undertaken. In 2004, with the adoption of the "Policy for the Development of Mutual Health Organizations in Rwanda," the government reiterated the importance of the MHO funding mechanism in order to generalize and to improve financial access to health care.

After the pilot implementations, MHOs were adapted to fit within the decentralization model that was being developed in Rwanda, specifically involving the Ministry of Decentralization and Local Affairs (MoDLA) and its agencies. This adaptation anchored them in the community and facilitated the mobilization of local authorities in the various administrative districts and district subdivisions. This involvement also resulted in the involvement of non-governmental organizations (NGOs) and religious leaders, which raised the population's awareness of the importance of enrolling in MHOs. Leadership at the central level was also mobilized to ensure the backing of the highest authorities in government.

In mid-2006, benefit packages were expanded, and coverage for the indigent, vulnerable groups and for people living with HIV was institutionalized by the government and foreign partners. The benefit packages now cover primary health care, secondary care, and tertiary care, which dramatically improved the price-quality ratio for MHO services.

Recognizing the potential problems involved in small risk pools, Rwanda established a National Guarantee Fund (FNG) and a District Solidarity Fund (FSD) to bolster financing mechanisms for MHOs. The FNG/FSD system[6] harmonizes MHO benefits with those received by the beneficiaries of other social health insurance systems and by providing care for indigents.

The percentage of the population contributing to MHOs continues to increase. At the end of 2008, national coverage was estimated at 85%. Another 6% of the Rwandan population was estimated to be covered by other mandatory insurance schemes, such as the RAMA, MMI, or other private insurance plans.

Summary of Health Financing Methods[7]

Method	Formal public sector	Formal private sector	Poor	Informal urban	Informal rural/farmers
Prepayment	RAMA and MMI	MHO or RAMA	MHO (*Mutuelles*) schemes		
Coverage (number of citizens)	297,000 (2006)	7.6 million (2008)			
Coverage (% of population)	3.3	85			
Source of revenue	RAMA: 15% (shared equally); MMI: 22.5% (17.5% government)	Member contribution of $7.60 USD per year for up to seven per family, plus contributions from government and donors for those who cannot afford this amount			
Revenue collection	Payroll deduction	Collected by MHOs			
Number of risk pools	One each for RAMA and MMI	One per district (approximately 392), but a National Guarantee Fund and District Solidarity Fund have been created to provide equalization and reinsurance support			
Payment methods	Fee-for-service	Some capitation and fee-for-service; output-based payment methods have been also implemented for some services			
Benefit package	Full range of services	Preventive and curative services, prenatal care, delivery care, laboratory exams, drugs on the MoH essential drug list, ambulance transport to hospital, limited district hospital services			
Facility coverage	Own facilities plus contracts with public/FBO	Contracts with district health centre and surrounding hospitals; recent changes have allowed subscribers to obtain service at any health facility			
Regulatory	RAMA/MHI Boards oversight	MHOs that are non-profit, self-administered organizations; policy direction from MoH			

CASE STUDY

The **Public Health Building Program** (PHP), funded by the Swiss Agency for Development and Cooperation-Switzerland, began in Rwanda in August 2002. To date five phases of intervention have been completed. The areas covered by the programme include the districts of Karongi and Rutsiro in the country's Western Province. The population of the project area was estimated in 2010 at 617,000 inhabitants, served by 41 health centres.

One of the interventions of the PHP was to support the establishment of a national policy for health financing by supporting the development of MHOs in the intervention area. The programme has provided direct support to a total of 45 health

facilities partners. Since 2008 in Karongi, and since 2009 in Rutsiro, the PHP has also supported the establishment of a system of grouping 30-50 households into Community Solidarity Associations (Ikimina). In each Ikimina members urge one other to pay MHO premiums. Each Ikimina agrees to use the services of the MHO only when all its members are up-to-date in their dues. This has enabled the District of Karongi to increase population adherence, which now reaches 99%. Plainly, the commitment and solidarity of people in small groups who share the same realities are important when promoting adherence to MHOs.[8]

The utilization of health services in Karongi and Rutsiro (see tables, below) demonstrate the degree to which the population, including the poor, sees the advantage in the use of health services.

Mutual Health Indicators 2005-2009 - District of Karongi[9]

Indicators	2005	2006	2007	2008	2009
Membership rate in MHOs (relative to total population)	58%	87%	74%	85%	99%
Number and % of poor people enjoying free membership cards	-	40,000 21% of total population	59,855 21% of total population	65,178 23% of total population	73,904 23.5% of total population
Rate of utilization of services by the population	-	0.50 contact/ inhabitant	0.52 contact/ inhabitant	0.79 contact/ inhabitant	0.72 contact/ inhabitant

Mutual Health Indicators 2005-2009 - District of Rutsiro

Indicators	2005	2006	2007	2008	2009
Membership rate in MHOs (relative to total population)	8%	94%	75%	87.62%	87%
Number and % of poor people enjoying free membership cards	-	35,000 13% of total population	72,115 27% of total population	67,826 24% of total population	67,826 23.1% of total population
Rate of utilization of services by the population	-	0.43 contact/ inhabitant	0.46 contact/ inhabitant	0.7 contact/ inhabitant	0.69 contact/ inhabitant

CONCLUSION

The experience of Rwanda shows that in a context of political will and opportunities for external funding, it is possible to institutionalize and generalize the approach of MHOs at the national level.

MHOs have proven an effective mechanism for increasing financial access to curative health care and consequently increasing the use of these services. The compulsory nature of public support to MHOs is certainly a way to achieve universal coverage, although it imposes regular health costs on family budgets. That said, it is important to continue to increase the quality of care in order to deal with increasing demand for health care. It also is important to continue to motivate public support for MHOs.

SOURCES

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[6] The FNG is sponsored through contributions from RAMA, MMI, private insurance systems, and foreign partners, including the Global Fund. The FSD is funded by the contributions of MHOs, administrative districts, transfers from the FNG, and contributions from development partners are involved at the district level.

[7] Abbreviations: FBO = Faith-Based Organization; MHI = Medical Health Insurance; MHO = Mutual Health Organization; MMI = Military Medical Insurance; MoH = Ministry of Health; RAMA = Rwanda Health Insurance Company (Rwandaise d'Assurance Maladie). Source: World Bank, Human Development Department Africa Region. 2011. *Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note*. Retrieved August 19, 2014 (http://p4h-network.net/wp-content/uploads/2013/10/WB_TanzaniaHealthFinancingPolicyNoteFinal.pdf).

[8] Savadogo et al. 2011.

[9] Savadogo et al. 2011.