

REPUBLIC OF RWANDA



MINISTRY OF HEALTH

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# RWANDA NATIONAL HEALTH INSURANCE POLICY

Kigali, April 2010

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## ACRONYMS

ARV	Anti Retroviral Drugs
AU	African Union
CBHI	Community Based Health Insurance
CEPGL	Communauté Economique des Pays des Grands Lacs
CORAR	Compagnie Rwandaise d'Assurance et de Réassurance
CPA	Complementary Package of Activities
CTAMS	Cellule Technique d'Appui Aux CBHI De Sante
DH	District Hospital
EAC	East African Community
ECASSA	East and Central Africa Social Security Association
EDPRS	Economic Development and Poverty Reduction Strategy
GDP	Gross Domestic Product
GNP	Gross National Product
GOR	Government of Rwanda
HC	Health Centre
HIMO	Haute intensité de main d'œuvre
IEC	Information Education and Communication
KFH	King Fayçal Hospital
MPA	Minimum Package of Activities
MDGs	Millennium Development Goals
MIFOTRA	Ministry Of Public Services, Skills Development, Vocation Training and Labour
MINAGRI	Ministry Of Agriculture and Animal Resources
MINALOC	Ministry Of Local Government, Community and Social Affairs
MINECOFIN	Ministry Of Finance and Economic Planning
MINICOM	Ministry Of Commerce, Industry, Investment, Promotion, Tourism and Cooperatives
MINISANTE	Ministry Of Health

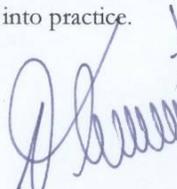
MMI	Military Medical Insurance
NEPAD	New Partnership for Africa Development
NGO	Non-Governmental Organisation
NRH	National Referral Hospital
PARN	Paquet d'Activités de Référence Nationale
PBF	Performance Based Financing
PRSP	Poverty Reduction Strategic Paper
RAMA	La Rwandaise d'Assurance Maladie
SORAS	Société Rwandaise D'Assurance
SSFR	Social Security Fund of Rwanda
UHI	Universal Health Insurance

## Foreword

In many African countries a considerable proportion of the population faces problems of financial access to essential health care services. This holds especially true for the informal sector and people living in rural areas.

In order to enhance health care coverage and provide financial protection against impoverishment due to the costs of catastrophic illness, the Government of Rwanda has implemented several financing mechanisms. Apart from social health insurance schemes covering employees in the formal public and private sector, a community based health insurance was established to improve access and offer financial protection to the majority of the Rwandan population working in the informal sector. In addition to the Community Based Health Insurance Policy, the present policy has been elaborated to provide a comprehensive guiding framework for a National Health Insurance system in Rwanda. Among the measures proposed is the creation of an overarching health insurance council that will take on an advisory and coordination role for all insurance mechanisms as well as the strengthening of partnerships between public and private institutions. By looking at the wider social health protection perspective it is hoped to fill current gaps in coverage and link the existing mechanisms more effectively.

To achieve the goals of equitable access to health care and universal coverage in the Rwandan health system I therefore urge all stakeholders involved to make use of this document and put its objectives into practice.



Dr Richard SEZIBERA

Minister of Health

# 1. Background

## 1.1 Economic and political context

Rwanda is a landlocked country with an area of 26,338 km<sup>2</sup> and a population of 10.4 million inhabitants<sup>1</sup>. It is the most densely populated country in Africa with a population density of 350 inhabitants per km<sup>2</sup>. Based on an annual population growth rate around 2.6%, it is estimated that the population will reach 16 million by 2020<sup>2</sup>.

Rwanda has achieved sustained GDP growth over the last 7 years. Per capita GDP grew from USD 235 in 2002 to USD 291.3 in 2008. In 2008 agriculture contributed 31% to the economy, while services contributed 47.7%, and industry contributed 15.6%<sup>3</sup>. Nearly 80% of the population was reliant on agriculture for family income in 2006<sup>4</sup>. Poverty is widespread as it affects 57% of the population<sup>5</sup>.

The Rwandan government is committed to sound financial management and transparency in all sectors. The fiscal performance has improved over the last five years, with revenue collection growing to around 13% of GDP in 2006<sup>6</sup>. The domestic fiscal deficit has widened from around 2% of GDP in 2001 to 6% in 2006. Priority expenditure, which allocates resources to pro-poor needs, has increased over the past five years. Rwanda has also benefited from both the Heavily Indebted Poor Country (HIPC) and Multilateral Debt Relief (MDR) initiatives resulting in a sustainable debt position.

Decentralisation reforms have increased the roles of Districts in service delivery in the health sector. The central government agencies' roles and responsibilities are mainly in policy formulation, regulation and support to local governments through capacity building, financing and monitoring and evaluation. Districts are responsible for economic development and planning and coordinating the delivery of public services at the local level. Fiscal decentralisation has created new fiscal relations including block grants to districts through the Local Authority Budget Support Fund, earmarked transfers to districts for health services, and other transfers to districts. Decentralisation reforms were deepened in the health sector in 2006 and have resulted in increased autonomy in budgeting and financial management of health facilities.

## 1.2 Health situation

Rwanda has made good progress towards meeting the health related MDGs. Under-five mortality rates have declined from 152 to 103 per 1000 in less than 10 years<sup>7</sup>. Child malnutrition, however, is still a challenge in the country as 24% are underweight. Positive trends in maternal health are also observed during the last decades: the rate of deliveries assisted by skilled staff has increased from 39% in 2005, to 52% in 2007; the percentage of women between 15 and 49 years of age using modern contraceptive methods impressively increased from 10% to 27%.

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<sup>1</sup> NISR Population Projections 2009-2014.

<sup>2</sup> The population is estimated to be 9.3 million end 2007 (based on projections of Census 2002).

<sup>3</sup> MINECOFIN GDP estimates, February 2008

<sup>4</sup> EICV2 2005-2006

<sup>5</sup> NISR; EICV2, 2005-2006

<sup>6</sup> World Bank and Ministry of Health, 2009. Rwanda : A Country Status Report on Poverty and Health. September 2009 (forthcoming).

<sup>7</sup> DHS 2005, IDHS 2008.

If these trends are maintained, Rwanda will meet the child mortality MDG by 2015<sup>8</sup>. This will require sustained efforts for: scaling-up successful community-based nutrition interventions and improving neonatal management. In order to reach the maternal health related MDG, however, Rwanda needs to invest important efforts to sustain the increasing trends in the coverage of family planning and professional assistance at delivery in health facilities and to improve the quality of reproductive health services. Rwanda needs also to strengthen preventive measures in order to reduce significantly the prevalence of HIV and AIDS and its burden on households, the health system and the economy.

Rwanda needs also to address major health systems bottlenecks which are constraining the extension of access to essential health interventions. Major progress has been made to improve the availability, distribution and motivation of qualified health personnel; however, there are remaining challenges in the human resources for health area including the lack of midwives and the shortage of medical specialists in hospitals. In addition, while geographical access to health facilities has been improved, unmet need remains considerable as approximately 40% of patients still have to travel more than 1 hour or more than 5 km to reach the closest health facility. Finally, Rwanda has made progress in strengthening the procurement and distribution systems of drugs and medical supplies in the health sector; however, the progress at the national level has not been fully matched at the intermediate and peripheral levels.

### 1.3 Health financing

Over the last few years, Rwanda has developed a comprehensive health financing framework building on global health care financing best practices. The health financing framework is still evolving as a result of profound transformation of key health financing functions of revenue collection, risk pooling and purchasing in the country.

#### Revenue collection

Revenue collection has undergone major quantitative and institutional changes. Total health expenditure (THE) in Rwanda has increased substantially in recent years<sup>9,10</sup>. Between 2003 and 2006, nominal health expenditure per capita has doubled from US\$ 17 per capita to US\$ 34. In 2006, total health expenditure reached 10.7 percent of GDP, compared to 6.6 percent in 2003.

Despite sustained efforts over the past years, increasing the level of public domestic health spending remains a major challenge. The increase in domestic revenue and in aid flows together with the major reduction in debt services led to a significant increase of total public expenditure in recent years. Compared to neighbouring countries, however, public domestic spending on health is still limited in Rwanda: it amounts to US\$ 6.3 per capita in 2006 compared to US\$ 23 in Zambia, US\$ 14 in Kenya or US\$ 12 in Mozambique.

The share of domestic resources to public health expenditure has decreased while external health resources increased. Donors' share of THE has increased to over 53 percent in 2006 compared to 42 percent in 2003: this increase, however, must be put in perspective as an important share of these expenditures is earmarked to the fight against HIV and AIDS.

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<sup>8</sup> World Bank and Ministry of Health, 2009. Rwanda : A Country Status Report on Poverty and Health. September 2009 (forthcoming).

<sup>9</sup> Total health expenditure includes domestic resources from the government, external resources from donors and private expenditure from private sources (households and other private).

<sup>10</sup> NHA 2006.

As a result, Rwanda is among the countries of the region (with Madagascar and Mozambique) that have the largest share of external resources flowing to the health sector, exceeding 50 percent of THE. Rwanda ranks among the countries with the highest per capita external assistance on health.

Although prepayment mechanisms have been extended with the scale-up of CBHI schemes, out-of-pocket expenditures are still the main mechanism of private expenditure in the health sector. Private health spending is composed mainly of household expenditures in the health sector: the share of private spending in THE increased to 28 percent in 2006 compared to 25 percent in 2003. Private expenditures amounted to US\$ 9.4 in 2006 out of which US\$ 7.5 constituted out-of-pocket expenditures.

