Our Health
Our Future

COMMUNITY-BASED HEALTH INSURANCE (CBHI)

29th August, 2017

Outline

- Development of CBHI scheme in Rwanda
- Implementation of the CBHI scheme
- Main challenges
- Future perspectives

Development of CBHI scheme.

1980's

- Most public health services funded by user fees following adoption of Bamako initiative
- Few form of associations with specific health goals, initiated and managed by FBO to cover their operating costs

1994-1995

- Public health system collapsed (including existing community risks sharing mechanism)
- Most health services were supported or provided by international agencies
- National Health Policy encouraged the development of mutual aid societies

Development of CBHI scheme..

1996-2000

- High burden disease and poor health outcomes
- Decrease in humanitarian assistance
- Reintroduction of user fees in public health facilities
- ↓ health care utilization raising concerns about financial access
- MOH pilots prepayment schemes in 3 health districts with help from DPs which showed successful results
- Membership 7.9% in 2000

Development of CBHI scheme

2000-2005

- Expansion of independent prepayment schemes in more districts across the country
- National CBHI Policy developed in 2004 aimed at consolidating schemes into one national CBHI scheme but not fully implemented until 2006
- Creation of CTAMS/MOH in 2005
- Membership increased from 7 % in 2003 to 44 % in 2005
- Premiums, copayments, and packages differ

Milestones in the development of CBHI scheme

2006-2007

- Family membership made compulsory
- Pooling system established at the district and national level
- Standardization of premiums (shared between members and government) and copayments
- Premiums for the vulnerable people are paid from GF grant
- Membership reached 75% in 2007

Milestones in the development of CBHI scheme

2008-2010

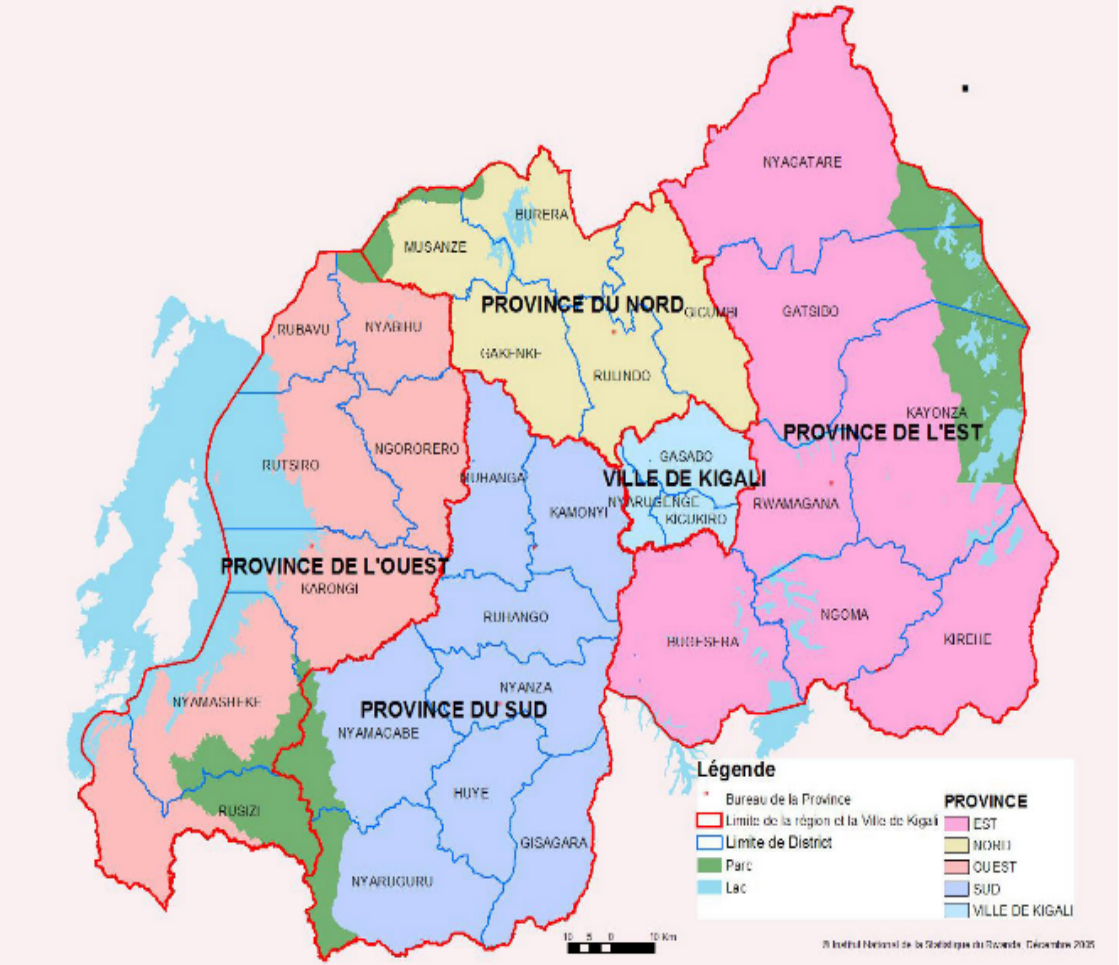
- Health insurance mandatory by law
- New law governing CBHI establishing organization, functions and management and describing membership rules, benefits, provider payment options and financing mechanism
- Membership reached 91% of the target population
- Recognition of some equity challenges

