



Strategies towards universal health coverage in Rwanda: Lessons learned from extending coverage through mutual health organizations

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Rwanda, situated in central Africa, experienced war and genocide in 1994. These tragic events contributed to the deterioration of infrastructure and services, including in the health system. As soon as the war ended, Rwanda undertook its reconstruction and many initiatives and innovations were initiated, some of which have resulted in positive outcomes. The health insurance system is one such example of satisfactory performance.¹

The health system has undergone several reforms, leading to the current high level of coverage, notably through mutual health organizations. In an initial first phase, between 1999 and 2001, a MHO pilot project was implemented in three districts. This was followed by a second phase that saw the extension of these initiatives between 2002 and 2005 to other districts either by political and administrative authorities, health providers or high-profile personalities. This resulted in a third phase, starting in 2006 and still on going, which witnessed a broad-based review on how to take advantage of a MHO approach to expanding the health insurance system nationwide with the aim of providing universal health coverage.

Rwanda's approach to extend health insurance coverage through MHOs has

been the subject of particular attention at both regional and international level. Several articles have presented MHO schemes as innovative financing mechanisms, focusing specifically on household fund collection, risk pooling and purchase of services from providers.² Recent studies have presented the results achieved, in terms of population coverage, improved access and avoidance of catastrophic health expenditure.^{3,4,5}

While it is true that the introduction of MHOs in Rwanda is a recent experience that is still facing many challenges – notably in terms of financing and risk pooling – its overall performance is generally deemed positive.⁶ In fact, substantial progress has been made towards the attainment of the main targets of universal health coverage – reduction of financial barriers for better access to health services and cutting of catastrophic health expenditure.

This article proposes to review a number of the “lessons learned” with a view to identifying the specific strategies adopted by the Government of Rwanda to achieve such performance. It presents ten strategies that can be of relevance in other countries or contexts. The section on discussions is aimed at better understanding the “strategies”, and focusing attention on the validation of good practices.

SUMMARY—Rwanda has undertaken several health sector reforms over the last two decades. One of particular interest is the health insurance reform and extension of coverage through mutual health organizations (MHOs). This strategy and its implementation is analysed in this article with a view to highlighting good practices or lessons learned, based on experience on the ground and on existing literature, that could be used in other countries. This report shows that it is possible to achieve health insurance coverage in countries such as Rwanda where the informal sector is as large as 90% of its total population. Ten good practices were identified as lessons learned and these are deemed to be key factors in moving towards universal health coverage in Rwanda and should be supported and reinforced in order to sustain the improvements in health care access.

*Voir page 54 pour le résumé en version française.
Ver a página 54 para o sumário em versão portuguesa.*

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Methodology

A desk review of the studies and reports cited above was undertaken, in parallel to discussions with the government authorities and other stakeholders to review the MOH approach and its role and function within the overall health financing system. To strengthen the analysis, the strategies that were identified were matched with available literature and compared with the good practices identified by other experts involved in other policy processes. Such comparisons enabled us to determine to what extent the choices and operational processes adopted in Rwanda were allied to possibly more generic practices in other parts of the world. Efforts were also made to verify to what extent the strategies adopted in Rwanda are referred to in scientific literature on health insurance extension through MHOs implemented in other low or middle-income countries. This dual comparison prompted reflections on the external validity of lessons learned in Rwanda.

Results – the ten best practices identified

1. Selection and management of destitute people

A strategy namely *ubudehe* (collective work) was devised to select and manage destitute people in order to determine MHO contribution subsidizations and exemptions. This approach is based on traditional values aimed at rallying the people around a collective and shared effort, with a view to improving their social conditions. In the past, the population living in the same smallest village level unit used to organize themselves to work in farms and build houses for poor people. Building on this practice was recognized and encouraged by some of the country's development partners. Under the new organization, the community identifies destitute people itself and determines the assistance they need. The participation of government and development partners involves sending aid to such organized population groups that have identified their own needs, within the overall context of poverty alleviation.

