



TOWARDS UNIVERSAL HEALTH COVERAGE IN RWANDA
Summary Notes from Briefing by Caroline Kayonga*
Permanent Secretary, Ministry of Health, Rwanda
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DISCUSSION

1. A brief history of health in Rwanda

Pre-Genocide—The Rwandan vision for health care was supported by the Bamako Initiative of 1988, which was adopted by many Sub-Saharan nations and aimed to revitalize health care strategy and strengthen equity in access to health care via decentralization to the local level. Following the Bamako Initiative, Rwanda decentralized management and district-level care strategy with the development of provincial-level health offices for health system management. Although progress was made toward decentralizing management to the province-level and, even further, to the district-level, this progress was disrupted at the time of the 1994 genocide.

Post-Genocide—The genocide of 1994 destroyed the strides made by Rwandan government: Rwanda was left with a hollow government infrastructure and a society plagued by ill health and disease. With the advent of peace, the government began working to restructure health care and to decentralize management to the most local levels in order to increase utilization rates and improve overall health. Despite the promise that the government offered free health care to all, the system was significantly under-resourced, which affected availability and quality. To address this problem, the government implemented user-fees in 1994 to supplement meager health center budgets. However, a survey in 2001 found that utilization of primary care declined to just 23% of the population, and health outcomes were deteriorating, with HIV/AIDS and other

* These synthesized notes were compiled based on Ms. Kayonga's comments at two public Brookings Institution presentations as well as several private meetings with Brookings fellows and staff.

infectious disease burdens on the rise. The decline in utilization and health indicators was attributed to high user-fees for primary-, secondary-, and tertiary-level care.

2. Key elements of Rwandan community-based health insurance

Vision and support—To increase utilization and improve health outcomes, the ministry of health decided in 2001 that changes would have to be made to the overall vision for the nation’s healthcare. This new vision was comprised of three pillars:

- Investment in strong prevention interventions of major diseases: Prevention services should be delivered free-of-charge to the entire population.
- Access to curative care through voluntary, pre-paid health insurance: Curative care will be accessible to Rwandan citizens via voluntary, community-based health insurance schemes.
- Performance based financing to improve quality of care: All entities involved in health care and insurance delivery and management will engage in performance-based contracts and financing to encourage high quality of care.

This national-level strategy was supported by district-level governing bodies, as well as sector- and local-level government and organizations. In addition, development partners and faith-based organizations played a role in supporting (via financing and service delivery) the ministry’s vision.

Community-based health insurance—The Rwandan health care system fully subsidizes preventive health services for the entire population. However, curative services (primary-, secondary-, and tertiary-care) are not (and will not be) fully subsidized by the government. Insurance for curative care has existed for some time in the formal sector, with civil servant, military, and private health funds. However, over 50% of the population is employed outside of the formal sector, leaving them financially vulnerable.

To make curative services affordable, to increase utilization, and to ensure sustainability of financing for these services within the informal sector, Rwanda has implemented sector-based health insurance schemes known as *mutuelles de santé* to raise revenues for curative health services. Mutuelles are community-based health organizations that offer voluntary, non-profit health insurance schemes for the informal sector. They are formed on the basis of mutual aid and the collective pooling of risks at the local sector level for primary care, with larger pools at the district level for secondary care, and the national level for tertiary care.

Financing— Approximately 50 percent of mutuelle funding is comprised of annual member premiums. Households pay annual premiums (standardized in January 2007 to the equivalent of US\$1.81) per person, per year. Where citizens cannot pay the individual or family premium up-front, microfinance institutions provide individual loans for the premium, to be paid within a year of disbursement with a 15% rate of interest. Further, donors and government programs support mutuelles by paying fees for those that cannot afford any level of coverage.

The remaining half of mutuelle funding is obtained via transfers from other insurance funds, charitable organizations, NGOs, development partners, and the Government of Rwanda. This funding is allocated in the following way:

- 13% from the Ministry health annual budget
- 12% from the annual contributions of Civil Servant's social insurance
- 12% from the annual contributions of the Military Medical insurance
- 12% from the annual contributions of the Genocide victim's fund
- 1% from the annual contributions of private's health insurance
- <1% from development Partners
- < 1% from local government

Services— Mutuelle members are entitled to three complementary benefit packages[†]:

- Primary care: Primary care delivered at the sector level via clinics, which are run either by government or NGOs.
- Secondary care: Specialized care delivered at the district level via district hospitals and specialists
- Tertiary care: Specialized care delivered at the national level via one of just a few specialized, national medical institutions

Mutuelle-funded services are provided through public or private non-profit, contracted facilities.[‡] (Mutuelle insurance does not cover care at private for-profit centers.) Providers are paid by mutuelles directly, either through monthly capitation rates, on a fee-for-service basis, or via (recently introduced) performance-based payments.