Milestones in the development of CBHI scheme

2011-2015

- New graduated premiums based on income (higher for middle and upper income groups – free for poor)
- Introduction of patient roaming
- Decrease in membership from 91% in 2012 to 76% in 2015
- Financial sustainability issues
- Move of CBHI from MOH to RSSB by July 2015

CBHI IMPLEMENTATION



- 30 administrative Districts
- 130+ Health Posts
- 499 Health centers
- 36 District Hospitals
- 4 Provincial Hospitals
- 8 Referral Hospitals
- 45.516 CHW

CBHI stakeholders

- MINECOFIN :
  - funds mobilization,
  - Overall supervision of RSSB as line Ministry
- MINISANTE:
  - Payment of subsidies provided by the law (13% of the MoH budget)
  - Designing the Health policy (Medical acts & service package, prices , coding…..)

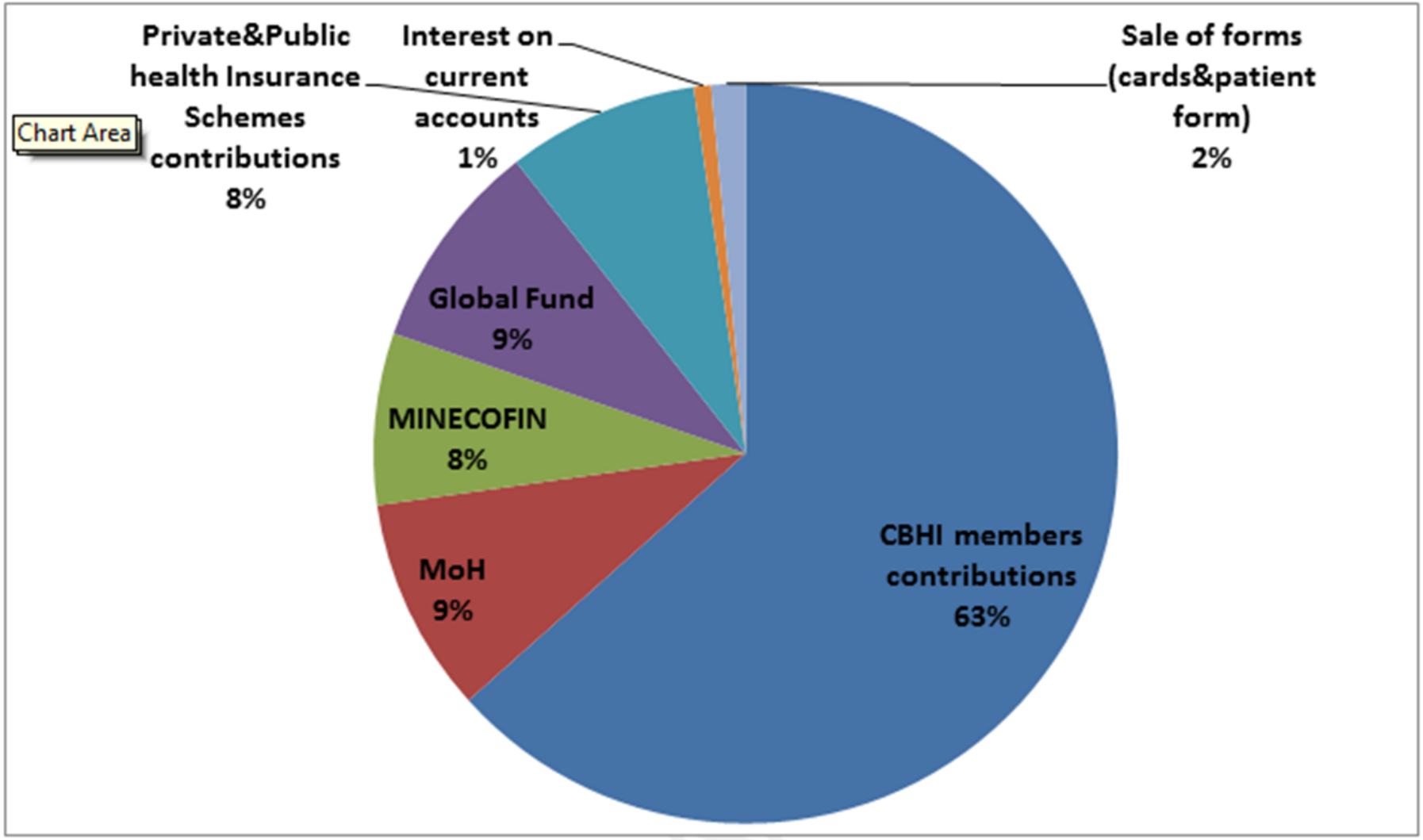
CBHI stakeholders ..