In a bid to determine the social category of each household at the village level for deciding on the MOH contribution exemptions and subsidizations, discussions were carried out within communities on the notion of poverty, its causes and consequences. The community

itself defined the various categories of rich/poor among its members and identified criteria for allocating community members to the various categories. The number of categories identified and their characteristics are described in Table 1.

Table 1. Household classification criteria for identifying destitute people using the *ubudehe* approach

Population group	Characteristics
<i>Abatindi nyakuja</i> (people living in abject poverty)	This group of people own no property, live from begging and the assistance of other people and consider that death would be a relief.
<i>Abatindi</i> (very poor people)	These people are homeless and lack food, access to food is not easy but they are able to work for other people in order to survive. They are poorly clothed and own no land or livestock.
<i>Abakene</i> (poor people)	These people depend on food deficient in nutrients, own a small plot of land, have low production and cannot afford to send their children to secondary school.
<i>Abakene bifashije</i> (less poor people)	These people own a small plot of land, some livestock, a bicycle and produce an average quantity of food; their children can attend secondary school and they face fewer difficulties accessing health care.
<i>Abakungu – jumba</i> (rich people because they have food)	This group of people own large areas of land, can afford a balanced diet and live in decent homes. They employ other people, own livestock and their children can easily attend university.
<i>Abakire</i> (rich people because they have money)	This group comprises people who have a bank account, can access bank loans, own a beautiful house, a car, livestock, fertile lands, sufficient food and have permanent employees.

Source: Ministry of Public Administration and Social Protection, "Ubudehe" programme, Kigali, Rwanda.



2. Resource mobilization mechanisms for the granting of microcredit to facilitate MHO subscription

Microcredits are granted to beneficiaries without any obligation of guarantee; only the moral guarantee of the administrative authority is required by *banques populaires*.⁷ Credits are granted annually, either to individuals, households, groups or associations. They are repaid over a 12-month period at an interest rate of 4%. It should be noted that the negotiations which led to these arrangements took place between the Government and the *banques populaires* which cover the entire national territory. This method is aimed at helping the population pay their MHO contribution in a single instalment. Information obtained from the banks show that 96% of debtors repay their debt regularly, without any delay. Another option would be to combine health insurance credits with loans for income-generating activities in communities organized within cooperatives. This enables people not only to borrow, work and repay collectively, but also reduces the insolvency risks related to credits granted only for health insurance.

3. Establishment of a legal framework for the operation of health insurance in Rwanda

The various health insurance schemes, including MHOs, in Rwanda were governed by several legal instruments: firstly, the decree of 15 April 1958 relating to “mutual organizations” which remained in force until 2006. Later, from 2006 to April 2008, a ministerial order set out the provisions of the law that was tabled before parliament for enactment, relating to the coordination of MHO expansion activities. Finally, Law No. 62/2007 of 30 September 2007 setting up compulsory health insurance in Rwanda was enacted in April 2008 and published in the Official Gazette of the Republic of Rwanda. This law sets out provisions relating to the creation, organization, operation and management of health MHOs within the strategy of extending health insurance coverage in Rwanda. It stipulates in Section 33 that: “Any person residing in Rwanda shall be bound to health insurance.

Any foreigner entering the country or territory of Rwanda shall also be bound to health insurance within a time limit not exceeding 15 (fifteen days)”. The application of this law, however, depends on ministerial orders that are still being prepared.

4. Decentralization and separation of functions

In the context of decentralization, district mayors sign performance contracts with the Presidency of the Republic. These contracts relate to four main elements:

- good governance;
- justice;
- economic development; and
- promotion of the well-being of the population.

For each element, the performance indicators to be assessed at the end of every year are defined. Performance indicators relating to MHOs are among the main indicators regarding the promotion of well-being of the population. Consequently, mayors are encouraged to sensitize communities on the importance of MHOs in order to satisfy these indicators.

