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HEALTH INSURANCE PROFILE: RWANDA

Table 1: Key country indicators

Development indicators*			
Total population, 2013	11.7 million		
Population median age (years), 2013	18.2		
Population living in urban areas (%), 2013	27		
Gross national income per capita (PPP int. $), 2012	1390		
Health Statistics at a Glance**			
	2005	2010	2014/15
Total fertility rate	6.1	4.6	4.2
Infant mortality rate (per 1,000 births)	86	50	32
Under-five mortality rate (per 1,000 births)	152	76	50
Percent of children 12-13 months fully vaccinated	80	90	93
Maternal mortality ratio (per 100,000 live births)	750	476	210
Antenatal care coverage (≥ 1 visit)	94	98	99
Births attended by skilled health personnel (percent of total births)	28	69	91
Unmet need for family planning	39	21	19
Contraceptive prevalence rate	17	52	53
Health care expenditure indicators (2013)***			
Expenditure ratio			
Total expenditure on health as % of GDP	11.1% ↑ avg. low-income countries (5%) ↑ global avg. (9.2%)		
Level of expenditures			
General government expenditure on health as % of total government expenditure	22.3% ↑ targets set by Abuja Declaration (15%)		
Selected per capita indicators			
Per capita total expenditure on health (PPP int.$)	162		
Per capita government expenditure on health at average exchange rate (US$)	41		
Per capita government expenditure on health (PPP int.$)	95		
Sources of funds			
General government expenditure on health as % of total expenditure on health	58.8%		
Private expenditure on health as % of total expenditure on health	41.2%		
External resources for health as % of total expenditure on health	38.0%		
Out-of-pocket expenditures as % of private expenditure on health	44.6%		

*World Health Organization (WHO) Global Health Observatory **Demographic Health Survey Program *** WHO Health Expenditure Database, Rwanda

Rwanda Health Insurance Overview

Rwanda has made substantial gains in the health and welfare of its population over a relatively short period of time, including stand-out achievements on the Millennium Development Goals (see Table 1). Universal access to equitable and affordable quality health services for all Rwandans is the overall aim of the Government of Rwanda's (GoR) Health Sector Policy. The priorities set forth in the Health Sector Policy are based on the development goals laid out in the Economic Development and Poverty Reduction Strategy and Rwanda's Vision 2020.

The *Mutuelles de Santé*/Community-Based Health Insurance (CBHI) scheme was developed to meet the needs of Rwandans outside of the formal sector, where access to and utilization of healthcare services had been historically very low. Beginning with pilots in 1999, and established as national policy in 2004, Rwanda quickly scaled CBHI across the country. Membership grew to 91% of the target population by 2010-11. Enrollment decreased in recent years, with a June 2015 estimate of 75% coverage, among those eligible for the scheme. The scheme features included strong public financial support (from GoR, development partners and other insurance providers) to allow the informal sector population access to the essential health care package. Rwanda's ambitious target this fiscal year is 100% target population coverage.[1]

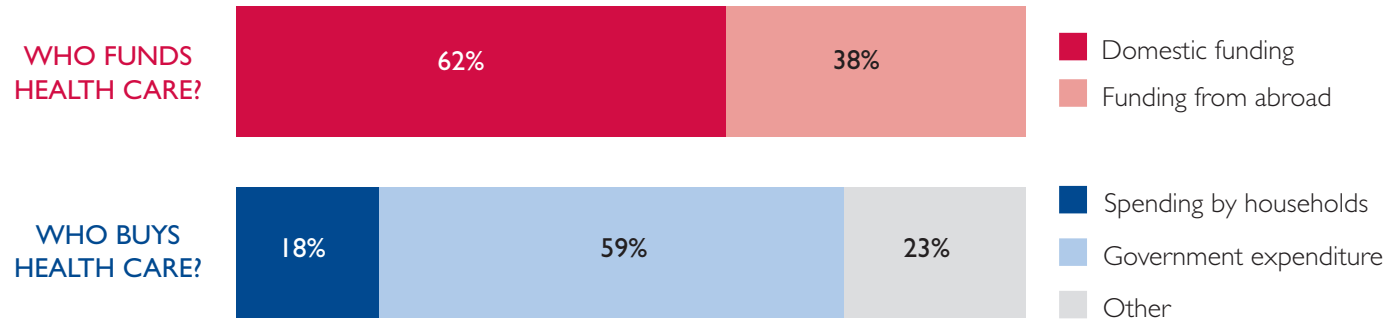
Health Expenditure in Rwanda

The progress seen in health outcomes corresponds with increased expenditure on health in the country. The 2015 Health Sector Policy lays out the goal of the health financing program: to ensure universal financial access to quality health services in an equitable, efficient, and sustainable manner.[2]