### **Risk pooling**

As a consequence of growing public spending from internal and external resources as discussed above, risk pooling in the health sector has been improved. However, most of the external assistance is still used for vertical programmes instead of targeting the entire health system. In addition, huge amounts provided by NGOs and some development partners are often not accounted for in the budget.

Health insurance coverage has been expanded for people employed in the formal sector, as well as informal and rural sectors of the economy since 2000. A medical insurance regime has been established in 2001 for public servants and their dependants: *Rwandaise d'Assurance Maladie* (RAMA). The military and their dependants are covered through a health insurance regime managed within the Ministry of Defence, the Military Medical Insurance (MMI). Risk pooling from private sources has been greatly improved as a result of the extension of community-based health insurance (CBHI) schemes, allowing the majority of the population access to healthcare services. Major achievements and major challenges of the development and extension of health insurance are summarized below.

### **Purchasing**

There are now a growing number of health financing agents which are responsible for the allocation of health resources in the Rwandan health sector. The Government, mainly through the MOH and districts, currently manages slightly over one-quarter of total health expenditure, while development partners and households are the two other key managers of health resources. Since the development of RAMA, MMI and the extension of CBHI, health insurance organizations are evolving as major managers of health resources.

Different packages of activities have been defined according to each of the levels of the health system in order to provide equitable and quality care across the country, ensure that there are procedural standards for operation and management, allow for better planning and management of resources, and provide the basis for establishing and evaluating the quality of health services. While government and donors continue to provide input-based subsidies to strengthen the capacities for delivering these packages of services at the primary, secondary and tertiary levels, supply-based allocation mechanisms are being improved with a greater focus on quality improvements based on performance-based financing mechanisms. Benefit packages of health insurance organizations have been tailored to the coverage of personal health care services based on packages of activities defined at different levels of the health service delivery organizations.

Accordingly, provider payment modalities are increasingly regulated through contractual arrangements with a greater emphasis on output and quality, not only through supply-based performance-based financing mechanisms (public and development partners), but also demand-based mechanisms. These adapting modalities result from the extension of health insurance coverage and the increasing role of health insurance organizations in the allocation of health resources.

These institutional changes are reflected in the restructuring of health spending in the country during the past few years. First, spending on pharmaceuticals and nondurables has increased five-fold between 2003 and 2006: this increase was supported mainly by households and sustained increases in the utilization of health services. Curative outpatient spending, which came at the third position after prevention spending and health administration spending in 2003, increased three-fold between 2003 and 2006, and were the largest health expenditure; curative inpatient spending nearly doubled in the same time period. Prevention and public health program spending nearly doubled between 2003 and 2006. Health administration spending experienced the lowest growth during the three year period. Second, health facilities receive public funds through the MOH programs, district transfers, and internally generated revenues. Internally, generated revenues have increased by 660% at health centres between 2002 and 2007; by 305% at district hospitals; and by 194% at referral hospitals during the same period. While health centres were capturing 44.6% of internally generated revenues by health facilities in 2002, their share has increased to 65.3% in 2007<sup>11</sup>.

## 1.4 Health insurance

### Major achievements

Upon independence in 1962, Rwanda inherited a “free of charge” health care policy which revealed later on to be unrealistic, ineffective and unsustainable. It was therefore abandoned. Apart from insurance for occupational diseases and injuries covered by CSR for formal sector employees, the abandonment of the system created a total vacuum, leaving the entire population exposed to diverse risks related to health without any insurance coverage. This vacuum was partially covered only with the creation of mandatory health insurance for public servants and military personnel. But these regimes cover only a very small portion of the population. This situation has changed dramatically with the emergence and extension of the CBHI system. At the end of 2008, Rwanda had achieved impressive health insurance coverage of 92% of its population. The national CBHI coverage rate was estimated at 85%; with other insurance schemes (RAMA, MMI and private insurance) covering an estimated 4% of the population.

The impressive achievement in health insurance coverage over the past ten years is a strong foundation for Rwanda’s ambition to realize universal health insurance coverage, but Rwanda will need to build on the internal factors which contributed to this achievement. Strong political commitment and leadership have been the hallmark of Rwanda’s achievement in the health insurance area. The political commitment has been specifically translated into policy measures to strengthen the equity and solidarity foundations of health insurance initiatives, the inclusion of the poor and the empowerment of citizens. In addition, an incremental policy development has provided space for experimentation and evidence-based policy making since 1998.

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<sup>11</sup> Ministry of Health, 2009. Health Sector Strategic Plan: July 2009 –June 2012. Ministry of Health, 2008. Rwanda Public Expenditure Review for the Health Sector: 2006-2007 Data and Trends from 2002-2007. April.

Participation in open policy debates on impact and strategies based on internal experiences and evidence has supported the adaptation of CBHI and their alignment with the ongoing decentralization process. Scale-up of CBHI has built on leadership at the central and district levels – seen from the strong support from the Presidency, leadership of ministries of health, finance and local government, and leadership of district authorities, religious leaders, health authorities and community leaders at the sector and cell levels. Rwanda needs to build on sustained political commitment, multilevel leadership, and evidence-based policy making to continue taking on major challenges in the health insurance area.

### **Major challenges**

Rwanda has built a remarkable system for extending health insurance coverage to both the segments of its population employed in the rural and informal sectors and the segments employed in the formal sector. There are specific challenges associated with health insurance systems targeted to these segments of the population that need to be addressed in order to sustain universal coverage.

The CBHI system targeted to segments of the population employed in the rural and informal sectors face many challenges. Although CBHI provides a comprehensive benefit package, the availability and completeness of products, commodities, and services for treatment at partner health centers needs to be improved. It is common practice for drug prescriptions for insured patients to be filled in private pharmacies without reimbursement. Finally, co-payments at the district and referral hospitals seem to remain a burden for poor, insured patients.

There are also major challenges with the financing mechanisms of the CBHI system at different levels. The financing of primary pools still relies mainly on the contributions of households who are relatively poor, and cross-subsidization from richer groups needs to be improved. Current contribution policies under the CBHI system are based on a flat rate for all income groups. The current flat membership fee with regressive burden on the households' budget is too high to enable poor households to pay their premiums themselves. The financial sustainability of CBHI is also threatened by the rigidity of contribution levels which have not been changed since 2005: the membership fee of CBHI, which was established at RwF 2,000 per person based on a costing of health care level conducted in 2003, is outdated, and needs to be adjusted to reflect today's real costs.

Although internal sources of funding have been identified, the national and district risk pools are under-funded as a result of weak contributions of potential sources and weak administrative capacity for resource mobilization. The current mechanism is highly fragmented. In this context, poorer sections and districts are at much higher risk of bankruptcy and are unlikely to achieve financial sustainability.

Relations with health care providers are also a major concern for the financial sustainability of the CBHI system. In many CBHI schemes, financial sustainability has been threatened by over-prescriptions, which have raised concern about the appropriateness of provider payment modalities. Major challenges include: overuse, over-prescription and over-charging of acts by providers; and the misappropriation of funds in some sections.

Finally, another critical issue under the CBHI system is the governance of the financing pools, which needs to be strengthened in order to improve oversight of the use of the funds. Management capacities at the sector, district and national levels need to be strengthened in order to empower members and to improve the institutional sustainability of the CBHI system. These challenges are exacerbated by low managerial capacity and lack of autonomy of CBHI schemes at district and section levels

There are also challenges associated with health insurance schemes targeted to segments of the population employed in the formal sector of the economy. Retired workers are excluded from the schemes with which they were affiliated during their working lives (RAMA, MMI) and they are obliged to join the CBHI. There is no specific legal and regulatory framework for private health insurance, which is operated as a normal non-life business.

## 2. Policy context

### Vision 2020

Developed in 2000, Rwanda's Vision 2020 elaborates a national long-term vision in terms of goals and objectives to be achieved by the year 2020. By that year Rwanda should: be a middle-income country; have halved the percentage of people living in poverty; raise life expectancy to 55 years; and have reduced its aid dependency. It expects to reach these goals by means of seven strategies/pillars, which include decreasing population growth, increasing access to education and improving the health of the people. This document serves as the basis for the elaboration of national and sector plans in the medium term.

Vision 2020 acknowledges the importance of education and health in ensuring an efficient and productive workforce. It also identifies demographic pressure as a major cause of the depletion of natural resources and subsequently, poverty and hunger. To reverse this trend and improve the health status of the population, health policies should target the poorest and seek to improve access, quality, and affordability of health care.

### Good Governance and Decentralisation Policy

The decentralisation process was launched in 2000, and entered its second phase in 2005, with an administrative reorganization aimed at reducing the number of provinces from 15 to four (in addition to Kigali) and reducing the number of districts from 106 to 30. Below the district level there are 416 sectors (*imirenge*), 2,150 cells (*akagari*) and almost 15,000 villages (*imidugudu*). The policy states that the minimum requirements are: at least one hospital for each district; at least one health centre (HC) per sector; and at least one health post (HP) for each cell. Additionally, a network of male and female community health workers is proposed below sector level.

