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**MINISTRY OF HEALTH
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Mutual Health Insurance Policy in Rwanda

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TABLE OF CONTENTS

PREFACE	3
1. INTRODUCTION	4
2. SITUATION OF MUTUAL HEALTH INSURANCE IN RWANDA	4
3. MUTUAL HEALTH INSURANCE POLICY	11
3.1. GENERAL OBJECTIVE	11
3.2. SPECIFIC OBJECTIVES	11
3.3. STRATEGIC ORIENTATIONS	11
4. ORGANIZATION AND MANAGEMENT OF MUTUAL HEALTH INSURANCE	12
4.1. TECHNICAL SUPPORT UNIT FOR MUTUAL HEALTH INSURANCE	111
4.2. INSURANCE PREMIUM	15
4.3. GRANT FROM MUTUAL HEALTH INSURANCE STRUCTURES	16
5. STRENGTHENING THE LEGAL AND REGULATORY FRAMEWORK	16
6. IMPROVING THE FUNDING OF MUTUAL HEALTH INSURANCE	17
7. STRENGTHENING THE FRAMEWORK FOR LOCAL PARTNERSHIPS	18
8. STRENGTHENING NATIONAL CAPACITIES	18
9. SHORT-TERM ACTION PLAN	18
9.1. MEDIUM-TERM EXPENDITURE PROGRAM	19
ANNEX 1: ROLE OF LOCAL ACTORS IN THE DEVELOPMENT OF MUTUAL HEALTH INSURANCE	21
ANNEX 2: ROLE OF PARTNERS IN SUPPORT FOR MUTUAL HEALTH INSURANCE	22
ANNEX 3: ORGANIZATIONAL STRUCTURE OF MUTUAL HEALTH INSURANCE	23
ANNEX 4: DETAILS OF THE TRIENNIAL BUDGET (2005-2007) OF THE PROGRAM FOR DEVELOPMENT OF MUTUAL HEALTH INSURANCE	24

PREFACE

One of the major problems facing the health system in Rwanda is how to reconcile, *within a context of poverty*, the objective of improving financial accessibility to health care and equity in the health system on the one hand, and the need to mobilize domestic resources for improving the financial viability of health services on the other hand.

Alternative mechanisms for community funding based on anticipated payment and risk pooling, such as mutual health insurance initiated in Rwanda in 1999, have demonstrated their considerable potential to reconcile the two objectives.

The present policy for developing mutual health insurance was elaborated by the Government of Rwanda with a view to centralizing the potential and especially meeting the increasing social demand for the extension of mutual health insurance.

In fact, establishing mutual health insurance across the country will ensure that the population of Rwanda, particularly those in rural communities and the informal sector have equitable access to quality services. Mutual health insurance are therefore intended to complete existing social and private health systems.

The present document develops the vision and strategic orientations underlying the national policy for development of mutual health insurance in Rwanda.

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1. INTRODUCTION

Since the reintroduction of the direct payment system in Rwanda in 1996, data from the Health Information System (HIS) show that households are increasingly finding it difficult to meet their health care costs. In fact, the average rate of utilization of modern health services is 0.28 new cases per inhabitant per year (representing 50% of the WHO standard of 1 new case per inhabitant per year in urban areas and 0.5 to 0.6 new cases per inhabitant per year in rural areas in development countries).

One of the most frequent reasons for the non-utilization and failure to meet health services is the high cost of health care. Indeed, financial barriers to access to care result in different forms of exclusion, including total exclusion or poverty, seasonal exclusion, temporary exclusion and partial exclusion. The risks of total exclusion or poverty are higher among the extremely poor population. The risks of seasonal temporary an partial exclusion are higher among population groups living on low and irregular income, the majority of whom are in the rural areas.

Policy options for dealing with low financial accessibility to health care are however limited. The alternate mechanisms for community funding, based on anticipated payment and risk pooling such as mutual health insurance, have proved to be strong options for reconciling the improvement of financial accessibility to health care and the need to mobilize domestic resources to enhance the financial viability of health services.

