

Rwanda

The Government of Rwanda has made significant efforts to develop its health-care system at the national and community levels, making it possible for most people in the country to access affordable health care. This has helped to achieve near universal health coverage and contributed to making ILO's Social Protection Floors Recommendation, 2012 (No. 202) a reality.

The social health protection system in Rwanda consists of Community-based Health Insurance (CBHI) schemes for formal and informal sector members, Rwandaise d'Assurance Maladie (RAMA), Military Medical Insurance (MMI), and private insurance schemes. While 96 per cent of people in Rwanda were covered by health insurance in 2011, CBHI had the highest coverage rate at 91 per cent. Started in 1999 as a pilot programme, it has since been rolled out nationwide. CBHI has greatly contributed to improving health standards in Rwanda, including increased life expectancy at birth and reduced child and maternal mortality.

National social protection floors (SPFs) guarantee access to essential health care and basic income security for children, persons of working age and older persons.

185 countries have adopted the Social Protection Floors Recommendation, 2012 (No. 202), an approach to achieve universal social protection.

This note presents a successful country experience of expanding social protection.



Main lessons learned

- The experience of Rwanda shows that it is possible for low-income countries to meaningfully extend an SPF for health care and move towards universal health coverage, even when the vast majority of people live in rural areas and belong to the informal sector.
- Near universal coverage was achieved due to strong political commitment, a decentralized and strong network of health facilities in all districts, community participation, and the use of cultural elements like *Ubudehe*¹ to include all people.
- CBHI subsidizes contributions for the poor and vulnerable, which has helped to extend coverage to otherwise excluded groups.
- The linkages between health centres and hospitals and communities are strengthened by a total of 45,000 community health workers (CHWs).
- Simple technology can be used to conduct routine surveillance of health events and reach out to people in rural and remote areas.

¹ *Ubudehe* is the Rwandan practice of solving local problems through collective action and mutual support.

1. What is Rwanda's social health protection system?

Over four years of civil war and genocide in Rwanda, close to 1 million lives were lost and the country was left in a state of near collapse in 1994. Since then, Rwanda has made striking achievements in rebuilding its health-care system and reaching near universal coverage. The following are the main health insurance schemes in Rwanda:

1. **Rwandaise d'Assurance Maladie**, which provides medical insurance to civil servants and employees of state-owned enterprises;
2. **Military Medical Insurance**, which provides basic insurance coverage to military personnel;
3. **Community-based Health Insurance schemes**, or *Mutuelles de Santé*, for formal and informal sector members; and
4. **private insurance products**.

The Government of Rwanda's Vision 2020 and the Economic Development and Poverty Reduction Strategy provide for a health-care system that is based on health equity and developed using a people-centric, inclusive, and social cohesion-driven approach.

To extend coverage to all Rwandans, the Government launched CBHI as a pilot programme in 1999 with a nationwide roll-out in 2004. Coverage increased significantly from 7 per cent in 2003 to 91 per cent in 2011 and has helped promote the participation of communities in their socio-economic development.

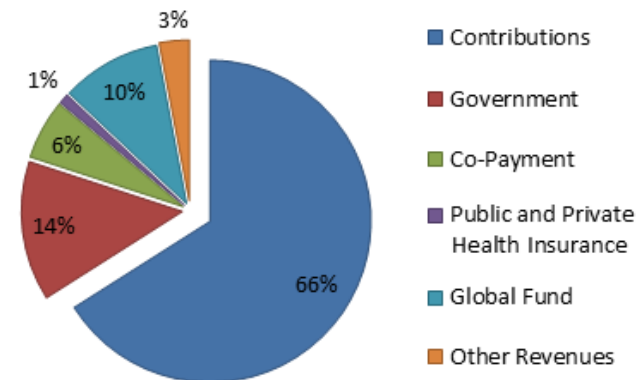
2. What is the CBHI system?

Legal framework: The CBHI schemes are regulated by Law No. 62/2007 and statutory orders which contain provisions for their creation, management, and implementation, including the membership rules, package of services, provider payment options, and financing mechanisms. The Law states that every person in Rwanda not insured by any other health insurance scheme must join a CBHI scheme, thereby making affiliation to CBHI mandatory in nature.