The Rwanda Decentralisation Strategic Framework (RDSF) has been developed to guide the implementation of the Government of Rwanda's policy of decentralisation as set out in the 2000 Policy Paper. The RDSF serves as the overall framework of reference for current and future interventions towards decentralisation in Rwanda. It goes beyond sectoral policy in that decentralisation is a transversal process that imposes itself as the principal focus of governance reform, the designated motor for the coherency of governance and, finally, as an important vehicle for collaboration between the Government and its national and international development partners.

This strategy is additionally meant to secure Vision 2020, the Millennium Development Goals and the Economic Development and Poverty Reduction Strategy in Rwanda as it is reinforcing the link between good governance and the attainment of broad reaching development objectives.

### **The Vision 2020 Umurenge Program (VUP)**

The Vision 2020 *Umurenge* Program (VUP) aims at ensuring that economic growth is pro-poor and that the majority of the population could benefit from the improvements in living standards that the country as a whole is experiencing. The VUP is implemented through the newly restructured system of decentralized local government and organized around the following: (i) labor-intensive public works that will provide support to extremely poor landless families and encourage saving and development of productive activities; (ii) support to the most vulnerable households that is intended to alleviate poverty, and (iii) micro-credit and financial service initiatives intended to increase investment in income-generation and entrepreneurial activities. A key VUP policy reform has been the institutionalization of the *Ubudebe* process of village-level community decision-making. *Ubudebe* incorporates what is essentially a “poverty-mapping” process, which has a systematic methodology and allocates each household to one of six ordinal income and poverty-related categories differentiated by well-defined qualitative criteria. The maps have become the basis for community decision-making under the VUP program about income support in cash or in kind to ultra-poor households from local and donor sources, as well as a guide to which households should receive subsidies for health insurance.

### **Social Security Policy 2009**

The Social Security Policy of 2009 (SSP 2009) defines the vision of Rwanda as regards health insurance as “to achieve the goal of health for all through universal health insurance”. The SSP 2009 recommends: (i) to establish a plan to achieve universal coverage and to integrate the pensioners within the “RAMA scheme” which will be incorporated within RSSB; (ii) to clarify and enforce Labor Code provisions relating to compulsory affiliation of all employees and the employers’ obligation to provide medical care to employees; (iii) to address price, service availability, and quality of service differentials between private sector medical insurance and community-based medical insurances; (iv) to identify financial resources to subsidize insurance premiums for those unable to make full payment, to the extent financially feasible expand coverage to HIV and AIDS, and (v) to consider permitting limited access to critical medical services available in neighbouring countries, to the extent fiscally feasible.

### **Health Policy 2004**

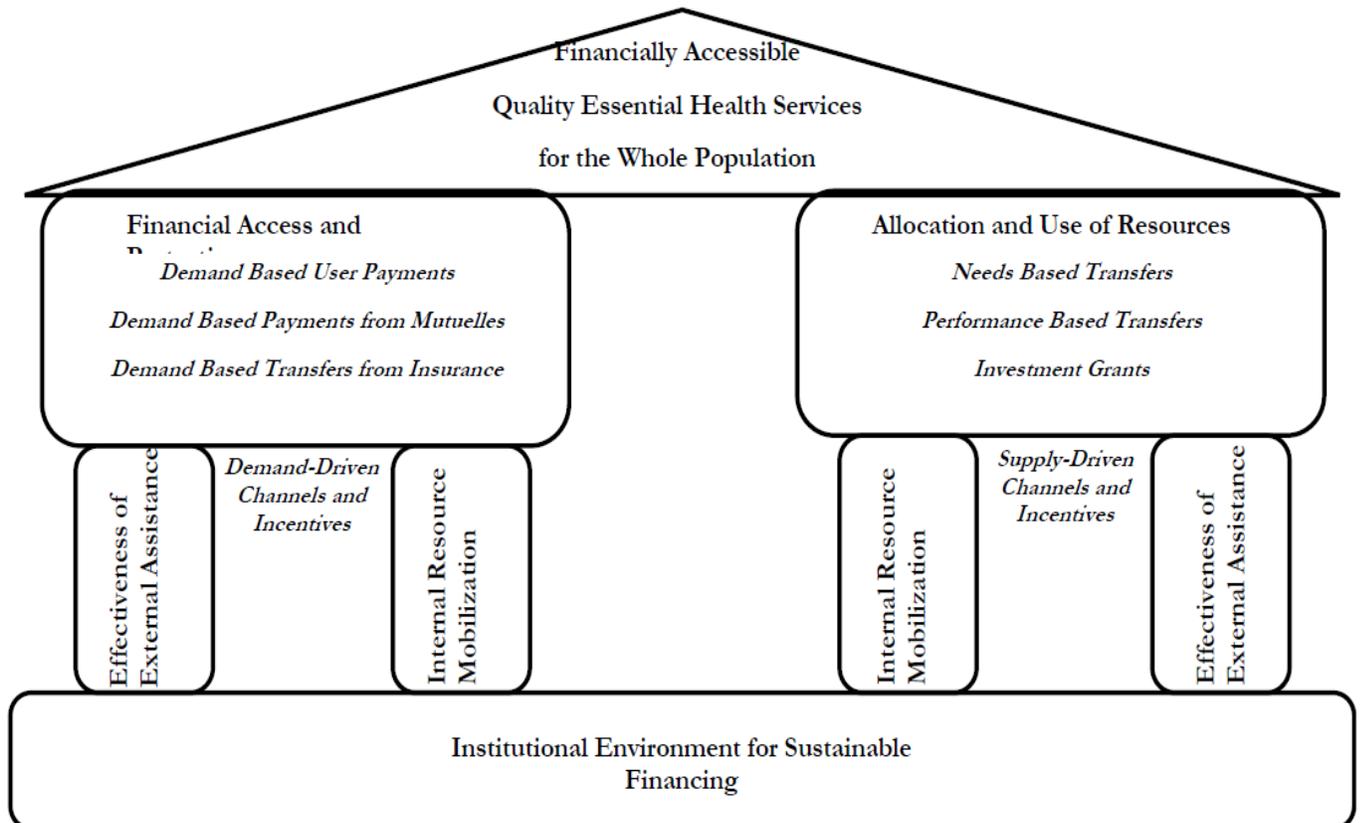
In 2004 the MOH revised its health policy, based on Vision 2020, the PRSP (2002) and the Good Governance and Decentralisation policy. The Policy's seven objectives that guide interventions in the health sector are:

1. To improve the availability of human resources;
2. To improve the availability of quality drugs, vaccines and consumables;
3. To expand geographical accessibility to health services;
4. To improve the financial accessibility to health services;
5. To improve the quality and demand for services in the control of disease;
6. To strengthen national referral hospitals and research and treatment;
7. To reinforce institutional capacity.

## Health Financing Policy 2009

In 2009, the Government of Rwanda developed a health financing policy. The goal of the health financing policy is to ensure that quality essential health services and particularly MDG-related interventions are financially accessible to the whole population in an equitable, efficient and sustainable manner under a results-based financing framework. Interventions to reach these objectives are focused on strengthening the Rwanda health financing framework as outlined in the figure below. The demand side channels of the health financing frameworks are aligned to interventions to strengthen risk pooling for improved financial access and household income protection. The supply side channels of the health financing frameworks are strengthened through interventions to improve efficiency in the allocation and use of resources and the coverage of high impact interventions. These two pillars of the health financing framework are strengthened by policy initiatives to increase internal resource mobilization, to improve the effectiveness of external assistance, and to strengthen the institutional environment for sustainable financing of the health sector.

**Figure 1. Rwanda Health Financing Architecture**



### 3. Guiding principles and values

The National Health Insurance Policy is based on the principles of Universal Health Insurance and on national Rwandan values which have underpinned the achievements of the current CBHIs. Basic principles of the National Health Insurance Policy are the following:

- *Equity, risk-sharing, and solidarity* are the guiding principles that support efforts in resource mobilization and risk pooling and promoting access to quality services in the health sector. Building on these principles, we ensure that the costs of illness of the sick are also shared by the healthy, and the costs of illness of the poorest are also shared by the wealthy among Rwandans.
- *Ownership, empowerment and participation*, and partnerships are the guiding principles upon which efforts to ensure the financial and institutional sustainability of the health financing framework will be built. Government of Rwanda will partner with grassroots institutions and community based and nongovernmental organizations.
- *Universality and quality*: the affiliation to health insurance is mandatory for each citizen and resident of the Republic of Rwanda. Each affiliated person benefits from health services of high quality regardless of his or her socio-professional activity, social status and level of contribution.

These guiding principles are broadly specified to provide a framework for subsequent and complementary elaboration of the health insurance policy into strategies, programs, rules and regulations, guidelines and procedures, and implementation arrangements.

### 4. Vision, Goals and Objectives

#### **Vision**

Rwanda's vision for health insurance at the 2020 horizon is for each Rwandan citizen to have access to essential health care and be protected from impoverishment due to health care expenditures.

#### **Goal**

The ultimate goal of this policy is to provide a national framework for strategies and actions aimed at assuring that all residents of Rwanda can be enrolled in a health insurance plan that provides access to quality health care.

#### **Objective**

To build a financially and institutionally sustainable health insurance system that can guarantee the coverage of all Rwanda's citizen with health insurance.

## 5. Intervention Areas

### 5.1 Community-Based Health Insurance

The CBHI schemes are state-community partnerships which provide health insurance coverage to populations employed in the rural and informal sectors of the economy, which includes the majority of the poor in Rwanda.