The recent decentralization process in Rwanda divided the country into 30 districts. As MHOs are developed according to districts, there are 30 MHOs in the country at the health centre level, there is a MHO branch in each health centre and at a lower level, that is, at the level of cells and communities (*imidugudu*), committees are set up to sensitize people on the need to subscribe to MHOs.

5. Development of human resources and establishment of management bodies

Several committees have been established at different levels:

- a) The MHO Technical Support Unit (CTAMS), set up at the Ministry of Health, provides support for the development of MHOs, facilitates experience sharing between districts and improves policies and strategies. The unit is also responsible for gathering MHO-related data, operational research, as well as training and dissemination of good practices. CTAMS has a staff of nine people, including a coordinator, a project

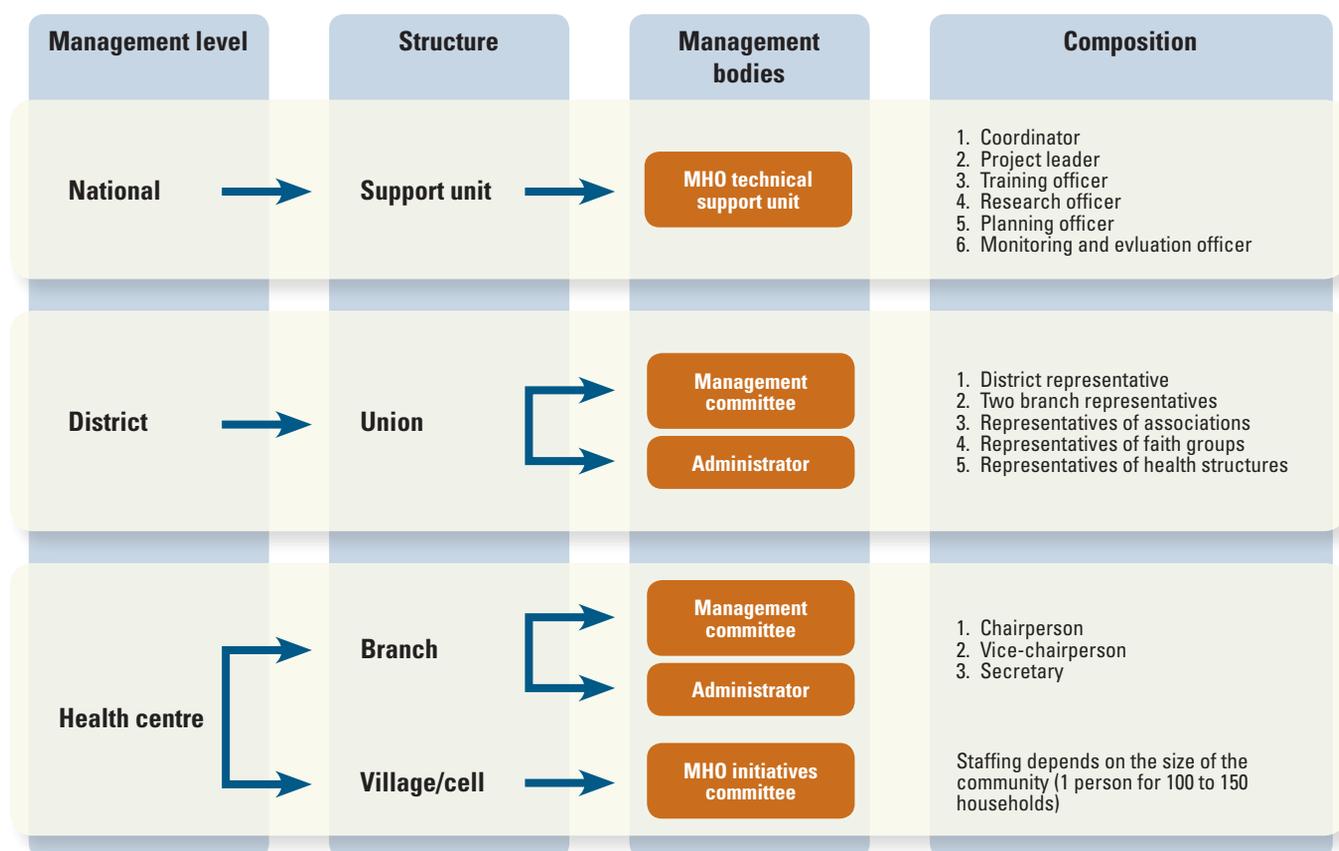
leader, a training officer, a research officer, a planning officer, a monitoring and evaluation officer, an accountant and a stocks manager.