One of these options is the mutual health insurance system, which not only allows the population to receive health care on time and in case of need, but also constitutes a poverty reduction strategy. The policy for development of mutual health insurance is intended to enhance the social potential of mutual health insurance so that the majority of the population of Rwanda could benefit from it.

2. SITUATION OF MUTUAL HEALTH INSURANCE IN RWANDA

2.1. BACKGROUND

In Rwanda, it was in the 1960s that community-based health insurance systems, like the *association Muvandimwe de Kibungo* (1966) and the *association Umubano mubantu de Butare* (1975) started to be constituted. However, these community-based health insurance initiatives were further developed only since the reintroduction of the payment policy in 1996.

The development of community-based health insurance initiatives in the form of modern mutual health insurance has been on the increase during the past five years. In fact, the number of mutual health insurance increased from six (6) in 1998 to 76 in 2001 and 226 in November 2004. The geographical coverage of mutual health insurance was also extended: whereas initially in 1999, these mutual health insurance were mainly developed in the four provinces of the country, they have since August 2004, been established in virtually all the eleven provinces of the country, as well as in

the City Hall of Kigali. They cover about 2.101.034 people, representing 27% of the population of Rwanda.

This rapid increase in the number of mutual health insurance, and beneficiaries testifies undoubtedly to the affirmation of a community dynamics in the search for solutions to the problems of financial accessibility to health care and protection against financial risks associated with diseases.

The table below shows the level of mutual health insurance coverage per province, which increased significantly in 2004.

Coverage rates per province

Province	Number of mutual health insurance (per sphere of influence of health centres)	Target population	Beneficiaries	Rate of subscription
BUTARE	30	689.618	172.404	25%
BYUMBA	27	672.396	188.270	28 %
CYANGUGU	7	577.120	92.339	16%
GIKONGORO	3	465.242	41.871	9%
GISENYI	11	821.158	270.982	33%
GITARAMA	36	849847	382.431	45%
KIBUNGO	33	667.135	306.882	46 %
KIBUYE	5	445.565	71.300	16 %
KIGALI NGALI	37	749.863	202.463	27 %
KIGALI CITY	18	572.896	120.308	21 %
UMUTARA	8	400.541	40.054	10 %
RUHENGERI	11	810.745	202.686	25%
TOTAL	226	7.722.126	2.101.034	27%

2.2. BASIC CHARACTERISTICS

Mutual health insurance in Rwanda are autonomous organizations, administered freely by their members, in the respect of the principles of democracy and freedom. In fact, the members adopt, in a general assembly, the Constitution and By-laws defining the organizational structure, the roles and functions of the different management organs, elect members of the management organs, and define their tasks.

Mutual health insurance determine their benefit packages, annual premiums and periodicity of the subscriptions; they establish conventions on care and health services, service providers and reimbursement modalities, according to the terms of the contract. Besides, they sensitize the population and ensure the recruitment as well as development of customer loyalty among members, and collect membership contributions.

Mutual health insurance ensure the day-to-day management of the resources collected and maintain transparency and traceability of the different bank and cash operations.

2.2.1. CURRENT ORGANIZATION OF MUTUAL HEALTH INSURANCE

The organizational structure of mutual health insurance was adapted to the institutional framework put in place by the decentralization reforms. In fact, mutual health committees are set up at the unit, sector and district levels. Representation on all these mutual health organs is democratic, voluntary and acquired through elections.

At the unit level, the mutual health committee is composed of 4 members, namely a chairman, a vice-chairman, a secretary-treasurer and an auditor. The basic authorities, including the unit coordinator, the information officer and the elected member in charge of women's affairs play a support and counselling role for elected members of the mutual committee at the unit level. The committee performs the following tasks at the unit level: sensitization on subscription and re-subscription, conscientization on the principle of solidarity, identification of associations, identification of leaders, convocation of meetings of the general assembly, preparation of inventory of members and non-members, drafting of reports and collection of subscriptions.

At the sector level, the mutual health committee is composed of all the chairmen of the mutual health committees at the unit level, the unit coordinators and social affairs officers. Their tasks include: sensitization, monitoring and evaluation of the mutual health committees of the units, collaboration with the treasurer of the mutual health committee in the sphere of influence of the partner health centre.