In addition to providing health insurance services, CBHI schemes provide a framework for revitalizing community participation and mobilization for health, for empowering individuals and communities in health, and ensuring their involvement in decisions regarding their own health. Building on their proximity to citizens and communities, the national network of CBHI has helped developed a new national distribution modality through which the state, districts, donors and non-government organizations provide health insurance coverage and health benefits to the poorest and vulnerable groups. Most of the policy challenges in the health insurance area are associated with how to improve the financial and institutional sustainability of the CBHI schemes. These policy challenges include how to fill the remaining gaps in population coverage and to sustain the coverage of the poorest, how to improve equity in financing and financial sustainability of CBHI, how to improve relations between CBHI and health care providers, and how to improve governance and management capacities of CBHI.

#### **Target population and population coverage**

There are ongoing challenges for improving the population coverage of the CBHI system to address the remaining uninsured gap of approximately 10% and cover the entire population through health insurance. Furthermore, among enrollees and beneficiaries of CBHI schemes in any given year, coverage is not effective throughout the entire year as a consequence of constraints for renewing enrolment and paying annual contributions in a timely fashion. Hence, there is a need for a better understanding of the remaining gaps in population coverage and for sustaining health insurance coverage of the very poor.

To face these challenges, the Government will build on the universality principle of the current health insurance policy to ensure that each citizen and resident of Rwanda benefit from health insurance coverage throughout the entire year regardless of his or her socio-professional activity, social status and level of contribution. Studies will be conducted for a better understanding of the factors associated with non-enrolment. The Government will promote more flexible arrangements for ensuring that beneficiaries of the CBHI schemes are not denied access to needed care as a consequence of delayed renewal of enrolment and payment of annual contributions. The Government will strengthen subsidy schemes for providing health insurance coverage to the poor. It will reduce co-payments for the poor and vulnerable groups who benefit from health insurance coverage.

#### **Benefit package**

Beneficiaries of CBHI schemes are entitled to all preventive and curative services provided by health centres (minimum package, PMA); all curative care provided by district hospitals (complementary package, PCA); and curative services provided at national referral hospitals (complementary package, PCA). Despite the comprehensiveness of the benefit packages of CBHI, there are challenges associated with the availability and completeness of delivered products, commodities, and services for treatment at partner health care provider organizations.

To face these challenges, the Government will build on the universality and quality principle of the current health insurance policy to ensure that each affiliated person benefits from health services of high quality.

The Government will prescribe and enforce a minimum health insurance package to be provided by all partner health care providers (including drugs). The Government will ensure that beneficiaries of CBHI schemes are provided information on benefits that they are entitled to and how to access these benefits, and will ensure that a mechanism is in place in every district for feedback, complaints and dispute resolution regarding benefits provided by CBHI schemes and their partner health care providers.

### **Financing mechanisms and contribution policies**

Under the CBHI policy of 2004, a policy of a flat rate of household contributions into the CBHI system was adopted to simplify communication in an environment where new concepts of health insurance and prepayment were being introduced and promoted in the health sector. Now that the population is familiarized with these concepts through many years of practice, the time has come to address the inequity and regressivity associated with the flat rate of household contributions into the CBHI system in order to improve equity in financing and the financial sustainability of the CBHI system. Challenges associated with weak contribution from CBHI sections, districts and the national risk pool to the financing of the district risk pools need to be addressed. The size of the national and district risk pools needs to be adapted to respond to the growing needs associated with increased and sustainable coverage of the CBHI system. Finally, information and analytical capacities need to be strengthened to support regular revisions of contribution policies.

To face these challenges, the Government will build on equity, risk-sharing, and solidarity principles of the current health insurance policy, to ensure that the costs of illness of the sick are shared by the healthy, and the costs of illness of the poorest are also shared by the wealthy among Rwandans. The Government will improve resource mobilization in the CBHI system based on ability to pay. The Government will improve the progressivity of contributions into the CBHI system by assessing the feasibility and implications of graduating contributions based on socio-economic categories and the conditions for national scale-up of new contribution policies. The Government will ensure that district risk pools are adequately funded by enforcing contributions from sections of CBHI, districts and the national risk pool. It will ensure that appropriate mechanisms for making co-payments affordable for beneficiaries are effectively implemented at all partner health care provider organizations. Private health insurance and social health insurance schemes contributions to the national and district pooling mechanisms of the CBHI system will be strengthened. The Government will systematically conduct periodic actuarial studies for revising the level of premiums and contributions, including actuarial studies for determining the level of resources needed to sustain the CBHI sections, the district risk pools, and the national risk pool.

### **Relations with health care providers**

CBHI first emerged during the last decade as a partnership between communities and health centres before their transformation to a state-community partnership. Such a partnership has been instrumental in the development and extension of CBHI; partnerships between district CBHI and district hospitals, however, have been rather weak. In addition, relations between CBHI and health care providers are becoming a major concern for the financial sustainability of the CBHI system as a consequence of over-prescription and over-charging of acts by providers. In many instances, contractual relations between CBHI and health care providers are not formalized. District hospitals are experiencing long delays for reimbursement as claim management capacities are limited at the district level and district risk pools are under-funded.

Finally, there is a need to fill the evidence gaps on the consequences of alternative provider payment modalities in order for the CBHI system to settle durably on fair provider payment modalities for structuring contractual relations with health care providers.

To face these challenges, the Government will build on the quality principle of the current health insurance policy to ensure that each affiliated person benefits from health services of high quality. The Government will ensure that contractual relations between CBHI and health care providers are formalized. The Government will assess current practice in order to improve fair provider payment modality policies. The Ministry of Health will determine periodically the schedule of tariffs for the reimbursement of health care providers. The Government will establish appropriate rules for regulating claims processing including rules regarding the maximum delay for payment and advances to be paid after claim submission. The Government will promote the use of technology to improve the efficiency of claim submission, processing and payment. The Government will ensure that partner health care providers comply with standard treatment guidelines issued by the Ministry of Health and that appropriate quality assurance programmes are effective at health care providers contracted by CBHI. The Government will ensure that regular reviews of health care services provided to beneficiaries of CBHI schemes are conducted with an emphasis on drug prescription practices and access to ambulance services.

### **Governance and management**

The scale-up of health insurance has resulted in numerous health insurance organizations which manage important financial resources of the health sector: district CBHI and sections of CBHI. The rapid extension of the CBHI system, however, has been achieved at the costs of weaknesses in governance of CBHI schemes, their relations with other actors, and operational management of CBHI. The ownership of CBHI schemes by members and member awareness of the activities and performance of their CBHI have been weakened by the rapid scale-up of CBHI. While members are well represented in management bodies at the section of CBHI, they are weakly represented in management bodies at the district and central level. Financial and administrative management capacities of CBHI are still weak at the sector and district levels as management information systems have not been adapted to the important size of membership pools and transactions with members and health care providers. The quantity and quality of human resources of section of CBHI and district CBHI are limited. Weaknesses continue to prevail in the application of the law regarding the organization and functioning of CBHI. Finally, there is a need to strengthen the CBHI information and monitoring system: analytic capacities and the capacity to produce reports and policy briefs have to be strengthened in order to support the policy dialogue on mutual matters in the country. To face these challenges, the Government will build on ownership, empowerment and participation, and partnerships principles of the health insurance policy to ensure the institutional sustainability of the CBHI system. The Government will partner with all grassroots institutions, community based and nongovernmental organizations to improve the governance and management of CBHI. The Government will support health promotion activities to ensure that citizens are well informed about the organization, functioning, management and financing of CBHI and their relations with members and health care providers. The Government will strengthen operational management capacities at the sector level: the quantity and professional profile of the operational management staff of section of CBHI will be increased and computerized information management systems will be adapted to strengthen their capacities.

Operational management capacities at the district CBHI will be strengthened by increasing the quantity and professional profile of the operational management staff and the development of computerized financial and administrative management systems. The CBHI information system will be strengthened in order to develop district CBHI capacities to produce annual activity and financial reports to be disseminated at the district level.

## 5.2. Social Health Insurance

### Target Population and Coverage

Rwanda's social insurance system includes two distinct regimes for its military and its workers in the formal sector, both public and private. The social health insurance regime provides health insurance coverage to workers employed in the formal sector of the economy and their families. The medical insurance scheme for public sector workers, which was established in 2001, protects its beneficiaries against the risks resulting from natural diseases, those which are caused by accidents and risks resulting from the pregnancy and childbirth and their consequences. This scheme is managed by *La Rwandaise d'Assurance Maladie* (RAMA). Private sector employers may choose to be affiliated with RAMA or contract with private insurance companies, although health insurance is not mandatory yet for private formal sector. Military personnel are covered by a health insurance regime known as "Military Medical Insurance" (MMI), which is managed within the Ministry of Defence. The National University of Rwanda based in Butare and several Schools and Institutes also have small health insurances schemes for students and teachers. Together with private insurance schemes, these formal social health insurance schemes cover about 6% of the Rwandan population.

The main policy challenge with the social health insurance scheme is related to the extension of health insurance coverage to pensioners and their dependants. The Social Security Policy of 2009 (SSP 2009) defines the vision of Rwanda as regards health insurance as "to achieve the goal of health for all through universal health insurance". The SSP 2009 recommends: to establish a plan to achieve universal coverage and to integrate the pensioners within the RAMA scheme. The SSP 2009 will provide a policy framework for clarifying and enforcing Labor Code provisions relating to compulsory affiliation of all employees and the employers' obligation to provide medical care to employees: such a policy framework will facilitate the extension of health insurance coverage to employees of private enterprises of the formal sector through the RAMA scheme.

