

# REACHING THE POOR WITH HEALTH SERVICES

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## Rwanda

### Community-Based Health Insurance and the Poor

Rwanda was recovering from the genocide of 1994, during which nearly a million of its people died. Gradually, the social fabric is being stitched together with support from the international community. The economy was recovering: gross domestic production (GDP) has grown at a yearly rate above 6 percent between 1995 and 2001, and in more recent years, between 4–6%. Still, Rwanda is one of the world's poorest countries, with GDP per capita of less than \$300 a year and 6 out of 10 Rwandans living in poverty. In rural areas, where 90 percent of the people live, 66 percent are impoverished.

Mutual aid and community solidarity value systems, born of need, have long been traits of Rwanda's society. Coping strategies in the health care, as in other areas, have been devised in neighborhoods, villages, and larger communities. Associations of *hamac* (system of mutual self help) carry the sick to health facilities. Resources are collected in neighborhoods and cells against emergencies; structured tontines are organized at cell level to meet priority needs, particularly for medical care. The partnership and community involvement framework in the health development strategies did not give much attention to these cultural traits of Rwanda's society before the 1994 war. Mutual aid initiatives in health have emerged in communities, partly in response to the reintroduction of user fees in public and mission health facilities. Health authorities and nongovernmental organizations (NGOs) have built on these community initiatives and have moved these spontaneous coping schemes to a deliberate strategy of building community-based health insurance (CBHI).

#### Emerging of the Community-Based Health Insurance Schemes (CBHI)

Drawing on local experience with mutual health organizations, in 1998 the Ministry of Health (MOH) initiated pilot experiments in the health districts of Byumba, Kabgayi, and

Kabutare. These pilots played a key role in the design and organization of CBHI schemes around the country, provided a platform for compiling information for evaluating CBHI results against health system objectives, and familiarized health sector actors and partners with strategies that would support their extension.

CBHI schemes in Rwanda are health insurance organizations based on a partnership between the community and health care providers. To regulate contractual relations between members and the mutual organization, CBHI schemes develop their own bylaws and organizational structures (general assemblies, board of directors, surveillance committees, and executive bureaus). Participation in a CBHI scheme is voluntary and based on a membership contract between the CBHI scheme and the member. CBHI schemes also develop contractual relations with health care providers for purchasing health care services included in their members' benefit packages. Bylaws of CBHI schemes and their contracts with health care providers include measures for minimizing risks associated with health insurance (adverse selection, moral hazard, cost escalation, and fraud).

The target population of each CBHI scheme is everyone living in their partner health center's catchment area. Low-risk events (health center package) in the CBHI benefit packages are shared at the partner health center catchment's area population. In each health district, CBHI schemes form a federation and performs a risk-pooling function for high-risk events (hospital package). The district federation also plays social intermediation and representation roles for individual CBHI schemes in their interactions and contractual relations with health care providers and external partners. The federation also provides individual schemes with training, advice and support, and information services.

Members make annual contributions to the CBHI scheme funds. Members can sign up as a family for US\$7.60 a year



for a family of up to seven members. The membership entitles covered family members to a benefits package that includes all preventive and curative services, prenatal care, delivery care and laboratory exams, drugs on the MOH essential drug list, and ambulance transport to the district hospital provided by the partner health centers. With a health center referral, members also receive a limited package at the district hospital. Sick members make a co-payment of US\$0.30 for each health center visit. At the hospital, referred members have direct access to the hospital package without any co-payment. Health centers serve as gatekeepers to discourage inappropriate use of hospital services.

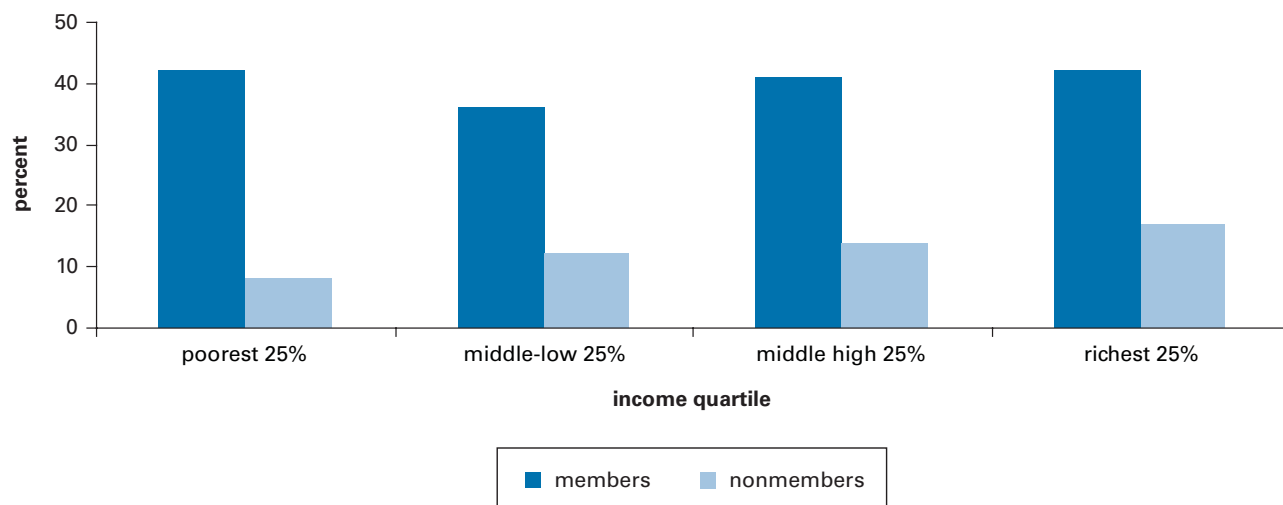
Since 1998, a cumulative process of learning about CHBI has been launched in Rwanda, involving CBHI schemes in the pilot districts and schemes in other districts, whereby members and promoters identify and design the legal tools needed to support mutual health organizations, exchange experiences, share information on strategies and tools, and learn from best practices. This learning environment has fostered innovative strategies for strengthening CBHI schemes in pilot districts and establishing new CBHI schemes in other parts of the country. These local initiatives, while maintaining the technical design of the pilot phase, have capitalized on the decentralization movement underway in Rwanda, incorporating partnerships between local administrative structures, grassroots associations, and microfinance schemes (*banques populaires*) to strengthen local CBHI support systems and expand enrolment.