- b) At the district level, there is a board of directors and a manager. The board is composed of seven people, and board members are elected for a term of three years, renewable once. The manager is a permanent officer in charge of the daily management and monitoring of health insurance activities in the district.
- c) At the branch level, there is a management board composed of five people, notably: the chairperson, the vice-chairperson, the secretary and two advisors, each from a sector. They are elected for a term of two years, renewable once.
- d) Finally, at the level of villages and communities, there are MHO committees in charge of sensitizing the community. Their staffing depends on the size of the community; on average, one person is responsible for 100 to 150 households. Figure 1 shows MHO management bodies at the various levels.

6. Upgrading of services provided to MHO subscribers

During the pilot phase, the health services provided to MHO subscribers were limited to minimal services proposed by health centres and complementary services offered by district hospitals. During the second phase, the system was similar, although complementary services could vary between the MHOs, and the contribution amounts were not the same. MHO subscribers complained about the gaps in coverage in comparison with the existing health insurance schemes for formal sector workers and civil servants (RAMA and MMI). Those covered by these schemes could access care in district and referral hospitals. With the advent of risk pooling between the district MHOs during the third phase (see next section on resource mobilization), community or district MHO subscribers could also access care in district and referral hospitals. This enabled the mobilization of additional resources for MHOs and is greatly appreciated by subscribers, as well as being an incentive to subscribe to a MHO since subscribers are entitled to

Figure 1. MHO management bodies and their composition at various levels of the health pyramid



the same services as those in the formal sector, except private health providers and pharmacies.

7. Mobilization of additional financial resources to support MHO initiatives

Several sources of financing are directed towards MHO support, in particular, member contributions that account for a large share of resources, government support and partner assistance. The Government of Rwanda allocates a budget to MHO strengthening. The funds are used for the operation of MHOs and district level inter-branch pools. The Government also negotiated with partners to secure their financial contribution to the MHO mechanism. The Global Fund, in the context of the 2005 Round 5, granted the Government of Rwanda US\$ 34 million over a five-year period to subsidize the coverage of complementary services in district hospitals and the MHO subscription of people living with HIV (PLWHIV). Such funds are also used to subsidize

MHO contributions of destitute people. Table 2 presents the contributions of the Government and the Global Fund to MHO strengthening.

Negotiations between the Government of Rwanda and its partners extended to include other development partners, e.g. US cooperation (USAID), German

cooperation (GIZ), Belgian cooperation (CTB), International Labour Organization (ILOSTEP), Dutch cooperation, Swiss cooperation, the European Union, World Bank, WHO and UNICEF. Such financial support enabled broadening of the scope of coverage to include services at referral hospitals.

Table 2. Contribution of the Government of Rwanda to health insurance strengthening through the Global Fund and under the state budget

Contributions (US\$ ^a)			
	2008	2009	2010
Subsidization of health insurance contributions of destitute people (basic and complementary services)	714 250	646 024	5 202 400
Subsidization of health insurance contributions of "poor people" (for complementary services)	937 166	1 098 278	6 094 316
Subsidization of health insurance contributions for orphans (basic and complementary services)	74 359	69 244	545 741
Subsidization of health insurance contributions for PLWHIV (basic and complementary services)	121 677	125 784	971 912
Total	1 847 452	1 939 330	12 814 368
Government contribution (US\$) under the state budget			
Total financial flows for health care	4 048 169	7 409 543	11 193 705

8. Raising community awareness on the importance of MHO coverage

Political and administrative authorities use various channels to raise awareness: popular gatherings, church services, community labour, etc. Officials from the MHO management bodies use the opportunity offered by these mass gatherings to transmit messages regarding MHOs.