### Benefit package

Services covered by RAMA are curative care and pre- to post-natal care including birth delivery. Health services are purchased from primary health facilities (Health post, dispensary, Health center, and other primary clinics), as well as from district and national hospitals and some accredited private providers. Except in the case of emergency situations, the referral system must be followed. The package of benefits includes out-patient, inpatient, maternity care (pre-post.), essential drugs, medical imagery, and laboratory tests.

### Contribution policies

For public workers, the contribution rate is 15% of the basic salary of which 7.5% is paid by the employer and 7.5% by the employee. For military personnel, the contribution rate is 22.5% of gross salary, of which 17.5% is paid by the government and 5% by each military staff. Households also contribute copayments to reduce moral hazard. The level of copayment varies with specific services, for example, there is no copayment for assisted birth delivery and surgery.

## **Relations with health care providers**

Formal contracts are established between social health insurance schemes and accredited public and private health care providers. Contractual relations between RAMA and health care providers are prepared by a Contract Commission established by law and composed of three representatives of RAMA and representatives of public doctors, a representative of independent doctors, a representative of independent pharmacists, a representative of RAMA insured members, a representative of employers and a state representative.

## **Governance**

The RAMA scheme is expected to cover an increasing share of the population with the extension of coverage of employees of private enterprises in the formal sector and economic growth and formalization of the economy. The Social Security Policy of 2009 (SSP 2009) RAMA will be merged with the Social Security Fund of Rwanda into Rwanda Social Security Board (RSSB).

### **5.3 Private Health Insurance**

Registered commercial insurance companies do provide health insurance policies to private enterprises and their employees or to individual Rwandans. Since health insurance has become mandatory in Rwanda and the majority of Rwandans will be covered through the non-profit social health insurance schemes and the CBHI schemes, the Government will prescribe the positioning of private health insurance as a third alternative for individuals not subjected to the mandatory social health insurance regime, but also as a source for complementary coverage in addition to basic coverage provided under the CBHI regime and the social health insurance regime.

### **5.4 National Solidarity Fund**

The majority of low-income households in Rwanda are provided health insurance coverage under the CBHI schemes based on their own contributions with the poorest and vulnerable groups being supported by a third party (either the state, districts, donors or non-governmental organizations). This group of low-income households also have the poorest risk profile compared to other segments of the population covered under the social health insurance schemes and private health insurance. RAMA and MMI provide coverage to Rwandans who are among the better-off in the country. Finally, as a consequence of its costs, private for-profit health insurance provides coverage mostly to the richest segments of the population. These different regimes provide coverage to segments of the population with variable risk profiles and levels of income.

The Government will build on this segmentation of the health insurance market and the equity, risk-sharing, and solidarity principles of the health insurance policy to ensure that all Rwandans have equitable access to health services of high quality, and the costs of illness of the poorest are shared by the wealthy among Rwandans. The Government will restructure the existing national risk pool fund of the CBHI scheme under the regime of law n° 62/2007 in order to adapt its mandate. The Government will ensure that the future national solidarity fund will play four major roles: (i) it will guarantee a minimum benefit package for all CBHI, including health care services provided at health centres, district hospitals and national referral hospitals; (ii) it will provide health insurance coverage through CBHI of the poorest and vulnerable groups; (iii) it will assist CBHI and district CBHI which went bankrupt due to various reasons other than mismanagement; and (iv) it will provide for technical assistance services for strengthening management capacities of CBHI and district CBHI.

The Government will improve the financial capacity of the national solidarity fund by instituting mandatory contributions from CBHI into the national solidarity fund proportional to contributions collected from their members, by strengthening transfer mechanisms from social health insurance schemes and private health insurance organizations, and by increasing government contributions. The Government will promote contributions from development partners to the national solidarity fund based on long-term commitment. The governance of the national solidarity fund will be restructured to ensure greater visibility and transparency in its financing and interventions. The National Federation of CBHI will become the fund holder of the national solidarity fund, but stakeholders contributing to its financing will be represented in its governing bodies.

## 6. Institutional Arrangements for Implementation

### 6.1. Governance Architecture

The principle and values outlined in section 3 of this policy guide the establishment of the governance architecture of health insurance in Rwanda (see Annex 1). *Equity, risk-sharing, and solidarity* are promoted through the establishment of risk pools and mechanisms of subsidies. To ensure that the cost of illness of the sick is shared by the healthy, three levels of risk pool (Community, District and National) are established as per the Health Insurance Law of 2007. To ensure that the cost of illness of the poorest is also shared by the wealthy among Rwandans, the mechanism of tax based and donor funded subsidy as well as cross-subsidy from RAMA to the CBHI to fund the premium of the poorest segment of the population will be strengthened. The introduction of stratified contributions will also improve the progressivity and resource mobilization of the health insurance system. *Ownership, empowerment and participation* will be further promoted through the creation of a strong partnership between the State and Rwanda's Community Based Health Insurance (CBHI) and Social Health Insurances (RAMA and MMI). These organizations will manage the risk pools and ensure transparency and citizens' voice. The Government of Rwanda's core functions in this partnership are to regulate the institutions providing health insurance and to subsidize the enrolment of the poor into health insurance mechanisms. Finally, to ensure *Universality and Quality* a national governance body for regulation, the Rwanda Health Insurance Council will be created to steward the system, monitor its outcomes and provide recommendations to Government and other key stakeholders on necessary policy changes including entitlements, packages of benefits, level of premium contributions, etc.

#### **Governance and role of institutional stakeholders**

*Rwanda Health Insurance Council.* Rwanda has managed to scale-up the coverage of health insurance to 85% of the population through health CBHI and a state-community partnership in a short time period. CBHI combined with RAMA and MMI cover 92% of the population in Rwanda. The insurance arrangement will be consolidated in the coming decade while preserving the strengths of the current system, particularly its state-community partnership nature and the decentralized arrangement and ownership of the CBHI schemes by the population. In that perspective, the Rwandan Health Insurance Council (RHIC) will be established to strengthen regulation, oversight of health insurance schemes, and ensure sustainability of the different schemes. The RHIC will be constituted by members from MOF, MLGSA, MOH, BNR, CBHI representatives, CSO representatives, MMI, RAMA, private health insurance companies, health providers and citizens' representatives. RHIC will not be a fund holder. An executive office is set-up to provide technical and managerial support and carry-out the decisions of the RHIC.

The mandate of the RHIC will include:

1. Prescribing and enforcing a basic guaranteed health insurance package to be provided by all health insurance schemes and partner health care providers;
2. Improving the progressivity of contributions into the health insurance system by establishing a mechanism of graduating contributions based on socio-economic categories;
3. Ensuring that appropriate mechanisms for making copayments affordable for beneficiaries are effectively implemented at all partner health care provider organizations;
4. Promoting flexible arrangements for ensuring that beneficiaries of the CBHI schemes are not denied access to needed care as a consequence of delayed renewal of enrolment and payment of annual contributions;
5. Ensuring that fair and appropriate provider payment modalities are the backbone of contractual relations between health insurance organizations and health care providers.

*Office of the RHIC.* The office of the RHIC will be composed of a team of experts who will be responsible for informing health insurance policy and cross-subsidization policies among health insurance regimes. It will maintain a database of health insurance organizations in the country. It will be responsible for conducting studies to generate evidence and inform the functioning of health insurance schemes. These studies will include risk analyses and actuarial analyses to support the periodic revision of contribution and premium policies and for determining the level of resources needed to sustain the CBHI section, the district risk pools, and the national risk pool. It will also carry out studies to generate the necessary evidence for adopting fair provider payment modality policies. Other studies will include obtaining a better understanding of the factors associated with non-enrolment, safeguard measures, cost and benefit analysis, client satisfaction assessment, and utilization analysis.

*Ministry of Health.* The Ministry of Health will ensure that the complete PMA is available in partner health centres-including drugs and improve the availability of ambulances at health centres and district hospitals to ensure accessibility to the PCA. It will ensure that partner health care providers comply with standard treatment guidelines issued by the Ministry of Health and that appropriate quality assurance programmes are effective at health care providers contracted by CBHI. MINISANTE will also determine periodically the schedule of tariffs for the reimbursement of health care providers. Finally, it will ensure that beneficiaries of CBHI schemes are provided information on benefits to which they are entitled and how to access these benefits. It will ensure that a mechanism is in place in every district for feedback, complaints and dispute resolution regarding benefits provided by CBHI schemes and their partner health care providers. Thus, it will support health promotion activities to ensure that citizens are well informed about the organization, functioning, management and financing of CBHI and their relations with members and health care providers. MINISANTE will be a member of the Rwanda Health Insurance Council overseeing the main risk pooling institutions. Its role will be to provide technical oversight on the recommendations of the office of the RHIC including recommendations on relevance, quality, effectiveness and impact of health interventions to be included in the health insurance benefit package. MINISANTE will also provide oversight on issues of measurement of the different dimensions of health service delivery including providing recommendations on studies and analysis to be conducted as well as reviewing study designs and conclusions.