Financing: The scheme is financed through various sources, such as member contributions, government subsidies, external donors, and other health

insurance schemes such as RAMA and MMI, as seen in the figure 1. Contributions are made on an annual basis and there is a waiting period of one month to access services. A co-payment is asked from members at the point of use of health services.

Figure 1. Sources of funding for CBHI, 2012-13



Source: Ministry of Health, Rwanda

The contributions are based on a three-tiered premium scaling system called *Ubudehe*, established in 2010. *Ubudehe* assigns households into one of six categories, based on their income and assets. The premium of the two poorest and most vulnerable categories, i.e. 2,000 Rwandan francs (RWF), is fully subsidized by the Government. The two middle categories pay a slightly higher premium of RWF3,000, while the two highest categories pay the highest premium of RWF7,000. The National Income Categorization Database is used by local governments to classify the beneficiaries into one of six categories. *Ubudehe* introduced the principles of solidarity and inclusion in CBHI and contributed to improving its financial sustainability.

Implementation framework: Figure 2 shows the previous governance and financing structure of the overall CBHI system. In October 2015, the management of CBHI was transferred from the Ministry of Health to the Rwanda Social Security Board in order to improve the financial management and efficiency of the system. Figure 2 also depicts the decentralization of CBHI to the district and sector² levels.

² Sectors are administrative subdivisions of a district.

Health-care services in Rwanda are delivered through a network of interconnected facilities. At the lowest level, health centres and health posts provide primary and preventive health-care services and offer pharmaceutical and basic laboratory support. District hospitals focus on preventive and curative services and health promotion. Provincial referral hospitals provide basic specialized services and have broader geographical coverage. National referral hospitals deliver specialized services and provide training tools and facilities for the expansion of medical services. CBHI members can access services at any of these facilities. The cost of ambulances is also covered.

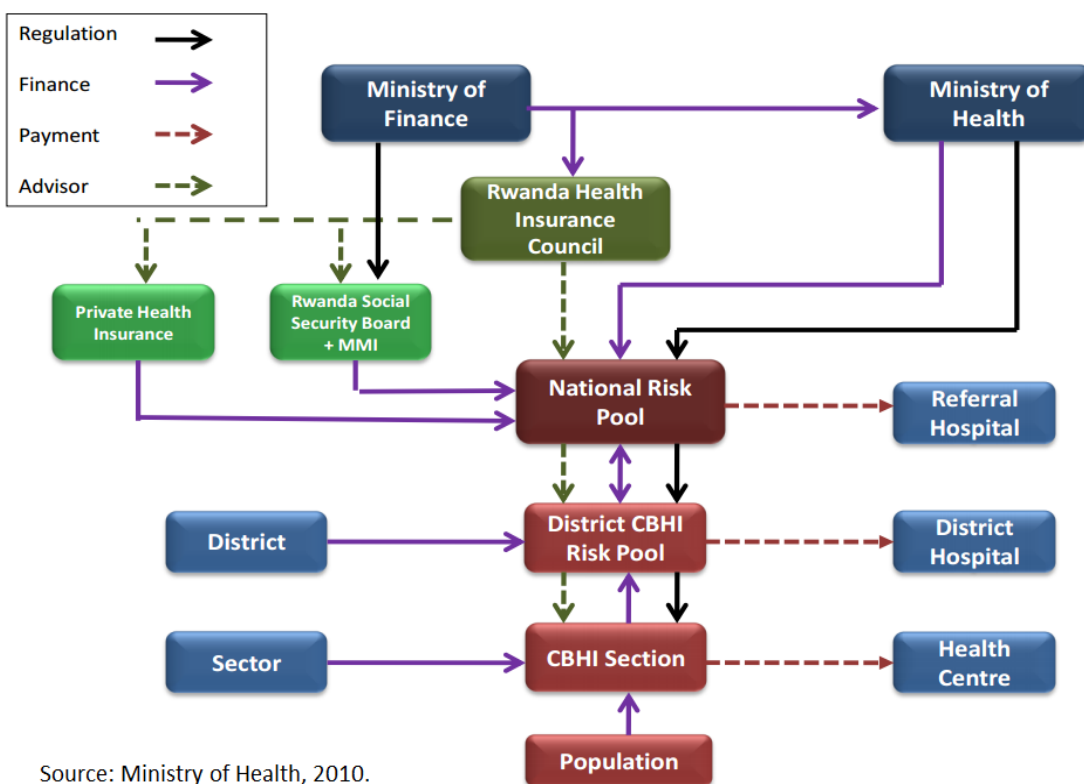
This system is complemented by a network of 45,000 community health workers who further contribute to strengthening the linkages between the health centres and hospitals and the communities. CHWs use simple mobile applications, such as RapidSMS and mUbuguzima, to conduct routine surveillance and monitor health events. In this way, they facilitate case management and monitoring of health indicators.