### CBHI Reaching the Poor

Since 1998, CBHI schemes have taken off in Rwanda. From a single CBHI scheme in 1998, the number increased to 60 in 2001 as a direct result of the pilot phase supported by the MOH. Starting in 2001, an adaptation phase, drawing on lessons learned and recommendations from the pilot phase, extended the number of CBHI schemes and increased enrolment rates in individual schemes. By July 2003, 97 CBHI schemes covered a half million Rwandans. In 2004, 214 CBHI schemes had developed all over the country as a result of the combined promotional efforts of central authorities (MOH and Ministry of Local Affairs), provinces, districts, local health personnel, local opinion leaders, and NGOs. In mid-2004, national coverage of CBHI schemes was estimated at 1.7 millions Rwandans, about 21 percent of the population. And the movement is still growing. In 2004, the level of coverage increased significantly to 27% (Mutual Health Insurance Policy in Rwanda, 2004).

With the removal of financial barriers to health care by CBHI schemes, plan members are four times more likely to seek modern health care when sick than nonmembers. The household survey results of the pilot phase summarized in figure 1 have been replicated based on routine data from health centers gathered during the pilot phase and more recently from health centers in the same pilot districts as well as results from health centers in the districts that set up CBHI schemes between 2001 and 2003. CBHI schemes coverage

Figure 1. Proportion of Sick Seeking Care from Modern Provider, by Income Quartile



Source: Byumba, Kabgayi, Kagitumba Household Survey 2000.

has also increased the use of reproductive health services, including prenatal care and delivery care. They had no effect, however, on the use of family planning services.

As a result of their insurance function, CBHI schemes prevented members from falling into poverty due to illness through two mechanisms. First, sick members of CBHI schemes seek care earlier in their illness than the uninsured, resulting in efficiency gains in the consumption of health care services. Second, sick members pay small out-of-pocket co-payments at the health centers. Consequently, out-of-pocket payments are reduced significantly among CBHI scheme members (figure 2).

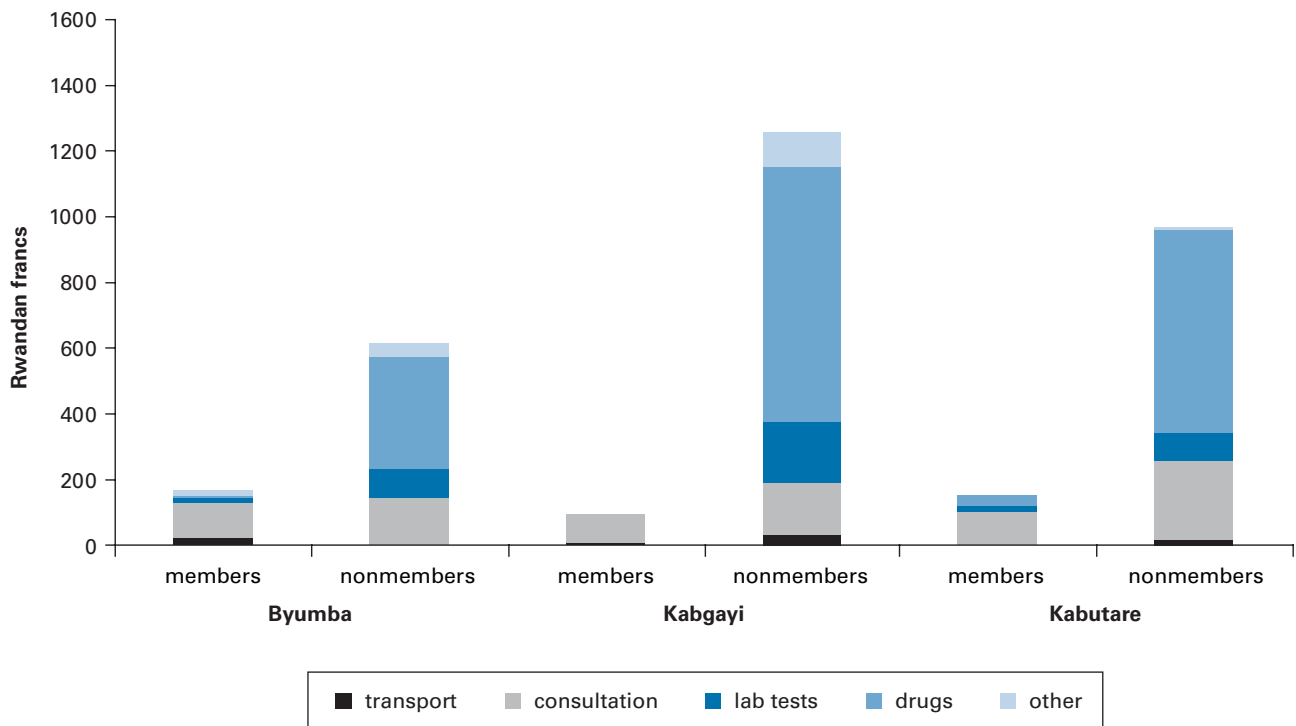
Greater access of the poor to CBHI scheme benefits are being promoted through two main strategies, microfinance and subsidies.