*Ministry of Finance.* The Ministry of Finance and Economic Planning will provide oversight of financing issues, including all issues linked to regulation of accounting and auditing. MINECOFIN will also be responsible for overseeing the quality of cost and actuarial analyses and developing strategies for resources mobilization. Most importantly MINECOFIN is responsible for ensuring the adequate financing of the subsidy to enrol the poorest households into the CBHI system. It will improve resource mobilization and ensure that district risk pools are adequately funded by enforcing contributions from sections of CBHI, districts and the national risk pool. MINECOFIN will be represented on the Rwanda Health Insurance council.

*National Bank of Rwanda (BNR).* The National Bank of Rwanda is entrusted with the financial supervision of both banking and non banking financial institutions. BNR regulates portfolio investments to ensure prudential financial levels, ensure minimum liquidity ratios, etc. BNR will also be responsible for strengthening operational management capacities at the sector level: the quantity and professional profile of the operational and financial management staff of section of health insurance organization CBHI will be increased and computerized information management systems will be adapted to strengthen their capacities. BNR will establish appropriate rules for regulating claims processing, including rules regarding the maximum delay for payment and advances to be paid after claim submission. It will promote the use of technology to improve the efficiency of claim submission, processing and payment. The BNR will be represented on the Rwanda Health Insurance council.

## 6.2. Revenue Generation

Revenue generation will be ensured through three main mechanisms: i) beneficiaries and employers' contribution to the community and social insurance pools in the form of premiums, ii) general government revenue from both internal revenue and budget support, and iii) other external contributions from ODA<sup>12</sup>. Contributions from beneficiaries will be compulsory for all residents of Rwanda.

The household contribution system will be stratified and beneficiaries' contributions will be tailored to their income. Income categories will be aligned with the current *Ubudebe* targeting mechanisms. Stratification will be based on the existing and well functioning *Ubudebe* process present in the 9000 *cells* (communes) of the country. *Ubudebe* incorporates a "poverty-mapping" process, which allocates each household to one of six ordinal income and poverty-related categories differentiated by well-defined qualitative criteria. The maps have become the basis for community decision-making about income support in cash or in kind to the poorest households from local and development partner's sources, and about which households should receive subsidies for health insurance.

For the first and second *Ubudebe* targeting categories the health insurance premium will be fully subsidized by tax or external contributions to the national budget (indigents and poorest). For the third category ("near poor"), the premium will be partially subsidized by tax revenue or from external partners. For all other categories, the premium will be fully covered by the beneficiary households. All categories would have access to the same health insurance card and same services. In addition and for a higher level of premium, beneficiaries will have the option to acquire a different individualized card which would provide additional benefits. Finally, households will be able to purchase complementary packages of services from private insurance agencies.

Government subsidy will focus on ensuring enrolment of the poor in insurance and guarantee their financial access to benefits. The public subsidy system will complement the households' contributions in the form of transfers to Community Funds to pay for the premiums of the poor and near poor.

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<sup>12</sup> Oversee Development Aid

The subsidy will be calculated on the basis of estimated beneficiaries in the district according to the poverty map. The subsidy will be coming from general revenue and included in the annual budget law as part of the budget of Local Governments. The subsidy will be transferred directly to CBHI bank accounts based on lists of beneficiaries on the basis of the *Ubudehe* targeting process and approved by the local governments.

Other ODA funded financial streams to benefit the health insurance system will follow the same mechanism as the public subsidy. Payment of premiums for specific groups or for the poor will be transferred directly to either the CBHI as per the list of beneficiaries or to the district or national risk pool.

### 6.3. Risk Pooling

The pooling function is organized at three levels. The Community Risk Pool is managed by the CBHI at sub-district level (*Umurenge*) and covers primary level of services. The District Risk pool is a fund at district level that brings together a proportional contribution from the community pool as well as subsidies from the Local Government. The National Pool for CBHI is a second level re-insurance mechanism to pay for tertiary care. The RAMA pool serves public workers and private workers in the formal sector and MMI pool serves the military personnel.

The CBHI Community Risk Pool brings together the premiums from beneficiaries as well as the public subsidy and external funds. The District Risk Pool is funded by a contribution from Community Pools based on their respective population composition and district contributions. Also, a mechanism will be elaborated to ensure risk-equalization among the different CBHI section within a district. The National Pool is funded by national revenues, contribution from the district pools based on their compositions as well as a cross-subsidy from RAMA; MMI and private insurances and external funds.

### 6.4. Purchasing

The Rwanda health sector benefits from multiple sources of financing and a clear allocation of areas of financing according to the specificity and added value of each one is critical. This complementarity is imperative to avoid duplication and inefficiencies. Health insurance will therefore provide financing in complement to other sources of funding provided by the government in the form of transfers to local governments and autonomous health providers including Needs Based Transfers (NBT), Performance Based Transfers (PBF), and Earmarked Transfers (ET). It will also complement direct contributions from those households to the purchasing of services.

Different packages of activities have been defined according to each of the levels of the health system in order to i) provide equitable and quality care across the country, ii) ensure that there are procedural standards for operation and management, iii) allow for better planning and management of resources, and iv) provide the basis for establishing and evaluating the quality of health services.

Health insurance funding will be specifically targeted at financing a package of mostly curative services, both outpatient and inpatient care, with the aim of increasing financial access and protect households from the impoverishing effect of illness. Specific packages of health insurance benefits will be defined by the three main institutions: CBHI, RAMA and MMI. The RHIC will oversee the definition of packages, ensure their technical relevance and financial sustainability and monitor their provision and impact, including impact on health indicators, income protection and client satisfaction.

As part of its mandate, RHIC will particularly define a guaranteed basic package (GBP) to be provided by all health insurance schemes in Rwanda. Health insurance agencies will have to provide this basic package to all their enrollees. Other services or more extended packages will be offered as complementary packages of services for additional levels of premium.

## 6.4. Provider payments mechanisms

Provider payment mechanisms will be chosen to support the principles of the policy and used to provide incentives to providers in terms of provision of relevant services of good quality to all. The advantages and disadvantages of various payment mechanisms are outlined below.

**Table 2. Advantages and disadvantages of different modes of payment of providers by health insurance**

Provider payment mode	Advantages	Disadvantage
Capitation	<p>Easy management. No need to verify bills. There is no motivation of provider to over bill.</p> <p>No risk on insurance: If payment of provider is based on portion of collected resources, no financial risk on insurance.</p> <p>Insurance not needed. Provider can manage directly the prepaid fees</p> <p>Incentives to reduce utilization: main reason for this mechanism to be used in countries who want to limit high utilization</p>	<p>Lack of competition: Insurance cannot contract with multiple providers to give choice to clients</p> <p>Fiscal risk: financial risk is transferred to the provider and the provider is likely to transfer this risk to government by claiming more resources from the direct needs based transfers (NBT)</p> <p>Reduced utilization and quality: financial risk is transferred to provider facility and the provider is likely to transfer the risk to the client by controlling cost. Provider reduces cost of care provided through rationing of quantity of services provided and decrease in quality of care. Motivation for development of technology is affected</p> <p>Capacity: Need purchasing capacity to ensure adequate case mix</p>
Fee for service and drug/product	<p><i>Transparency:</i> Direct link with demand. Payment is based on real cost.</p> <p><i>Accountability:</i> Insurance organizations can be a powerful partner of providers by control provision through accounting procedures</p> <p><i>Flexibility:</i> insurance can contract quality standards on price of services.</p>	<p>High transaction cost in terms of accounting.</p> <p>Need accounting capacity for health insurance organizations</p> <p>Incentive to overprovision</p>
Diagnosis related group (DRG)	<p>The health insurance pays the output/outcome instead to pay multiple inputs of providers.</p> <p>As tariff is based on a health problem which covers physical exam, lab test and drug, the transaction costs are reduced.</p>	<p>Need robust and updated actuarial studies.</p> <p>Need country specific DRG categories</p>

Advantages and disadvantages need to be examined when choosing provider payment mechanisms. Rwanda's system should be seen in light of the specificities of its low income context which is unusual for a health insurance mechanism. This low income context is a one of low utilization, high fiscal risk (unpredictability and scarce resources) and weak institutions. Any mechanism will therefore need to support the current objectives of HSSP to increase utilization of services, avoid the excessive transfer of risk to Treasury, and make sure not to undermine the still young and fragile CBHI system.

The recommendations for the provider payment mechanisms mode are thus the following:

1. Maintain the fee-for-services and products/drugs at health center and for outpatients wards to continue to provide incentives to high utilization, reduce the fiscal risk and continue to make health facilities accountable to CBHI through a simple and transparent payment mechanism;
2. Strengthen management and accounting capacity of CBHI, and include rigorous regulation of providers billing;
3. For inpatient care, progressively move away from fee-for-service in light of the high cost involved: develop a hospital simplified DRG system adapted to the Rwanda situation
4. Conduct studies before introducing any major change in the providers' payment mechanism system and develop a strong M&E system.

## 7. Cost and Financing of Health Insurance in Rwanda

### Cost and Financing Gap

Estimating the cost of delivering future services encompasses a certain level of uncertainty as overall cost of provision of services depends on both clients and providers' behaviours which themselves are affected by policy options, and derived incentives. It is therefore not always accurate to infer future costs from current ones. In the case of Rwanda, one additional and major source of uncertainty is the fact that all available information dates back to 2005-2006, when both service provision and coverage with health insurance were at a much lower level than today. Between 2005, when the last survey was conducted and 2009, enrolment in health insurance has dramatically expanded from about 40% to more than 92%. This extremely dynamic situation, as well as Rwanda's unique achievement as the only developing country having reached 92% universal coverage, makes projections more perilous than in any other context.

