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Community-Based Health Insurance in Rwanda

Rwanda has lived one of the most tragic moments of its history with the genocide of 1994, which resulted in nearly one million deaths and the destruction of the social fabric of the country. Since 1994, however, the country is being rebuilt: gross domestic production (GDP) has grown at a yearly rate above 6 percent between 1995 and 2001, and social infrastructures have been rebuilt with support from the international community. Rwanda remains, however, one of the poorest countries in the world: per capita GDP is still under \$300; the incidence of poverty is as high as 60 percent of the population, and reaches 66 percent in the rural areas where nearly 90 percent of the population live (Ministry of Finance and Economic Planning, 2002).

Mutual aid and community solidarity value systems have remained resilient traits of Rwanda's society and continue to be translated in coping strategies in the health care area. In all local communities, associations of hamacs carry the sick to health facilities. Resources are specially collected in neighborhoods and cells to face emergencies; structured tontines are more and more organized at the cell level in order to face priority needs in general, medical care

needs in particular. Little attention has been paid in the past to these cultural traits of Rwanda's society within partnership and community involvement frameworks in health development strategies. After the 1994 war, however, mutual aid initiatives have emerged in the health sector as community responses to the reintroduction of user-fees in public and mission health facilities. Building on these community initiatives, health authorities and non-government organizations have moved these emerging strategies to a deliberate strategy of building community-based health insurance schemes in the health sector.

Community-based health insurance schemes (CBHI)

Building on the experiences of mutual health organizations which have emerged in the country, the Ministry of Health (MOH) initiated in 1998 pilot experiments in the health districts of Byumba, Kabgayi and Kabutare, which played a key role in the design and organization of CBHI schemes in the country. It provided also a platform for the compilation of information to support the assessment of CBHI schemes, and to familiarize health sector actors and partners with the strategies needed to support their

implementation on a large scale.

CBHI schemes in Rwanda are health insurance organizations based on a partnership between the community and health care providers. The CBHI schemes develop their bylaws, organizational structures including general assemblies, board of directors, surveillance committees and executive bureaus to regulate contractual relations between members and the mutual organization. Participation in the CBHI scheme is voluntary and is based on a membership contract between the CBHI scheme and the member. In addition, CBHI schemes develop contractual relations with health care provider organizations (health centers, hospitals) for the purchasing of health care. 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 individual CBHI schemes are inhabitants of the catchment's area of their partner health center: low risk events (health center package) which are included in the CBHI benefit package are shared at the partner health center catchment's area population. CBHI schemes in a given health district, however, establish a federation at the district level which plays a risk-pooling mechanism 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. Finally, the federa-

tion plays other support functions, such as training, advice and support, information, for individual schemes.

Contributions to the CBHI scheme funds are on a yearly basis. Members have the option to sign up as a family with up to seven members, which costs US\$7.6 per family per year. Payment of the yearly premium entitles covered family members to a benefit package which includes all preventive, 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 pay a co-payment of US\$0.30 for each visit at the health center. At the hospital, refereed members have direct access to the hospital package without any co-payment. Health centers play a gatekeeper function to discourage the inappropriate use of hospital services (Schneider et al., 2001).

Since 1998, a cumulative process of learning in the community-based health insurance area, involving CBHI schemes of the pilot districts and CBHI schemes in other districts, has been launched in Rwanda. Such a learning environment has facilitated the emergence of innovative strategies for strengthening existing CBHI schemes in pilot districts and implementation of new CBHI schemes in other parts of the country. These local initiatives, while maintaining the technical design of the pilot phase, have built on the decentralization movement

underway in the country, and partnerships between local administrative structures, grassroots associations, and micro-finance schemes (*banques populaires*) to strengthen local support systems of CBHI schemes and to increase enrollment in the schemes.

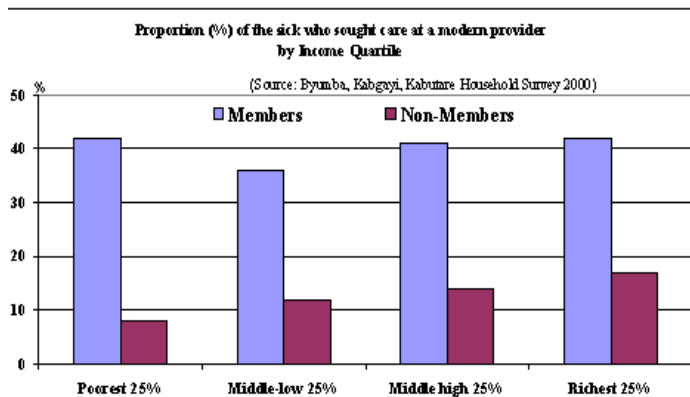
CBHI and the poor

CBHI schemes have experienced an important growth during the past five years in Rwanda. From one CBHI scheme in 1998 to sixty in 2001. Starting in 2001, an adaptation phase drawing on lessons learned and recommendations from the pilot phase extended the number of CBHI schemes and increased enrollment rates in individual schemes: consequently, on July 2003, ninety-seven CBHI schemes, covering half a million Rwandans, were functional in the country. The development of CBHI schemes is currently in an extension phase: in 2004, two hundred and fourteen CBHI schemes have developed all over the country as a result of the combined effects of promotional activities of central authorities (Ministry of Health and Ministry of Local Affairs), provinces, districts, local health personnel, local opinion leaders and non-government organizations. In mid-2004, national coverage of CBHI schemes is estimated at 1,7 millions Rwandans: about 21 percent of the Rwanda population are currently benefiting from CBHI coverage in the health sector (Ndahinyuka, Jovit. 2004).

