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The road to UHC in Rwanda: what have we learnt so far?

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Vision of the health sector in Rwanda

"Pursuing an integrated and community-driven development process through provision of equitable and accessible quality health care services to all citizens"

This is in line with the country's vision ***"to be become a middle income country by 2020"***

Health Sector context: Simultaneous reforms

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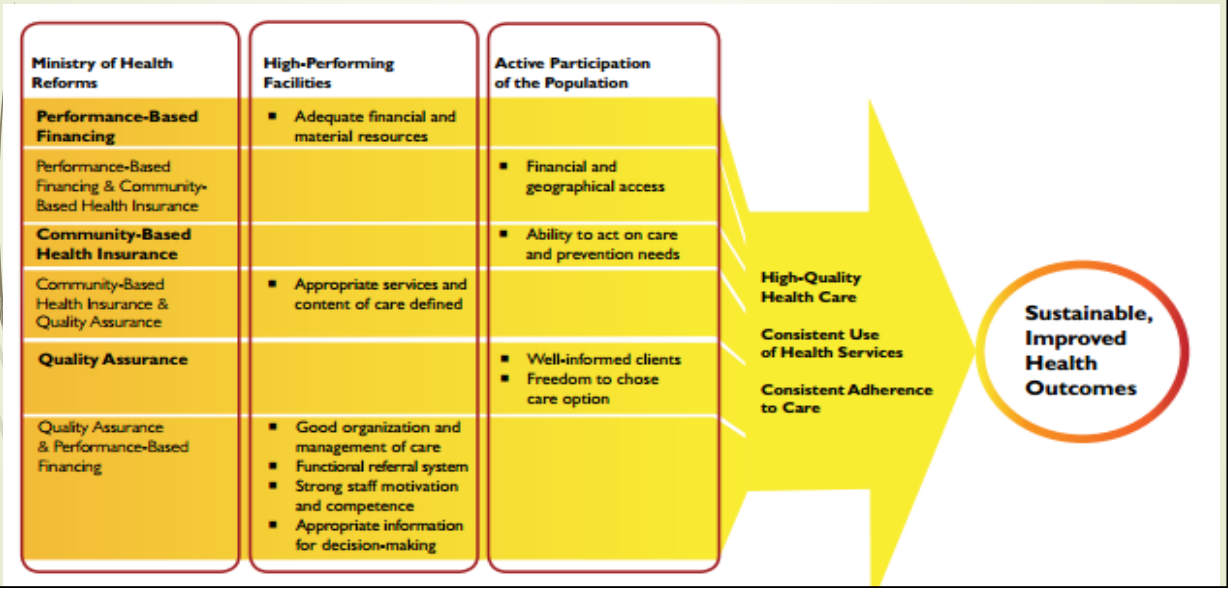

Context/ Opportunities

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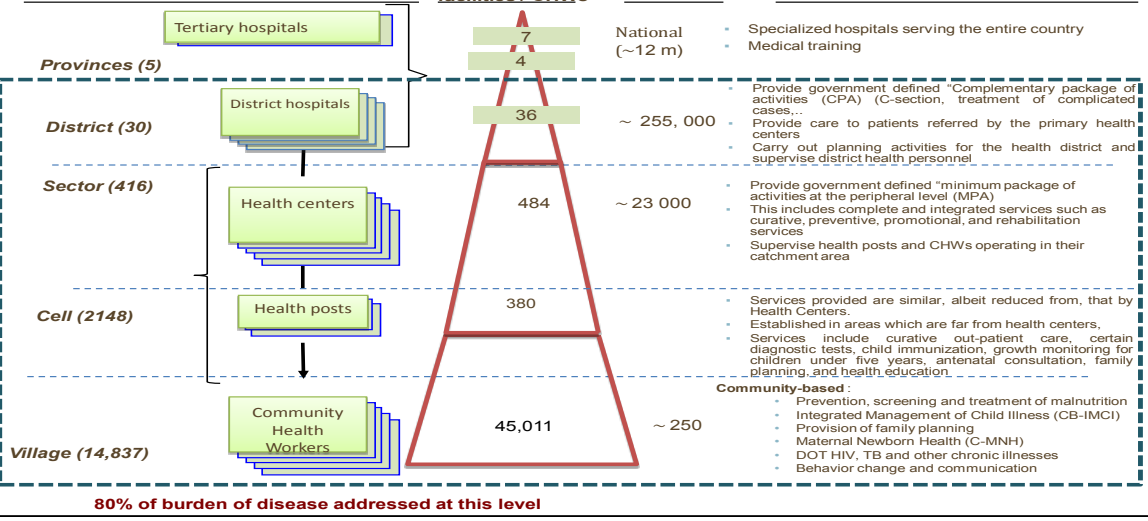
Rwanda's Health System