Looking at the overall level of expenditures, the cost of the national plan (HSSP), and the projection of overall financing, one can assess the financial gap. Total health expenditures in Rwanda were US\$34 per capita in 2006 (National Health Accounts). The cost of implementing the HSS plan was estimated at US\$46 per capita. This cost projection is shared as follows: 36% for human resources for health, 25% for drugs and other commodities, 22% for infrastructures and equipment, 9% for health insurance and performance based financing and 8% for administration. The estimated cost of the health insurance (Financial Access pillar of the strategy) is US\$ 4.15 per capita. According to the NHA of 2006, the contribution from health insurance premiums was about US\$ 2.7 leaving a gap of US\$ 1.4. Both methods seem therefore to indicate a similar order of magnitude of the gap which would be about RwF 7.5 billion in 2009.

### Financing

What are the opportunities for filling this resource gap over the next decade? The full financing of the guaranteed basic health insurance package (GBP) will rely on a combination of strategies to raise revenue while protecting the poor:

The first strategy will be to increase the efficiency of collection of the insurance premium by the health insurance organizations, including CBHI and RAMA. For this the premium will be adjusted to capacity to pay and regularly updated by the upcoming RHIC office. In addition to the increase of the basic premium for higher income groups, a VIP premium card for personalized access will be created to offer improved alternatives to those who can afford it while channelling more resources in the CBHI pool.

The second strategy will be to focus the financial support of the GoR on subsidizing the enrolment of the poor, thus offsetting the impact of the increase in premium on vulnerable households. This will be done by building on the successful experience of the *Ubudebe* process. The GoR will provide full subsidy for the poorest category of income according to the MINALOC *Ubudebe* classification.

The third strategy is to encourage development partners who do not provide budget support to channel an increasing part of their resources to the health insurance system following the model used by the GFATM.

The fourth strategy is to increasingly integrate the national risk pool with the RAMA pool. This will be done by increasing the proportional contribution of RAMA to the CBHI system

The fifth strategy is to create an earmarked levy on alcohol and tobacco and channel the funds into the health insurance mechanism.

These combined strategies should allow covering the cost of the Guaranteed Basic Package (GBP) over the next 10 years. Table 3 and Figure 2 summarize the projected future resources available to finance this per capita requirement. The scenario is based on 2006 NHA data in which total health expenditures are at US\$34 per capita, donor expenditures at US\$18, and out-of-pocket spending at US\$ 8 per capita. In the scenario presented the health insurance over time becomes the dominant source of health financing for curative care progressively replacing other existing sources of financing, such as direct transfers to MOH, out-of-pocket payments and to lesser extent development assistance provided in the form of direct supply side transfers to health facilities. About half of the package is financed by premiums, with the other half subsidized by the Government and development partners, a levy on alcohol and tobacco, cross-subsidies of other health insurances, extra budget funds as well as incentive packages/premiums.

The premiums are expected to be derived from household's contributions, but equally important, through subsidies from MOF and development assistance. The premiums from households will progressively replace the current payments at service delivery point. Since those are currently at about US\$5 premiums could be increased to cover the full cost of the package. Subsidies from government revenue will be expected to fully subsidize the premiums of the poor and partial subsidies to the premiums of the near poor. In this scenario, development assistance remains an important source of financing. However, it is expected that development assistance will shift part of what is currently allocated in the form of earmarked funding to support the health insurance system as already done by several partners.<sup>13</sup> Annex 3 provides two potential financing scenarios based on the *Ubudebe* stratification and different assumptions of revenues and costs for the insurance system.

In this scenario contribution group 2 will be expected to pay RWF 3000 per person per year and group 3 will pay RWF 7000. Contributions for the first group which will be subsidized by GoR and external funds are RWF 2000. The total population contribution to CBHI from 2010 to 2014 in this stratification scenario is in annex 3 table 3. Under the assumption of an annual population growth of 2.6% and increasing adherence to CBHI of 2% in 2011 (88%) and 2012 (90%) as well as 1% in 2013 (91%) and 2014 (91%) as well as a RWF 2900 cost estimate the CBHI will have a positive financial gap in all but the last 2 years (2013 and 2014). The accumulated reserves from 2010 to 2014 in 2014 is in annex 3 table 4.

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<sup>13</sup> As discussed previously there are many inefficiencies in the way development resources are currently being used. Development partners will have several options for allocating resources (through budget support, through earmarked financing to support premiums, and finally through earmarked financing that does not distort the sector's priorities causing misalignment and inefficient use of the sector's resources.

Table 3. Projection of health financing resources available, per capita US\$, 2010–2020

	2010	2015	2020
Government transfers to MOH <sup>a</sup>	6.4	6.4	6.4
ODA <sup>b</sup>	16.6	15.0	13.5
OOP <sup>c</sup>	6.2	4.8	3.7
Premiums <sup>d</sup>	4.2	11.4	30.7
Total	33.4	37.6	54.4
Gap	7.1	2.9	-13.9

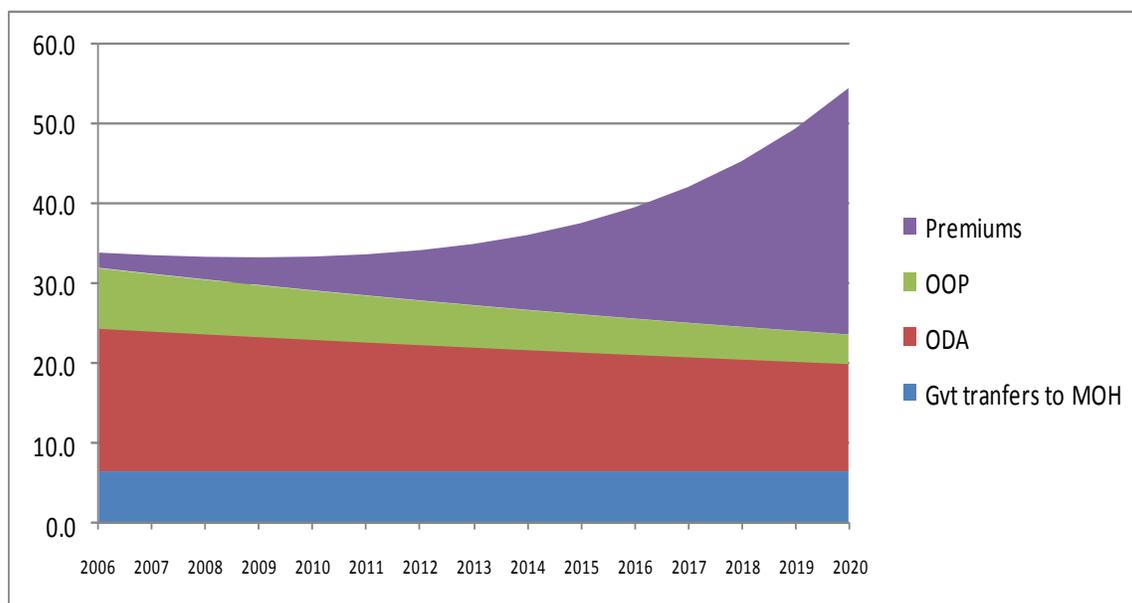
Notes. a. Government transfers to MOH are assumed to remain constant at current levels. Note: future increases in government contributions are included in the premium projection.

b. ODA is assumed to decrease over time, but at a very modest pace of 2% per year, part of ODA is channelled to premiums

c. OOP is expected also to decrease at a rate of 5% per year, with the expectation that prepayment mechanisms will progressively replace OOP as a source of financing.

d. Premiums are assumed to increase at a pace of 20-25% per year. The current projection used 22%. As mentioned, this is expected to absorb additional resources from government and donors, as well as replace OOP as a source of financing.

Figure 2. Projection of health financing resources available, per capita US\$, 2010–2020