Quality of Care— Quality of health care services in Rwanda is mandated and maintained via stringent performance-based financing for public and private non-profit health centers. All district mayors are required to sign performance contracts with the President of Rwanda for all public sectors (e.g., agriculture, hygiene, infrastructure, etc.), including health. District mayors, in turn, utilize performance-based contracts with health facilities to encourage fulfillment of standards, with subsidies and financing contingent on performance. Health performance targets include indicators for declining morbidity and mortality associated with prevention and curative care, as well as access to care. Performance against indicators is monitored with quarterly evaluations and through analysis of results in annual reports.

Organization and management—The government of Rwanda has tried to decentralize all implementation of health care policy, with the central government responsible for stewardship activities only (e.g., including policy development, capacity building, monitoring and evaluation, and resource mobilization). The government decentralizes all other implementation activities:

- Sector-level: A sector comprises roughly 50,000 people. Each sector must have at least one health center for primary care. Each sector has a mutuelle that is managed by people who are elected by the community.
- District-level: A district is comprised of multiple sectors (usually about 5), with roughly 250,000-500,000 people in each District. (There are 30 Districts in Rwanda, which now has about 10 million people total.) Each District has at least one hospital/secondary care facility.

[†] Under new law and harmonized tariffs, it is possible for any mutuelle member to seek health care at any health center across the country. However, this new law has not been realized in practice, as capacity to transfer bills and funds are still limited.

[‡] 90% of the nation's health care facilities are run by the public sector or private non-profit organizations; 10% of the nation's health care facilities are private and for-profit.

- National level: Tertiary care is provided at national-level teaching hospitals

Risk pooling for mutuelles is managed at both the central and district levels. The central level manages subsidy funds obtained through non-mutuelle insurance funds, charitable organizations, NGOs, development partners, and the Government of Rwanda. This national solidarity fund channels subsidies down to the district mutuelle solidarity funds as well as to tertiary hospitals for care of mutuelle members who are referred by district hospitals.

While the national solidarity fund manages mutuelle subsidies, member premium contributions are managed at the district level. These contributions are pooled from sector-level mutuelle groups up to the district levels, and disbursed by the district-level mutuelle management entities to the appropriate district- and sector-level facilities based on need and service utilization.

At the district level, mutuelle funds are managed by a designated government entity. The district entities employ district agents that are responsible for monitoring and supervision of the various sector mutuelle organizations that comprise each district mutuelle management entity. The district entities are also responsible for the management of the district-level solidarity funds. At the sector level, mutuelle organizations are owned and managed privately by their members; members elect management officials to be trained in sector-level mutuelle organization and management.

3. Keys to success and challenges

Keys to success and sustainability—The following attributes have been identified as keys to success and sustainability for the community-based health insurance schemes in Rwanda:

- Quality services: Ensuring high quality of services delivered is essential in maintaining and expanding mutuelle membership. Members must feel that they are receiving quality care in order to renew membership; potential members must see benefits of membership in quality services.
- Financial access: Annual premiums and out-of-pocket payments must be priced in a manner that is affordable to the informal sector. There should be subsidies for the very poor who will not be able to afford any contribution but require coverage.
- Community-orientation: There is a strong sense of community in Rwanda that was essential in building community-based health insurance and scaling it to the national level. In Rwanda, most government programs have roots in the strong community-orientated culture (e.g., community pooling in agriculture, hygiene, and health).
- Bottom-up Architecture: To capitalize on the strong community culture, instead of a top-down approach, mutuelles were built from the grassroots levels up to the national level. This bottom-up approach was essential in ensuring large uptake and scale-up.
- Political Will: In order to be successful in implementing any kind of large scale scheme, there must be a clear vision and related policy objectives set forth by the government. Ideally, donors and other stakeholders help the government develop policy—or at the minimum, they should support the policy and its goals. In order to scale-up mutuelle pilots in Rwanda, there was a strong commitment from all stakeholders, including the government, communities, donors, and providers. Not only is political will essential to successful implementation, it is essential for maintaining program success since stakeholder buy-in and support is required for refining existing strategic frameworks when required.