At the level of the partner health centre, there is a management committee of the mutual health society composed of a chairman, a vice-chairman, a secretary-treasurer and an auditor, who are all elected. In addition, the chairman of the health committee and the holder act as advisers. The committee is responsible for collecting subscriptions, managing subscriptions, drafting reports and organizing general assemblies. The secretary-accountant is paid by the mutual health insurance society and ensures, on permanent basis, the day-to-day administrative and financial management of the mutual health society.

At the District level, there is a committee composed as follows: the Mayor, the focal point of the mutual health insurance society, heads of health centres, assistant mayors for social affairs, chairmen of mutual health committees of zones of influence of health centres, and civil society representatives.

At the health district level, there is a federation of mutual health role is to provide technical assistance to the different mutual health in the Districts and manage the contractual relationships with district hospitals.

2.2.2. SUBSCRIPTION POLICY

Most of the mutual health insurance in Rwanda use a policy of family subscription; and even when the insurance premium is individual, the family must register all the members. Concerning the insurance premium, there is vast disparity in the present operation of mutual health insurance. In fact, the premium per household of 2 - 7 members varies from Frw 2500 (Kabutare) to Frw 3500 (Byumba) or Frw 5000 (Gitarama) and Frw 11500 (Kigali City). For mutual health insurance that use a policy of individual subscription (per capita), it varies between Frw 600 (Kigali Ngali) to Frw 1000 (Kibungo).

The patient's contribution towards the cost of medical treatment, or contribution of the mutual health member at the time of using health services, also varies between Frw 100 Frw and Frw 150 per disease episode or between 5% and 25% of co-payment of the real cost of the care.

Health care and services covered by mutual health insurance comprise all services and drugs provided at the health centre (minimum package of activities "MPA")¹, but also a limited number of services at the hospital (complementary package of activities "CPA"²).

2.2.3. COVERAGE OF POOR PEOPLE AND VULNERABLE PERSONS

The pilot experiences of Byumba, Kabgayi and Kabutare have shown that even with the establishment of mutual health insurance some population groups still face financial constraints, denying them access to care. These groups may be excluded from health care because of their inability to pay the annual contributions to the mutual health insurance, simply as a result of stigmas associated with their risk profile.

¹ MPA: Minimum Package of Activities: care provided at health centers: Prenatal consultation, postnatal consultation, vaccination, family planning, nutritional service, curative consultations, nursing care, hospitalization, simple childbirth, essential and generic drugs, laboratory analyses, minor surgical operations, health information, education and communication, transportation of the patient to the district hospital.

² CPA: Complementary Package of Activities: care provided in district hospitals: consultation by a doctor, hospitalization in rooms, eutocic and distocic childbirth, caesarian operations, minor and major surgical operation, referred serious malaria, all diseases of children from 0 - 5 years, medical imaging, laboratory analyses, etc.

Some local initiatives of Districts and Non-Governmental Organizations (NGOs) take advantage of the establishment of mutual health insurance to mobilize public subsidies and grants from donors to enable vulnerable groups and poor people to subscribe to mutual health insurance.

2.2.4. MAJOR CHALLENGES

Mutual health insurance in Rwanda are confronted, in their development, with a number of organizational, technical and operational challenges.

At the organizational level:

- The voluntary nature of subscription to mutual insurance is the reason for the low level of subscription by the population. In the final analysis, only people who frequently fall sick subscribe to mutual health insurance, resulting in an adverse selection that handicaps the financial viability of mutual health insurance.
- Health care and services covered by mutual health insurance are inclusive only at the level of health centres, while care and services provided in hospitals are partial and often do not cover major risks like surgery.
- Premiums are fixed, not according to the real costs of care, but rather the contributing capacity of the population.
- Lack of a specific legal framework for mutual health insurance, guaranteeing their moral and legal status, their independence and autonomy.