## 8. Conclusion

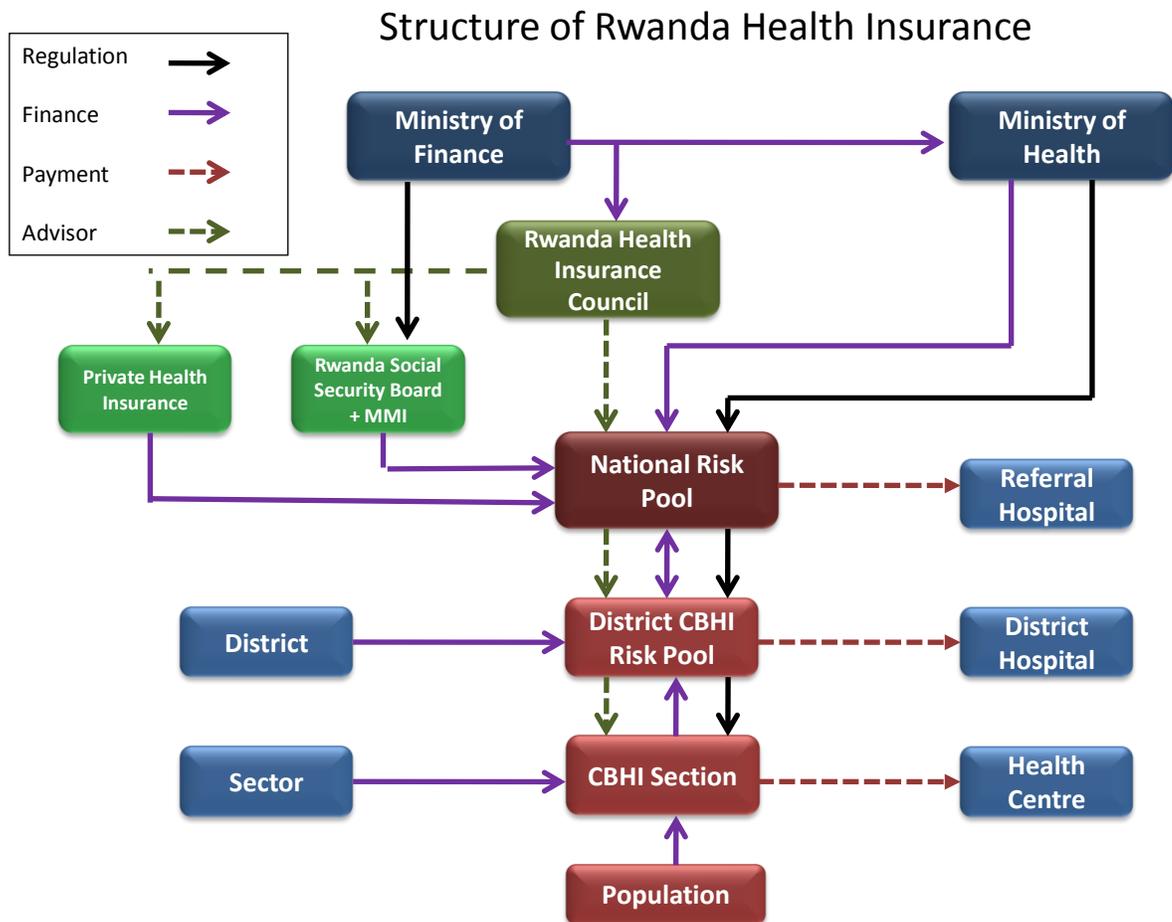
The development of Rwanda's first Health Insurance Policy marks an important step in the evolution of the health sector. With its innovative approach of using mixed financing to cover all segments of the population, the Government of Rwanda provides a strong framework for achieving universal coverage while strengthening information and monitoring systems, improving resource mobilization, increasing member representation in management of schemes to promote ownership, and strengthening governance and accountability of and within the system.

Rwanda has scaled-up health insurance coverage to 86% of the population through health CBHI and a state-community partnership in a short period of time. CBHI combined with RAMA, MMI and private insurances cover 92% of the population in Rwanda. The insurance arrangement will be consolidated in the coming decade while preserving the strengths of the current system, particularly its state-community partnership nature and the decentralized arrangement and ownership of the CBHI schemes by the population. The partnership approach, which emphasizes integration and cooperation among key stakeholders, provides a strong basis for improving the population coverage of the CBHI system to address the remaining gap of 10% and cover the entire population through health insurance.

The Government's political commitment to achieving universal health coverage has been translated into policy measures to strengthen the equity and solidarity foundations of health insurance initiatives, the inclusion of the poor, and the empowerment of citizens. Successful scale-up of CBHI has depended on leadership at the central and district levels, such as strong support from the Presidency, leadership of ministries of health, finance and local government, and leadership of district authorities, religious leaders, health authorities and community leaders at the sector and cell levels.

The Health Insurance Policy demonstrates the strong political commitment and leadership necessary to build on the impressive achievement in health insurance coverage over the past ten years. With 92% of Rwandans now covered by health insurance, this policy presents a strong platform for Rwanda to realize universal health insurance coverage by 2020, adhering to the guiding principles and values of equity, risk sharing and solidarity; ownership, empowerment, and participation; and universality and quality. Rwanda needs to build on sustained political commitment, multilevel leadership and evidence-based policy making to continue to face challenges in the health insurance area.

## Annex 1: Architecture of the National Health Insurance System of Rwanda



## Annex 2: Summary of roles of institutions by the three functions of health financing

	Functions	Institution	Remarks
Revenue Collection	Setting and collecting taxes (e.g. establishing a new tax to fund health insurance)	MINECOFIN	
	Setting premium rates	MOH, RAMA, MMI	
	Collecting premium contributions	CBHI, RAMA, MMI	
	Setting membership rules and registering (enrolling) members(beneficiaries)	MOH, RAMA, MMI	
	Marketing to new members in the case of voluntary enrollment	CBHI, RAMA, MMI	
Pooling	<b>Pooling funds</b>	<b>CBHI, RAMA, MMI</b>	
	Pooling or risk equalization among insurance funds if there are multiple funds	District Association of CBHI for district pool  National Federation of CBHI for national pool.  MINECOFIN	District association of CBHI and national federation of CBHI will serve pooling and risk equalization role for first referral and second referral packages of care, respectively. Government will subsidize (MINECOFIN)
	Setting membership rules and registering (enrolling) members(beneficiaries)	MOH, CBHI, RAMA, MMI	
	Fund financial management (investments ensuring reserve requirements, cash flow management)	CBHI, RAMA, MMI	
	<b>Setting a basic benefits package</b>	<b>MOH, RAMA, MMI</b>	
Purchasing	Delivery of benefits package	Providers: public, parastatal, FBO/NGO, and private-for-profit	
	Setting the provider payment mechanism and rates	MOH, RAMA, MMI	
	Setting eligibility and qualification standards for providers to participate	MOH, RAMA, MMI	
	Enforcing/implementing eligibility and qualification standards for providers to participate (utilization and quality management)	MOH	
	Claim processing (reviewing and paying bills from providers and beneficiaries)	CBHI, RAMA, MMI	

## Annex 3. Financial Projections

### Population Stratification for Health Insurance based on the Ubudehe process

POPULATION	2010	2011	2012	2013	2014
<b>Total pop</b>	<b>10,329,517</b>	<b>10,598,085</b>	<b>10,873,635</b>	<b>11,156,350</b>	<b>11,446,415</b>
<b>Population CBHI</b>	<b>8,883,385</b>	<b>9,326,315</b>	<b>9,786,272</b>	<b>10,152,278</b>	<b>10,530,702</b>
Group 1 (Ubedehe 1 + 2)	2,300,797	2,415,516	2,534,644	2,629,440	2,727,452
Group 2 (Ubedehe 3 + 4)	5,170,130	5,427,915	5,695,610	5,908,626	6,128,868
Group 3 (Ubedehe 5 + 6)	1,412,458	1,482,884	1,556,017	1,614,212	1,674,382

Annex 3 table 1: Population projections for CBHI membership

### Cost of healthcare

In order to analyze the financial implication of CBHI stratification, the total costs of providing health care at all levels has been calculated for 2010-2014 based on the following assumptions:

**Population:** 10.4m in 2010 with 2.6% growth (NISR population estimates: medium scenario)

**Utilization rate:** annual increase of 4% till 2014, based on previous growth

**General increase in prices:** Annual increase in prices of 15%

Considering these estimations and assuming streamlined and efficient management, per capita health care costs have been estimated at RWF 2900.

	2010	2011	2012	2013	2014
<b>Total Population Mutuelles</b>	<b>8,883,385</b>	<b>9,326,315</b>	<b>9,786,272</b>	<b>10,152,278</b>	<b>10,530,702</b>
<b>Total cost of health care RWF millions (assumed at RWF2900 per</b>	<b>25,762</b>	<b>30,535</b>	<b>34,572</b>	<b>38,699</b>	<b>43,313</b>

Annex 3 table 2: Annual projected health care costs

### Financing Scenario

Contribution group 1 pays a premium of RWF 2000, group 2 RWF 3000 and group 3 RWF 7000.

### Financial contributions from premiums 2010

Contribution from Premiums 2010 - 2014					
Population	25 397 597 710	26 663 933 745	27 978 950 478	29 025 363 225	30 107 275 666
GoR	4 601 593 429	4 831 031 018	5 069 288 684	5 258 880 081	5 454 903 391
<b>Total contribution</b>	<b>29 999 191 140</b>	<b>31 494 964 763</b>	<b>33 048 239 161</b>	<b>34 284 243 306</b>	<b>35 562 179 057</b>

Annex 3 table 3: Revenues from premium contributions for stratification 2010-2014

### Revenue and financial gap with annual per capita health care costs of RWF 2900

<b>FINANCING</b>					
Contribution from population	25 398	26 664	27 979	29 025	30 107
Contribution from third party to cover indigents	4 602	4 831	4 831	5 259	5 455
Contribution from other insurance companies (5% premiums)	917	1 009	1 110	1 221	1 343
Contribution from VAT (1%)	-	1 424	1 615	1 776	1 954
Contribution from co-payment	3 341	3 772	4 070	4 391	4 738
<b>Total Financing</b>	<b>34 257</b>	<b>37 700</b>	<b>39 605</b>	<b>41 672</b>	<b>43 597</b>
<b>Total cost of health care (assumed at RWF2900 per capita)</b>	<b>25 762</b>	<b>30 535</b>	<b>34 572</b>	<b>38 699</b>	<b>43 313</b>
<b>Financing Gap (Scenario 2)</b>	<b>8 495</b>	<b>7 164</b>	<b>5 032</b>	<b>2 974</b>	<b>284</b>
Accumulated reserves (RWF Bn)	8 495	15 660	20 692	23 665	23 950

Annex 3 table 4: Financial gap analysis for stratification