- MINALOC:
  - Mass mobilization & sensitization,
  - Ubudehe and NIDA databases management,
  - To issue Ubudehe certificate for those who are not in the database
- RSSB: Full management of CBHI scheme
  - Collection of contributions
  - Registration & membership management
  - Benefits provision
  - Payment of service providers
- BNR: regulator

Collection of premiums

- Category I: GOR sponsored through National Budget or Common basket
- Category II and III: entire contribution at once or in installments
- Category IV
  - Waiting period: 1 month
  - Payment for all household members

CBHI Source of funding



Collection of premiums

- SACCOs (Saving and Credits Cooperatives)
- Commercial banks
- Mobile payment Agents across the country: Equity Bank (1.100), Mobicash
- Payments thru Cooperatives: Tontines (Ibimina)

* All revenues (contributions & subsidies): pooled into RSSB accounts

Coverage rate 2016-2017= 84.2%

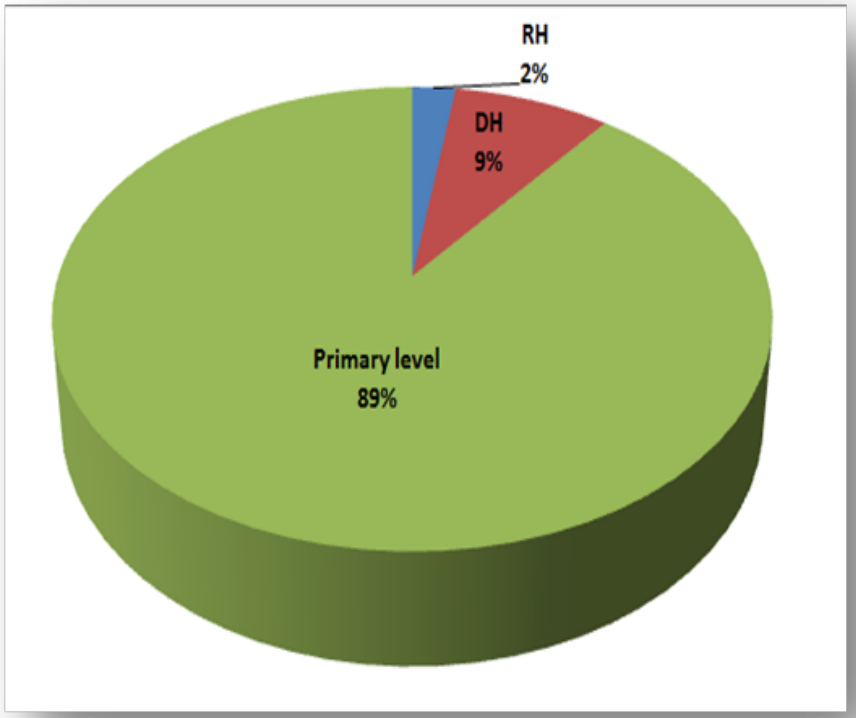
Benefits provision

Benefits package	Health facilities
Primary package	health center (HC)
Complementary package	district hospital (DH)
Supplementary package	provincial hospitals (PH)
Tertiary & specialized package	referral hospitals (RH)

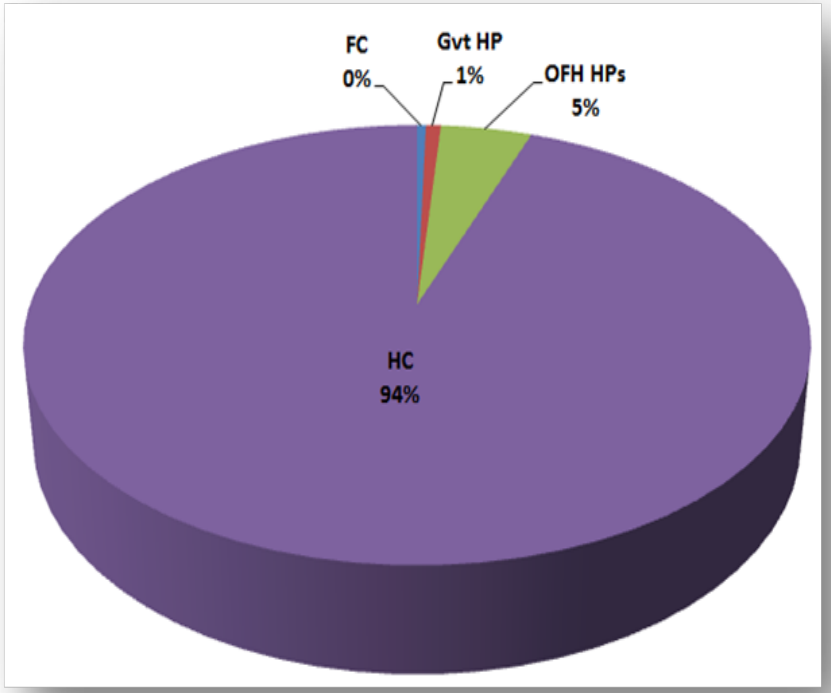
- All Public health facilities
- Private health facilities: King Faisal Hospital & health posts
- Respect of referral system from HC to DH, DH to PH & RH
- Patient roaming (access, regardless of the place of residence)

Health services utilization

Distribution of visits at the three levels of care



Distribution of visits at primary level



Payment of service providers

- All facility payments are centrally made from RSSB Head Office
- Direct payment by RSSB to health facilities' accounts
- Co-payment by patients to health facilities: 200 RwF & 10%
- Invoices from health facilities to section or district branches
- Verification system process before any payment

Key changes in CBHI

- Legal personality: from 30 to 1 autonomous CBHI
- Information system for collection of premiums manual – automated
- Benefit provision: easy patient roaming
- Financial: centralized management
  - 1 pool for all contributions – not at section level
  - payment from RSSB Head Office – not by the District
- Co-payment: paid directly to the health facility, not to CBHI agent
- Timely payment to service providers – availability of quality services & medicines

Challenges

- Reaching the "lost to coverage": ± 9%
- Premium level increase
- CBHI System automation
- Review of Provider payment mechanism
- Alternative financing mechanisms

Perspectives

Technology-based management:

- Registration processes to be automated: membership management and collection of contributions
- Interface with key national services: NIDA, LODA (updates), ..
- Unique identifier: from birth to retirement
- Interface with Health facilities: EMR (Electronic Medical Records)
- Claims management
- Benefits package coverage: NCDs!

Mituweli

Ubwisungane mu Kwivuza