At the technical and operational level:

- Over-utilization of the services by subscribers who hastily solicit health care services.
- Non-coverage of health care costs by partner health facilities due, on the one hand, to the low level of contributions and inadequate number of subscribers, and, on the other hand, the low level of risk sharing between sick people and healthy people.
- Abusive prescription of drugs by some health facilities.
- Poor quality of the care provided in some health facilities.
- Over-invoicing of mutual health insurance by some health facilities.
- Low management capacities of some mutual health committees.
- Benevolent nature of membership of mutual health committees.
- Lack of grants to mutual health insurance, in general and, particularly, for bearing the cost of treatment in hospitals.

2.2.5. OPPORTUNITIES

The development of mutual health insurance enjoys a favourable institutional environment. In fact, this development is in line with the framework of the Government's Vision 2020, in accordance with the health sector policy and Poverty Reduction Strategy Policy (PRSP). Besides, the health sector policy acknowledges the commitment of political leaders in mobilizing the population to combat diseases and subscribe to health insurance, as a major asset that could contribute to the improvement of the health status of the population.

Moreover, the rapid development of mutual health insurance benefited from the following dynamic factors:

- The pilot phase of the mutual health insurance initiated by the Government in 1999, with the establishment of health care pre-payment systems in Byumba, Kabgayi and Kabutare health districts, indeed serves as a platform for strengthening and extending mutual health insurance systems in Rwanda.
- Since then, a cumulative learning process has been initiated throughout the country, supported by training workshops, forums for exchange of experiences and evaluation, as well as inter and intra-province study tours.
- The diversity of local experiences from which deliberate strategies for promoting mutual health insurance are elaborated.
- The strengthening of institutional capacities for the establishment and monitoring of mutual health insurance through:
 - (i) the elaboration of the trainers' manual on the establishment, management and monitoring of mutual health insurance
 - (ii) the elaboration of sensitization modules, pamphlets and other teaching materials
 - (iii) the preparation of standard mutual health insurance management tools
 - (iv) the training of a core of national trainers on mutual health insurance
- Emergence of innovative strategies for strengthening existing mutual health insurance and establishing new ones, such as involvement of local authorities in the mobilization and sensitization of the population.

Indeed, the experiences of Bungwe District adequately testify to the essential role played by the District authorities in strengthening the Bungwe, Manyagiro and Kikuyu mutual health insurance. (See box in annex 1).

The emergence of innovative strategies for strengthening existing mutual health insurance and establishing new ones is also observed through the development of local partnerships, not only with decentralized financial institutions - including the *banques populaires* - to improve the financial capacities of the population to subscribe to mutual health insurance, but also with civil society organizations and NGOs for the coverage of poor people and other vulnerable persons (see box in annex 2)

3. MUTUAL HEALTH INSURANCE POLICY

The present state of extension and globalization of mutual health insurance in Rwanda calls for the establishment of a policy to support their development.

3.1. GENERAL OBJECTIVE

The general objective of the policy is to assist grassroots communities and Districts to establish health insurance systems that will promote improvement of their financial accessibility to health care, protection of households against financial risks associated with diseases and strengthening of social inclusion in health.

To complement the social insurance systems, such as the *Rwandaise d'Assurance Maladie* (RAMA) and private insurance systems that target population groups in the formal sector of the economy, the mutual health insurance policy will be targeted at rural communities and the informal sector in order to ensure their equitable access to quality health services.

3.2. SPECIFIC OBJECTIVES

The policy aims at attaining the following specific objectives:

- To create a favourable environment for the development of mutual health insurance in Rwanda.
- To strengthen the capacities for establishing and managing mutual health insurance.
- To strengthen the subscription of the population to mutual health insurance.

3.3. STRATEGIC ORIENTATIONS

Five intervention orientations will strengthen the process of implantation, extension and monitoring of mutual health insurance in the country. They concern notably:

- Establishment of a technical unit, in charge of the day-to-day management and monitoring of mutual health insurance.
- Strengthening of the legal and regulatory framework of mutual health insurance.
- Improvement of the funding mechanisms of mutual health insurance.
- Strengthening of frameworks for partnerships with mutual health insurance.
- Strengthening of national and provincial capacities in the area of mutual benefit systems.