Furthermore, the Rwanda Health Management Information System, launched in February 2012, is a web-based application that is used to collect data from health facilities.

Decentralization and community participation are encouraged through management, implementation, and monitoring of CBHI schemes at the sector and district levels. Being close to the people, CHWs form the final layer in the decentralized health-care structure. The people are sensitized about health care and CBHI through various awareness-raising measures and are involved in the management of CBHI through electing members to the CBHI committees.

Coverage: The high coverage rate of 96 per cent can be attributed to several factors, especially political commitment, strong leadership, community participation, a decentralized health-care structure using CHWs, provision of incentives to the staff (i.e. performance-based financing), and effectively coordinated donor assistance. Rwanda employs evidence-based policies and practices by scaling up pilot initiatives that prove to be successful.

Figure 2. Structure of the CBHI system in Rwanda³



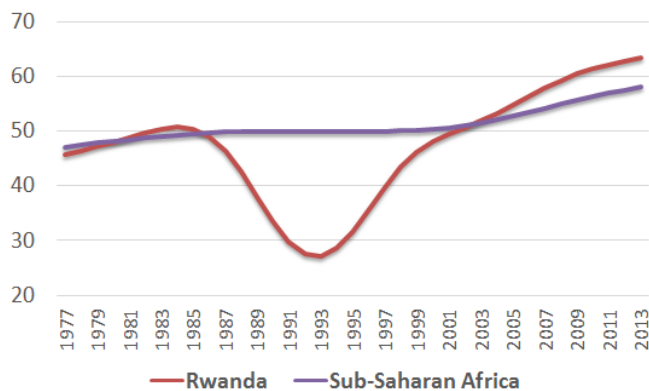
Source: Ministry of Health, 2010.

³ From October 2015, the management of CBHI was transferred to the Rwanda Social Security Board.

3. What are the key achievements in Rwanda?

The Rwandan genocide of 1994 and civil war had a devastating effect on the health-care system, creating a shortage of health workers and destroying infrastructure. Since then, the country has faced an enormous challenge to reconstruct its health-care system and infrastructure, improve the coverage and quality of health care, and tackle high HIV prevalence. This was done over a period of time through several measures, such as decentralizing services to the district level, installing the CBHI system, encouraging community participation in its management and financing, putting into place HIV and malaria programmes, and increasing immunization among children.

Figure 3. Average life expectancy (in years)



Source: World Bank, 2016.

These measures have contributed significantly to improving health standards in the country. As seen in the figure 3, life expectancy at birth for Rwandans fell sharply during the years of civil war and genocide. Since then, it has increased steadily to its current level of 64 years, which is higher than the life expectancy of 57 years for sub-Saharan Africa. The under-five mortality rate, which was among the highest in the world in the early 1990s, has declined to 42 per 1,000 thereby achieving the Millennium Development Goal (MDG) 4 on child health. Rwanda has also made significant improvements in reducing maternal mortality which stands at 29 deaths per 10,000 live births (Source: World Bank, 2016).