Rwanda is among the leaders in the African region in terms of its total spending per capita. In an analysis from 2012, Rwanda was one of only four African countries to have met the targets of the Abuja Declaration (to allocate at least 15% of national budgets to the health sector) and of the High Level Taskforce on Innovative International Financing for Health Systems (to spend at least US$44 per capita on health).[3] Government expenditure on health in 2013 was at 7% of GDP and 22 percent of general government expenditure (US$41 per capita).[4]

The out-of-pocket (OOP) payment rates as a share of total health expenditure (THE) have been falling from 25% in 2000 to 18% of THE in 2013 (US$13 per capita). An impact evaluation of the CBHI scheme in Rwanda, using data from 2000 and 2006, found that households that were members of *Mutuelles* were significantly less likely to incur catastrophic health spending than uninsured households.[5]

Figure 1: Health funding source and health care purchasing



Source: WHO Health System Financing Country Profile, Rwanda 2013

The incidence of financial catastrophe resulting from OOP payments for health services has also substantially decreased between 2000 and 2010, with the proportion of all households (insured and uninsured) spending over 10% of household consumption falling from 11% in 2000 to 2% in 2010. This has been a major conclusion of most studies.[6] In terms of CBHI members, the proportion of households spending over 10% of household consumption and thus incurring financial catastrophe was only 0.4% according to the 2013 CBHI household survey.[7] If this percentage is set at 20%, only about 0.08% of CBHI households spend more than 20% of their household income out-of-pocket on health services in Rwanda, and incur financial catastrophe.[7]

Key Points in the Growth of Health Insurance in Rwanda

The primary increase in health insurance coverage in Rwanda occurred over a relatively short period of time with the evolution of pilots for health insurance. In response to low health care utilization rates and high costs to users, the GoR developed health insurance pilots to meet the health care needs of Rwandans in the informal sector.

The CBHI scheme was launched in select areas in 1999. In 2001, a formal health insurance plan for civil servants was initiated, followed by the Military Medical Insurance scheme in 2005.

Participation rates rose quickly following nationwide rollout of the CBHI plan, implementation of a national policy, and standardization of CBHI schemes. In 2005, CBHI schemes were available in 96% of health centers. In 2006, CBHI premium pricing was adjusted to include free premiums for the poor. While at only 7% enrollment in 2004, in just three years, CBHI participation rates had reached 75% in 2007.[8] Outpatient department consultation and utilization rates on a per capita basis increased significantly from 0.31 in 2003 to 0.94 in 2014. CBHI is only one factor, however, since the government has also made major improvements in the availability of services, increases in resources such as staffing and medicines, and quality of care. Performance-based financing has also contributed significantly to these improvements.

Figure 2: Per capita expenditure in US$ (constant 2013 US$)