4. ORGANIZATION AND MANAGEMENT OF MUTUAL HEALTH INSURANCE

4.1. TECHNICAL SUPPORT UNIT FOR MUTUAL HEALTH INSURANCE

The technical support unit for mutual health insurance will have a Board, whose members will be appointed from the following institutions: a representative from the Ministry of Health, a representative from the Ministry of Local Administration, Community Development and Social Affairs, a representative from the Ministry of Finance and Economic Planning, (Department in charge of poverty reduction), a representative from the *Union des Banques Populaires*, a representative of Prefects, a representative of District Mayors, towns and municipalities, a representative from Kigali City Council, a representative from BUFMAR, a representative from RAMA .

The role of the technical unit is to offer support for the development of mutual health insurance by contributing to the elaboration of strategies, formulation of policies, monitoring and evaluation of mutual health insurance. In fact, apart from the elaboration of the legal and regulatory framework of mutual health insurance, the technical unit is responsible for the development, updating and dissemination of (management, monitoring, training) tools. It ensures the conduct of studies, research-action activities, dissemination of results, as well as identification, documentation, and dissemination of best practices. Finally, it is also responsible for the training and sensitization of the actors in the provinces and Districts.

The technical unit will be composed of 4 persons, including a public health expert, an expert in health economy, a jurist and an expert in monitoring and evaluation.

The technical unit will work with community mutual benefit structures, the Districts and provinces in implementing the program.

4.1.1. Role of the Provinces

The role of the provinces is to provide technical support to the Districts in the establishment and monitoring of mutual health insurance and coordination of program activities at the provincial level. In this regard, the province assists the Districts to define the priorities, programming and identification of sources of funding. It coordinates the training and counselling support activities. It provides support to the provincial federations of mutual health insurance. It facilitates the sharing of information and best practices as well as development of partnerships between mutual health insurance societies and health prevention and promotion programs in the province. In collaboration with the Districts and non-governmental organizations, it provides necessary support for care and treatment of poor population groups.

The province plays its role through an agent specifically in charge of mutual health issues, including the following tasks:

- Coordinating and organizing sensitization campaigns on mutual health insurance in the province;
- Coordinating and organizing training on mutual health insurance in the province;
- Coordinating and organizing the supervision of mutual health insurance in the province;
- Coordinating and organizing audits of mutual health insurance;
- Organizing mutual health insurance into a federation;
- Coordinating the development of action plans of mutual health insurance;
- Developing a databank on mutual health insurance in the province;
- Evaluating mutual health insurance in the province;
- Coordinating and organizing trips for exchange of inter-mutual experiences;
- Analysing and making recommendations on reports on the functioning of mutual health insurance in the province.

4.1.2. Roles of Districts, Towns and Municipalities

The District is responsible for facilitating the development of mutual health insurance in the entire district. It supports the initiation of mutual health insurance, activities of sensitization, establishment and monitoring of mutual health insurance. It supports the formation of federative mutual health structures in the District and development of partnerships between mutual health structures, *banques populaires* and associations, and involvement of mutual health structures in priority health programs. In collaboration with the provinces and non-governmental organizations, it supports care and treatment of poor population groups. The District ensures the regulation of mutual health insurance at the local level, including audits. It plays the role of arbitrator for contractual relations between the mutual health insurance and health care providers within the District.

At the level of Districts, towns and municipalities, it is the vice-mayor for social affairs who will be charged with the support and monitoring of mutual health insurance.

His main tasks are as follows:

- Coordinating and organizing sensitization campaigns and training courses on mutual health insurance ;
- Coordinating and organizing the supervision of mutual health insurance;
- Coordinating and organizing the auditing of mutual health insurance;
- Organizing mutual health insurance societies into a federation;
- Supporting the development of action plans of mutual health insurance;
- Developing a databank on mutual health insurance;
- Evaluating mutual health insurance;

- Coordinating and organizing trips for exchange of inter-mutual experiences;
- Analysing and making recommendations on reports about the functioning of mutual benefit structures.