CBHI has helped to reduce out-of-pocket (OOP) payments, as seen in figure 4, making health care

more affordable for its members. People can access care before their condition worsens, which decreases the total cost of treatment.

Improvement of infrastructure, especially in rural areas, has increased demand and access to health care and it is estimated that at least 60 per cent of the population lives within 5 kilometres of a health centre. Following the introduction of CBHI, utilization of health care increased from 31 per cent in 2003 to 107 per cent in 2012.⁴

4. What are the challenges?

Declining enrolment rates: Even though health-care reforms in Rwanda helped to significantly increase coverage, there are still gaps in the implementation and universal coverage has not yet been reached. Furthermore, enrolment rates have declined slightly since 2011, partly due to incorrect categorization of members in the *Ubudehe* system. Some members are categorized as wealthier than they actually are and tend to drop out. Other members, whilst correctly classified, experience difficulties in paying the premiums due to seasonal or irregular incomes.

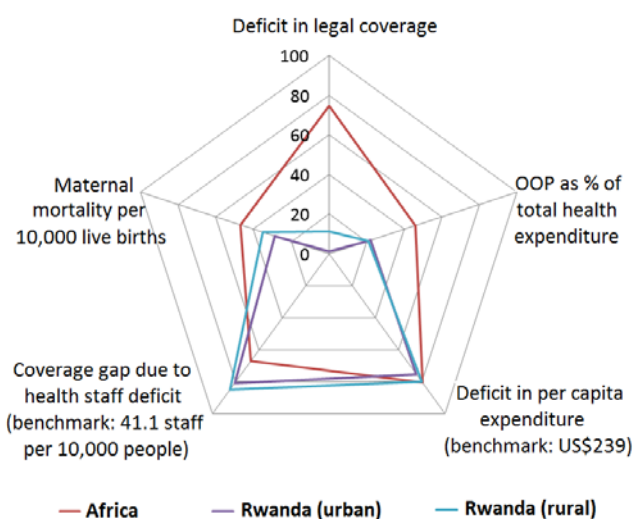
People also tend not to enrol unless they are in need of health care. This is facilitated by the fact that the waiting period of one month has not been strictly enforced. Furthermore, some members may access health-care services without paying the entire premium. There is no penalty system in place for such cases. Greater use of technology and mobile applications could help improve compliance.



⁴ One person could utilize health services for different health problems.

Staff and financial deficits: According to Recommendation No. 202, universal health protection should be based on entitlements prescribed by law and constitute services that meet the criteria of availability, accessibility, and quality. Figure 4 shows five indicators to measure the deficits in effective access to health care in urban and rural Rwanda compared to Africa as a whole. While most Rwandan people were legally covered by health insurance in 2010, access to health services was still hampered for some 80 per cent of the population due to deficits in the professional health workforce and funds. The deficit in professional health workers such as doctors, nurses and midwives was partly compensated by the large number of CHWs who visit people's houses to monitor health events and suggest early intervention. However, improvements are needed for effective and timely access to health care in Rwanda.

Figure 4. Effective access to health care (2010)



Source: Scheil-Adlung, 2015.

In addition to the insufficient number of skilled health workers, capacity building is needed for health workers and managers. Distribution of health workers across regions has to be made more equitable, especially between urban and rural areas.

CBHI's low contribution rates have resulted in hospitals bearing large debts and patients having to buy drugs themselves from pharmacies without reimbursement. Further investments in the health-care system are needed at the national and district

levels with an upward adjustment of contribution rates to help build financial robustness and sustainability. At the same time, the challenge of a large informal sector with limited capacity to pay their contributions on a regular basis and make their co-payments needs to be considered.



Next steps: Rwanda has made great advancements in providing health protection to its citizens through its focus on inclusion of the informal sector and people in rural areas. In this way, CBHI has supported the implementation of Rwanda's Economic Development and Poverty Reduction Strategy; however, more work is needed to address the current challenges in the health-care system. Some of these challenges, such as better financial management, greater efficiency, and better provision of quality health care, are envisaged to be addressed through the recent transfer of the operations to the Rwanda Social Security Board.



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Building Social Protection Floors

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