Design : Coverage- Services- Cost

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Formal Sector

RSSB-MMI: .....%

- Public servant and Army force.
- % on the salary (15%: 7.5 by the employer)
- Access to service up to the tertiary level .
- Co-payment: 10 - 15%

Private Insurances:

- Para-statal and individuals
- Premiums
- Access according to premiums package.
- Co-payment

Informal Sector

CBHI: covers 80% (2015 – 2016).

- The majority of the population
- Voluntary adhesion based on membership according to the stratification.
- Access to service through referral system:HC→DH→TH→RH(different packages at each level)
- Flat fees at HC, 10% at DH,TH and RH

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CBHI structure, benefit package, and financing (Formal Model)

	Public health care delivery system	Benefit packages	Financing sources
National Pooling risk **(start the 1st row with CBHI branches/Health centres)**	Tertiary hospitals (5)	Government defined Tertiary package of activities for patients referred by District hospitals	· Government · Social health insurance (RAMA, MMI) · Private health insurance · Development partners · CBHI district pooling risks (4.5% coming from CBHI branches)
CBHI at the District or Mutuelle (30)	District Hospitals (42)	Government defined "Complementary package of activities (C-section, treatment of complicated cases) for patients referred by primary health centers	· National pooling risks · CBHI branches (40.5% of members' contributions) · Government · Development partners
CBHI branches (479) **(and then the 3rd row with National**	Health centers (479)	Government defined "minimum package of activities." This includes complete and integrated services such as curative, preventive,	· Members contributions · Subsidies for the poor and other vulnerable people from Government &

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CBHI structure, benefit package, and financing **(Current Model)**

	Public health care delivery system	Benefit packages	Financing sources
National Pooling risk (start the 1st row with CBHI branches/Health centres)	Tertiary hospitals (5)	Government defined Tertiary package of activities for patients referred by District hospitals	· Government · Social health insurance (RAMA, MMI) · Private health insurance · Development partners ·Members contributions
CBHI at the District or Mutuelle (30)	District/Provincial Hospitals (42)	Government defined "Complementary package of activities (C-section, treatment of complicated cases) for patients referred by primary health centers	
CBHI branches (479) (and then the 3rd row with National pooling/ Tertiary)	Health centers (479)	Government defined "minimum package of activities." This includes complete and integrated services such as curative, preventive, promotional, and rehabilitation services	

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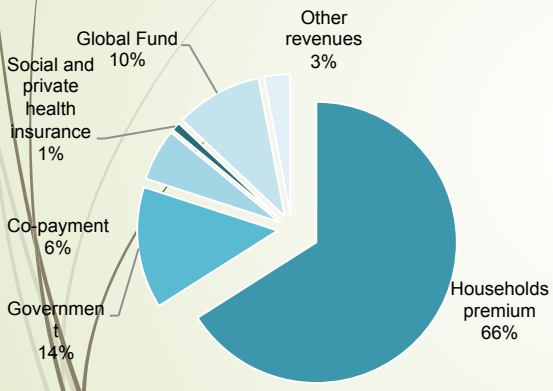
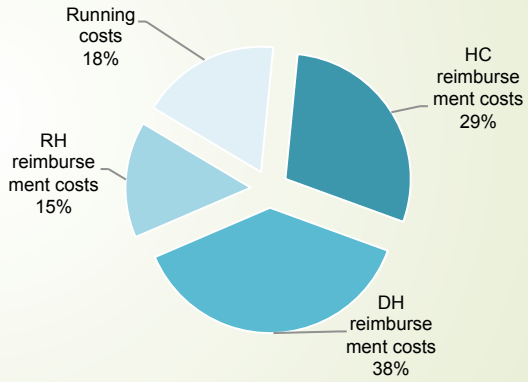
CBHI: Sources of revenues Vs Expenses (2012-2013)

CBHI : Sources of revenues



CBHI: Expenses (2012-2013)



Source: MOH annual report, 2012-2013

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Some challenges and strategies to overcome them

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Programmatic Sustainability: No separation of functions MoH = Purchaser and Provider

- Move the management of CBHI from MoH to RSSB (Under MoF)
- Creation of a regulation Body: Rwanda Health Insurance Council.