CTAMS has produced a number of brochures on MHOs and has sent them to district MHO offices for dissemination. Sensitization messages are aired on national radio and bi-weekly television programmes, even where the number of viewers is limited – only 3.9% of the population owns a television.⁹

Finally, in the context of sensitization efforts, it should be noted that each year the Ministry of Health organizes a health insurance day during which it awards prizes to the best MHOs.

9. Synergy between MHOs and other health system processes with a view to improving health care quality and political leadership

Other health system mechanisms, including performance-based financing (PBF) and quality assurance (QA), have developed in Rwanda and synergies between the various approaches could facilitate their institutionalization. For instance, the increase of service utilization due to MHOs will also have a positive impact on the quantitative indicators used in the context of PBF and thus leads to increased funding flows to health facilities that operate under a PBF contract with the Government.

Regarding quality assurance, the strategy facilitates continuing supervision and technical audit which, additionally, is useful for the management of MHOs and PBF.

10. Political leadership and involvement of political and administrative authorities in extending coverage through MHOs

The Government of Rwanda is involved at the highest level in the promotion of

universal health coverage. It has already been mentioned that the Presidency of the Republic signs contracts with district mayors with a view to meeting certain indicators.

Within the framework of performance contracts signed between the Presidency of the Republic and districts, an annual evaluation is conducted to ensure the effectiveness of the performance indicator relating to social well-being (see point 4 on decentralization and separation of functions). Mayors who fail to comply with the performance commitments undertaken with the Presidency of the Republic are expected to resign. The practice of performance assessment thus encourages political and administrative authorities to undertake commitments that they have a duty to honour, for the benefit of the population, at risk of losing their position.

Conclusions and recommendations

The support from the Government of Rwanda to the MHO approach deserves particular attention. The high level of government involvement that characterized the establishment of the MHO schemes enabled the population to understand the importance of pooling risk and created public support of the MHO approach. Today, the population adheres strongly to the MHO system but in the years ahead, there will be a need to strengthen ownership by the population in order to sustain MHOs in Rwanda.

Performance of health facilities is not due to a single strategy but rather to a combination of different strategies, including: MHO, PBF and AQ.

It is also worth noting that households constitute a major direct source of MHO financing. Financial viability therefore depends on the capacity and will of households to pay to these mechanisms. Consequently, contribution costs should remain affordable and the various mechanisms enabling the population to mobilize funds strengthened. In fact, new mechanisms, such as the classification of populations in income categories, depending on their capacity to pay, should

be reinforced and sustained in order to consolidate the system. Support from development partners for subsidizing the contributions of destitute people and PLWHIV remains significant. Hence, the Government should continue to mobilize both domestic and external resources for strengthening these subsidization mechanisms. Combining further innovation in the contribution categories according to capacity to pay of households and consolidating the subsidization policies could lead to resource mobilization in line with Rwanda's economic development and growth in the long run. External support will also be indispensable to accompany the process in the foreseeable future.

Lastly, it is incontrovertible that research is a useful instrument that needs strengthening in order to improve universal health coverage and the mechanisms to achieve it, and to enable political leaders to defend their policy decisions on the basis of reliable facts. 📄

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7. The Rwandan Government, with support from Swiss technical cooperation, developed a network of *banques populaires* throughout the national territory. Farmers can deposit their money and the bank requires no minimum amount for opening an account. This bank also grants credits to its members at an interest rate of 4%, contrary to commercial banks where the interest rate is between 12% and 18%.
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