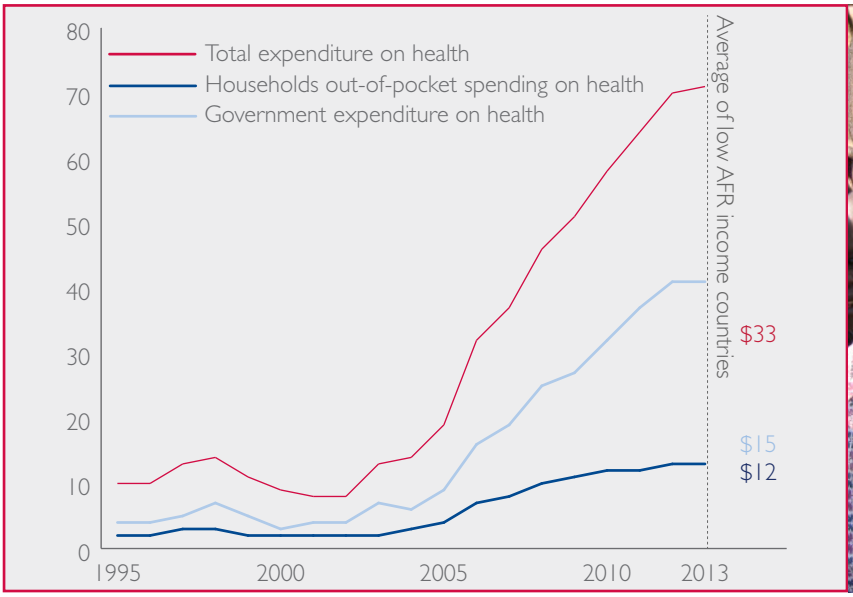
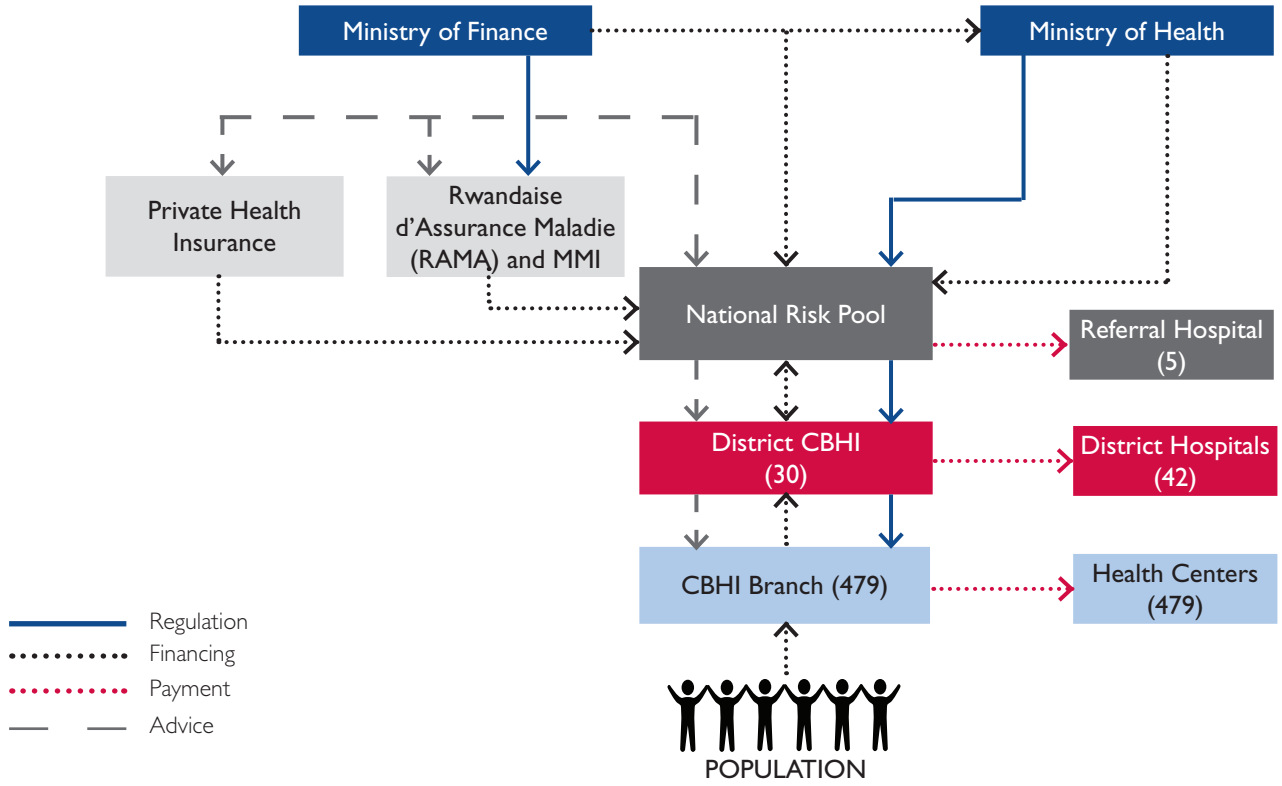


Photo by Management Sciences for Health

Source: WHO Health System Financing Country Profile, Rwanda 2013

Figure 3: Rwanda Health Insurance Organizational Structure prior to CBHI transition in 2015



Source: MOH CBHI Policy, 2010

Organizational Structure

Publicly-managed health insurance in Rwanda comprises three schemes. The majority of the insured population is covered by CBHI, with civil servants and military personnel enrolled in separate schemes which combined, cover approximately 6% of the total population. Private health insurance products are available for purchase. According to a 2015 report, six of eight private general insurers in the country offered medical insurance plans.[9] Health insurance coverage is compulsory by law, although participation rates remain below 100% of the total population.

In 2014, it was determined that managerial responsibility for the CBHI program would move from the Ministry of Health (MoH) to the Rwanda Social Security Board (RSSB). The RSSB was established in 2010, operating under the Ministry of Finance and Economic Planning (MINECOFIN). This transition began in July 2015.[10]

The figure above depicts the relationships between parties in the CBHI as well as the pooling structures, as implemented prior to the recent transition of CBHI management to RSSB. Both the MoH and the MINECOFIN maintain roles in the health insurance program. Per the 2015 Health Sector Policy, the MoH will continue to hold responsibility for development of policy and regulations, while management of health insurance schemes will be under the responsibility of RSSB or private companies.[2]

The pooling structure has since changed, with the introduction of a centralized pool under RSSB, where funds are electronically transferred to central-level RSSB accounts each day, and facilities will conduct electronic billing. This poses a very big reform in financial management.