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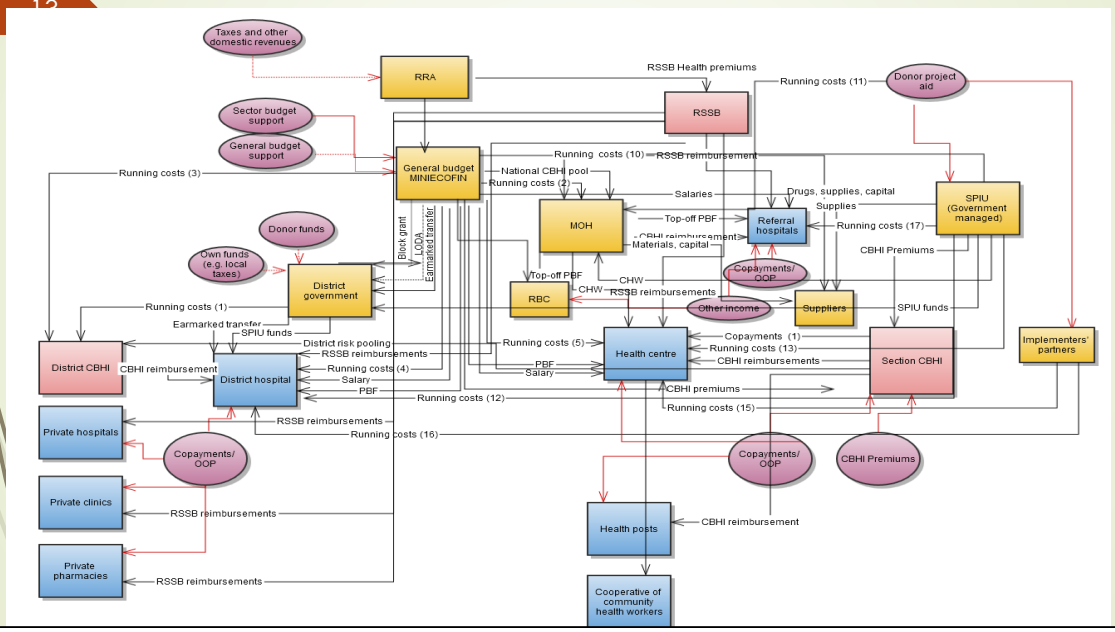
Financial Sustainability: Practical strategies

- Increased Resources:
  - Diversification of resources (Population contributions, Government, SHI & PHI);
- Cost containment measures:
  - Control on abuse & over-utilization: Co payment & mandatory referral system;
  - Mitigation of insurance risks:
    - Adverse selection: Enrollment by HH and no Individuals
    - Overbilling: Rigorous bills verification
- CBHI sustainability study scenarios: Revision of premium levels, universal mandatory enrollment

Flow of health care resources



Pending challenges

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- Still have a lot of people uninsured (~ 20%);
- Co payment is still a barrier for the less poor for the health care at tertiary level;
- Effectively targeting the poor to benefit the subsidies
- Fee for service payment causing high administrative burden

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Some results….

Coverage rate (CBHI)

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Effect of CBHI on access to care, 2013

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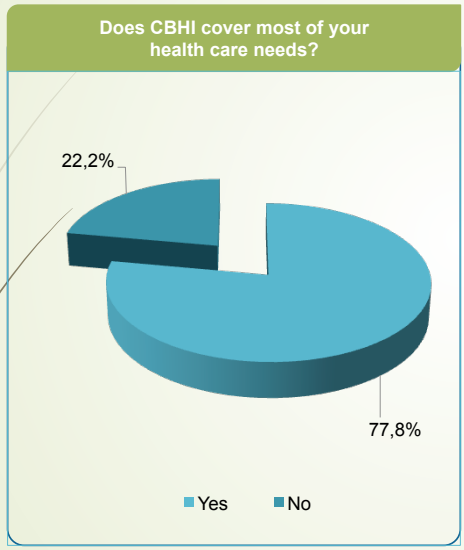