As a consequence of the removal of financial barriers to access to health care by CBHI schemes, members of CBHI schemes are four times more likely to seek modern health care when sick than

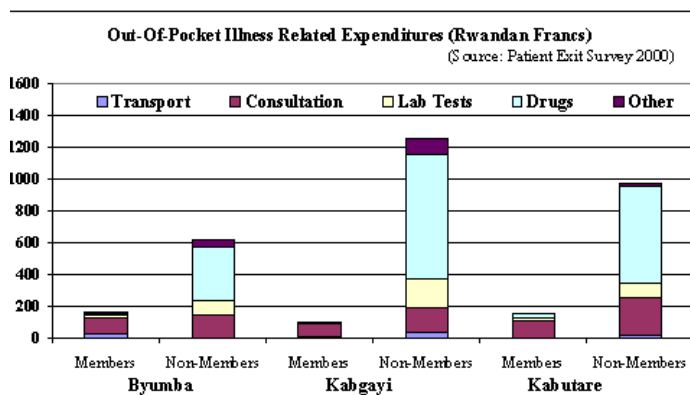
non-members (Diop, 2000). The household survey results of the pilot phase summarized in Figure 1 have been replicated based on routine data from health centers during the pilot phase and recent results from health centers in the same pilot districts and results from health centers in the districts which have implemented CBHI schemes between 2001 and 2003 (Butera, 2004). CBHI schemes coverage 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.

Figure 1



As a result of their insurance function, CBHI schemes protect the income of their members against financial risks associated with illness through two mechanisms. First, when sick, members of CBHI schemes seek care earlier 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 as demonstrated by the comparison of members and non-members of CBHI schemes' out-of-pocket payments in Figure 2.

Figure 2



Greater access of the poor to CBHI scheme benefits are being promoted through two main strategies. First, building on partnerships between CBHI schemes, grassroots associations and micro-finance schemes (*banques populaires*), existing and newly formed grassroots associations are motivated to enroll as a group in the CBHI schemes under a financing scheme where the micro-finance schemes provide small loans to the associations' members to pay for their yearly contributions to the CBHI schemes. Such a financing scheme has boosted enrollment of the poor in the CBHI schemes. In addition, it has opened opportunities for poor CBHI members for greater access to larger micro-finance loans to finance income-generating activities. Such financial arrangements developed as a consequence of the institutional arrangements between CBHI schemes, micro-financing schemes and health centers, and innovations introduced by local actors.

Second, non-government organizations and administrative districts are building on the institutional bridges between the community, the CBHI schemes and health care providers to finance the enrollment of the poorest, indigents and vulnerable groups (orphans, widows, people living with HIV/AIDS). Under these demand-based subsidy schemes, community leaders play administrative functions in the identification of the poorest and indigents and vulnerable groups, the CBHI schemes manage the consumption of health care for these groups, while the subsidies are financed by non-government organizations and administrative districts who serves as intermediaries for primary sources of finance (state, external aid).

Main Lessons

While the extension of CBHI in Rwanda is still underway, the experience of the past five years provides valuable lessons for the development of micro health insurance schemes in developing countries. First, the development of CBHI in Rwanda built on an incremental approach which drew lessons from internal experiences and external experiences 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 USAID\ Rwanda and Abt Associates Inc., which improved on the technical design and organization of CBHI schemes in the country. The MOH kept a respectable distance from the

design and management of the schemes to ensure the autonomy and the appropriation of the schemes by communities and local health providers. It generated information on the performance of the schemes and convened multiple forums for stakeholders to exchange experiences and to debate on the consequences and implications of the CBHI schemes on the Rwanda health system. Such an incremental approach provided a platform for learning and drawing policy directions for the development of CBHI in the country.

Second, as consensus built-up on the benefits of the CBHI schemes, a multi-level leadership developed in the country to provide support to the adaptation and extension of the schemes. Political leaders at the central level, starting from the Presidency, called for the mobilization of all actors to support the implementation of CBHI schemes throughout the country. Local communities were motivated by the MOH support in designing and establishing CBHI schemes; such support was boosted by the Ministry of Local Affairs involvement in promotion activities. At the province and district levels, prefects and mayors continue to play a key role in coordinating promotional activities. At the grassroots levels, cell and sector representatives are playing a key role in sensitization activities, along with health personnel and local opinion leaders. Such a multi-level leadership has strengthened the legitimacy of CBHI in the country and enabled the mobilization of intersectoral support for the development of the schemes.

Third, the involvement of decentralized entities and non-govern-

ment organizations in CBHI promotion activities under a policy environment where community development was a central theme, mobilized intersectoral action, resulting in local initiatives which improved access of the poor to CBHI benefits. Partnerships between local micro-finance schemes, CBHI schemes, and grassroots associations have widened opportunities for the poor to access CBHI and micro-finance credit. Access of the poorest and indigents to CBHI benefits is being strengthened, due to the use of CBHI schemes as intermediate local solidarity funds in the targeting of demand-based subsidies to the poorest and indigents in the health sector by non-government organizations and administrative districts.

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