- Large, uninsured informal sector: Community-based health insurance offers insurance options to those left uninsured by the formal sector. Where a large informal, uninsured sector exists (as in Rwanda), there is a market for community-based health insurance.
- Results-driven atmosphere: The results-driven atmosphere created by the President of Rwanda is an essential element in the success of mutuelles. Results-driven contracts with district mayors and with health facilities incorporated both quality and quantity indicators, ensuring that quality services were delivered to a large quantity of people. The resulting quality of services delivered to mutuelle members encourages membership renewals and attracts new members.
- Continual improvement: To coordinate and improve health service delivery, mutuelle leaders are divided into health clusters that are organized into several technical working groups. These working groups (e.g., the family planning working group, the maternal and child health working group, the strategy working group, the mapping working group, etc.) meet to discuss, analyze, and identify methods for improving service delivery.

Ongoing Challenges—The following areas have been identified as ongoing challenges to the community-based health insurance schemes in Rwanda:

- Numerous Priorities: In Rwanda, initially it was difficult to implement any kind of comprehensive reform because there were too many priorities in the public health arena. After targeting the most important areas of health, the government was able to build strategies to address these issues.
- Financial gaps: Often the cost of care is higher than mutuelle payments are able to cover. This puts the sustainability of mutuelles in question. In order to understand the costs of service delivery and to ensure sustainability of the system, Rwanda is undertaking a costing study in partnership with RTI, USAID, and a school of public health.[§]
- Increasing participation: Attracting more mutuelle members is an ongoing challenge faced at the local and national levels. In the last year 73% of the population joined a mutuelle, though many enrollees enrolled mid-year, after they had a health episode, rather than at the beginning of the year. There is still a need to communicate the benefits of joining.
- Quality of care: Maintaining the quality of care is essential to sustaining and growing mutuelle membership. Rwanda has started to utilize performance-based contracts to ensure that service quality is preserved (and improved).
- Human resource constraints: Rwanda, like many developing nations, faces human resource constraints in the health care field due to brain drain. The nation needs to build its health care workforce to ensure sustained, quality service delivery.
- Institutional capacity and management ability: Post-genocide Rwanda faces tremendous resource constraints, including a lack of institutional and management capacity to govern the nation and to build its private sector. Capacity is a particularly an issue in management of the sector-level mutuelles. To address these issues and to build sustained institutional and management capacity within the public and private sectors, the nation has developed organizations that build skills and train high-potential individuals to undertake management and governing positions within both the public and private sectors.

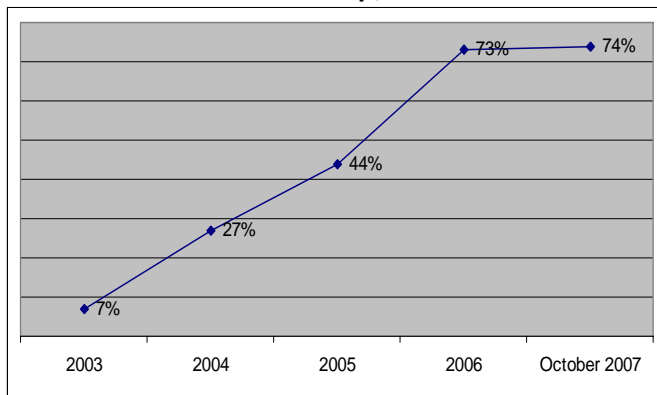
[§] Results of this study should be available by early November of this year. We will follow-up with CKayonga to obtain findings of the study.

4. Results

Rwanda has lost ten years in health gains due to the genocide: Health indicators have improved significantly since 2001, but by 2005 they are only back to pre-genocide levels. Nonetheless, the nation has seen significant improvement in health even in the past several years. For example, the use of modern contraceptives jumped 20% between 2005 and 2007, and bed net utilization increased. The Minister of Health seems confident that other indicators have seen similar improvements in the past few years. She is considering implementing an interim Demographic Health Survey to evaluate these gains. It is important to note, however, that the Minister is hesitant to attribute all health gains to mutuelle membership and primary care utilization (as opposed to preventative care utilization), but she maintains that there is certainly a correlation between primary care service utilization and health improvements.

By 2006, nearly 75 percent of Rwanda's population had enrolled in mutuelles and independent evaluations have found evidence of increased access and use of health care among beneficiaries, as well as lower levels of out of pocket spending.

Chart I: Mutuelle Membership, 2003-2007:



THE BROOKINGS INSTITUTION

1775 Massachusetts Avenue, NW Washington, DC 20036-2118

Tel: 202-797-6000 Fax: 202-797-6004

www.brookings.edu/global/health