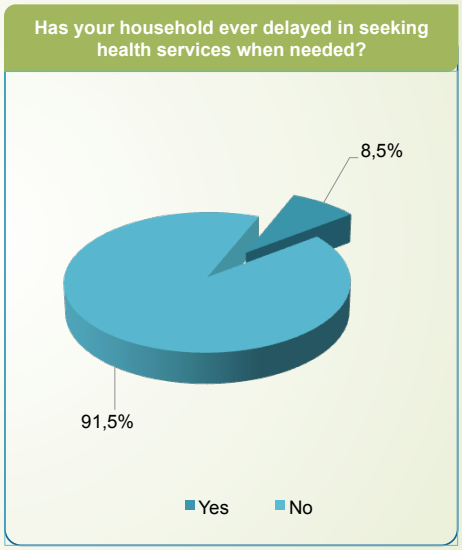

Effect of CBHI on financial protection, 2013

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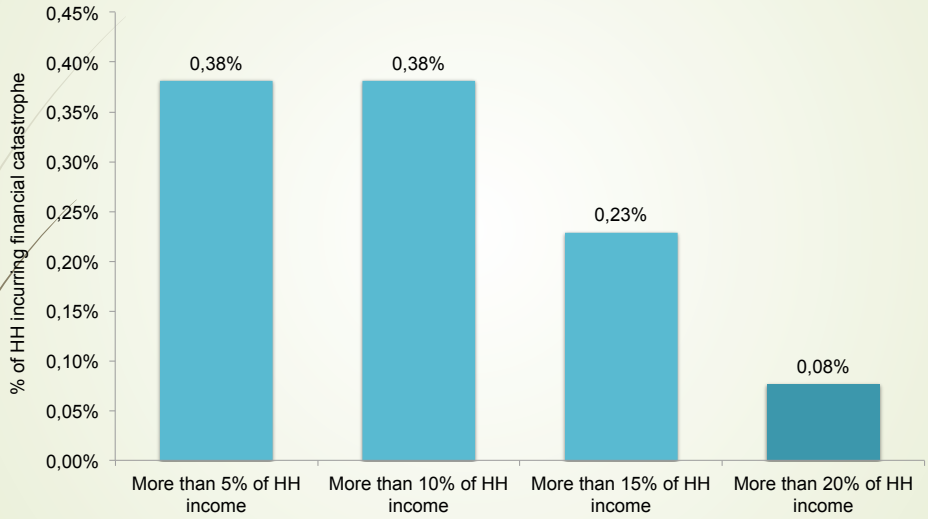

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Sample of outcome

Maternal and Child health indicator	DHS 2000	DHS 2005	DHS 2010	DHS 2014-15
Neonatal mortality rate (per 1000 births)	44	37	27	20
Infant mortality rate (per 1000 births)	107	86	50	32
Under five mortality (per 1000 births)	196	152	76	50
% of children 12-23 months fully vaccinated	75	80	90	93
Maternal mortality ratio	1071	750	476	210
% of births attended by skilled health personnel	27	28	69	91
Antenatal care coverage (at least 1 visit)	92	94	98	99
Unmet need for family planning	36	39	21	19
Women 15-49 using modern contra-ceptive methods	6	10	45	48
Contraceptive prevalence rate	-	17	52	53

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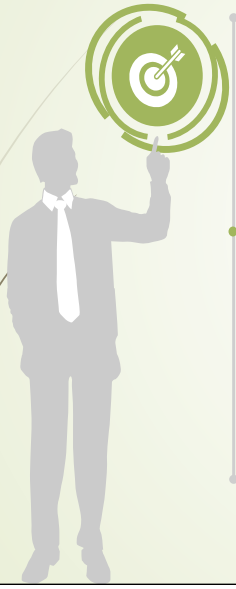
Key lessons learned



- **It takes time to build a successful CBHI scheme**
  - Phase 1 (1999-2003) political commitment and piloting;
  - Phase 2 (2004-2006) expansion of independent, district-level schemes across the country;
  - Phase 3 (2006-2009) consolidation into a national scheme and standardization;
  - Phase 4 (2010-2015) focusing on increasing domestic financing and sustainability and fine-tuning for greater equity

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Key lessons learned

- Need a strong and consistent government support especially in early stage of development
- Strong demand and support from communities and related organization is essential
- Important support can be provided by development partners but it is necessary that it is initiated, designed, coordinated and managed by government for integration
- Continuous community sensitization on the role and importance of health insurance

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Key lessons learned

- Ensure access to comprehensive package of services and quality of care
- Premiums and copayments must be set carefully. System for subsidizing/exempting the poor is crucial to ensure their access
- Risk managements strategies to reduce adverse selection and moral hazard are important
- Proper financial management systems are critical
- Subsidies from government and/or support from donors is likely for financial sustainability of scheme targeting the informal sector and the poor

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MURAKOZE!
THANK YOU!