User Costs and Premium Structure

CBHI developed as a highly decentralized system, utilizing existing community-based health structures for the majority of management and administration at the local level. Each of Rwanda's 30 districts has a *mutuelle*, composed of several branches, each covering a health center and the surrounding communities.

The scheme's revenue depends heavily on premiums collected from members at the community level, and distributed up the system. The local health center receives 55% of this revenue to cover claims. Forty-five percent is transferred to the district for hospital claims and for onward transfer to the national level for referral hospital claims. Health center copayments cover CBHI scheme running costs. Health centers and hospitals are reimbursed based on fee-for-service through itemized monthly billing.

As initially implemented, a flat premium was charged per member of the scheme regardless of economic status. With the implementation of a national policy in 2006, premium subsidies for the poor were put into place. The Rwandan *ubudehe* process is utilized to implement the tiered fee system, based on new premium structures but into place in 2011-12. This community-led, participatory method conducts a poverty-mapping exercise for categorizing members into three groups by economic status. The poorest members are exempt from premiums. Members in the second and third categories pay premiums into the system at differing levels, as well as copayments at fixed amounts for health center visits and at fixed percentages (10%) of the bill for hospital visits.

Enrollment in CBHI has fluctuated over the history of the program. In 2010 and 2011, participation rates are reported to have reached over 90%. For the 2013/14 year, the MoH reports enrollment in CBHI at 73%.[8] As of January 2016, CBHI subscription is reported to have increased to 79%.[10]

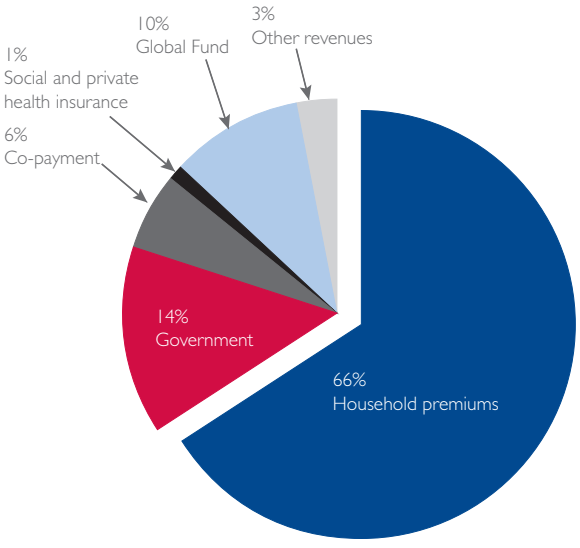
Benefits Package

Members of the CBHI are entitled to a benefits package including both outpatient and inpatient care at public facilities throughout the country. Basic care and referrals to district or tertiary hospitals are provided through the local health center. User copayments are required as described above, and the plan does not set a cost limit to the amount of care available.

Benefits provided by service delivery level
■ **Health Centers** "Minimum package of activities" as defined by the GoR and including curative, preventative, promotional, and rehabilitative services.
■ **District Hospitals** "Complementary package of activities" as defined by the GoR for patients referred from a primary health center.
■ **Tertiary Hospitals** Tertiary services defined by the GoR for patients referred from a district hospital.

Prescription drug prices are set by the MoH at a reference price. Individuals are charged a percentage of that reference price based on their insurance enrollment. The rate for CBHI members is set at 50% of the reference price, 100% for the other public plans, 120% for private health insurance members, and 150% if uninsured.[9]

Figure 4: CBHI Sources of Funds, 2012-2013



Source: MOH Annual Report 2012-13

CBHI Program Funding and Future Plans

A majority of funding in the CBHI program comes from premiums paid by member households. Figure 4 details the sources of funds of the CBHI program as of 2012-2013. Two-thirds of CBHI funds came from premiums. The GoR was the next-largest contributor, at 14% of CBHI funds. As required by policy, social and private health insurance plans also contribute to funding CBHI, comprising 1% of total funding sources for 2012-13.

The GoR has laid out a goal of universal access to equitable and affordable quality health services for all Rwandans. Full participation of the population in health insurance is one component of the plan to achieve this goal. The challenge faced in achieving full insurance coverage is in balancing affordability of user premiums and copayments with financial viability of the system.

The MoH 2015 Health Sector Policy states that health financing sustainability will be ensured though increased mobilization of domestic resources, as well as an increased role for the private sector and civil society. It also calls for encouraging the establishment of private insurance companies, in order to diversify health insurance options for the population. Diversification of resources is being sought through a number of avenues, including public-private partnership models, additional services for fee (such as "VIP wings"), and exploring the Innovative International Financing for Health Systems through dedicated taxes. Further financial self-reliance in the health sector is being encouraged through income-generating strategies across the health system.

Endnotes

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