**Microfinance.** Building on partnerships between CBHI schemes, grassroots associations, and microfinance schemes (*banques populaires*), grassroots associations, new and old, are motivated to enroll as a group in the CBHI schemes. Microfinance schemes then make small loans to the associa-

tions' members to pay for their annual dues to the CBHI schemes. Microfinance has boosted enrolment of the poor in the CBHI schemes and has opened opportunities for poor CBHI members for access to larger micro-loans to finance income-generating activities. Such financial arrangements developed as a consequence of the institutional arrangements between CBHI schemes, microfinance schemes, and health centers, and innovations introduced by local actors.

**Subsidies.** NGOs and administrative districts are using the institutional bridges between the community, the CBHI schemes, and health care providers to finance the enrolment of the poorest, indigents, and vulnerable groups (orphans, widows, and people living with HIV/AIDS). Under these demand-based subsidy schemes, community leaders exercise administrative functions in identifying the poorest, indigent, and vulnerable groups; the CBHI schemes manage health care use for these groups; and the subsidies are financed by NGOs and administrative districts that serve as intermediaries for primary sources of finance such as state funding and external aid.

Figure 2. Out-of-Pocket Illness-Related Expenditures



Source: Patient Exit Survey 2000.

## Learning from the Rwanda CBHI Lessons

CBHI in Rwanda is still a work in progress, but experience there since 1999 affords some valuable lessons for the extension of micro health insurance schemes throughout the country as well as for adaptation by other developing countries.

**Lesson 1.** CBHI in Rwanda is being built on an incremental approach, drawing lessons from internal experience as well as external experience of prepayment schemes in southern Africa and mutual health organizations in western Africa. The MOH provided the leadership to initiate the pilot phase and secured technical assistance from the U.S. Agency for International Development (USAID)/Rwanda and Abt Associates Inc. to improve the technical design and organization of the already functioning CBHI. The MOH kept a respectable distance from the design and scheme management, giving communities and local health providers autonomy and operating room. The pilot generated information on the scheme performance and convened multiple forums for stakeholders to exchange experiences and to debate the consequences and implications of the CBHI schemes for the Rwanda health system. The incremental approach provided a learning platform and opportunities to derive policy directions for the development of CBHI.

**Lesson 2.** As consensus built up on the benefits of CBHI, a multi-tiered leadership developed in the country to support adaptation and extension. National political leaders, starting with the president, called upon all stakeholders to mobilize

for implementation of CBHI schemes throughout the country. Local communities were motivated by the MOH support, and this support in turn, boosted promotional activities by the Ministry of Local Affairs. At the province and district levels, local officials and mayors actively coordinate promotional activities by the Ministry of Local Affairs. At grassroots, cell and sector representatives, together with health personnel and local opinion leaders, are active in sensitization activities. This multilevel leadership and activism has strengthened the legitimacy of CBHI and won intersectoral support for it.

**Lesson 3.** Intersectoral action was mobilized with the involvement of the decentralized entities and NGOs in CBHI promotional activities under a policy environment in which community development was a central theme. The resulting local initiatives improved access of the poor to CBHI benefits. Partnerships between local microfinance schemes, CBHI schemes, and grassroots associations have widened access for the poor to microfinance credit and to CBHI. Access of the poorest and indigents to CBHI is being broadened by using CBHI schemes as intermediate local solidarity funds to target demand-based subsidies for the most underprivileged in the health sector by NGOs and administrative districts.

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This brief is intended to summarize good practices in Health, Nutrition, and Population. It was adapted from François Pathé Diop and Jean Damascene Butera, "Community-Based Health Insurance in Rwanda," *Development Outreach* 7 (2 May 2005): 19–22. The views expressed in this note do not necessarily reflect those of the World Bank.