4.1.3. Role of community mutual benefit structures

Mutual health insurance, as community structures, are characterized by a democratic and voluntary participation of members in the representative organs and the day-to-day management. These organs are found at five main levels (see **annex 3**):

4.1.3.1 Committee of the mutual health insurance in units and sectors

At the level of the units and sectors, there are mutual initiative committees (CIM), whose members are elected by members of the mutual health insurance.

The mutual initiative committee is notably in charge of:

- organizing sensitization campaigns among the population and recruiting new members;
- validating the number of dependents of members;
- participating in the collection and recovery of membership contributions.

4.1.3.2. Management committee of the mutual health insurance at the health centre

The mutual health insurance at the health centre is managed by a management committee whose members are elected by delegates of the mutual initiative committees (CIM). In addition to administrative and financial duties, the management committee is in charge of:

- sensitizing the population to subscribe to mutual health insurance;
- supervising the mutual initiative committees in the units and sectors;
- controlling costs of health care services;
- validating membership cards;
- holding consultations with partners.

4.1.3. 3. Union of mutual insurance in the Districts, Towns and Municipalities.

The different mutual health insurance at the health centres of a given District are grouped into a union of mutual health structures to facilitate coordination of the sensitization and ensure efficient monitoring in the Districts, Towns and Municipalities. The operating budget would partly come from the districts, towns and municipalities and partly from the mutual health insurance structures at the rate of 2, 5 % of the total amount of the annual premiums.

4.1.3. 4. Federation of mutual health insurance structures in the provinces and Kigali City Council.

The different mutual health unions of the different Districts in a given province are grouped into a provincial federation.

The role of the federation is to provide technical assistance to the different mutual insurance unions and manage the contractual relations with district hospitals. The budget of the federation comes from contributions from mutual insurance structures of health centres at the rate of 2.5 % of the total amount of annual premiums, from the budget of the province, and the actors.

4.1.3. 5. National confederation of mutual health insurance.

Provincial federations of mutual health insurance form a confederation at the national level. It is a forum for exchange of experiences and formation of consensus at the level of mutual health insurance policies. The operating budget would be financed with funds from public subsidies and actors. Pending the establishment of a reinsurance mechanism that can only be done over time, the national confederation should also play a technical role of levelling disease risk at the national level. To that end, a 5% contribution from the total amount of contributions collected by mutual health structures in all areas of influence or Districts will be deposited in a “reserve fund or disease risk levelling fund” account and will be used to assist mutual health insurance structures facing financial difficulties for sound and justified reasons.

4.2. INSURANCE PREMIUM

Statistics of the National Information System (NIS) in 2003 show that the average cost per new case of disease at the level of the health centre was Frw 1.188 per annum. Of the 8.128.553 inhabitants of Rwanda, the target population for mutual health insurance is estimated at 7.722.126 inhabitants (excluding the population in the formal sector, estimated at 5% of the total population). Moreover, the national standard of using modern health services is 75%. Hence, the number of persons expected to report each at the health centres would be close to 5.791.579 inhabitants. Providing health care and services to all these inhabitants would require an amount of $(5791594 * \text{Frw } 1188)$ Frw: 6.880.413.672.

Based on these figures, the annual premium of the mutual health insurance per inhabitant at the level of the health centre would be Frw 891 $(6.880.413.672/7.722.126)$, rounded off to Frw 1000.

In hospitals, the average cost of hospitalization for 8 days was Frw 9017 in 2003. Since the discount rate of hospitalization risk determined by the Ministry of Health is 9%, the number of persons expected at the hospitals would be $(7.722.126 * 9\%)$ 694991 persons. The corresponding cost of caring for them would amount to $(694.991 * \text{Frw } 9017)$ =6.266.733.847

At the hospital, the premium per person should be (Frw 6.266.733.847/7.722.126 persons) Frw 811, rounded off to Frw 1.000.

Hence, the annual premium per inhabitant, including primary health care at health centres (PMA) and care at the secondary level of hospitals (PCA) should be Frw 2.000.

4.3. GRANT FROM MUTUAL HEALTH INSURANCE STRUCTURES

As part of the support to the process of developing mutual health insurance and in order to ensure their smooth functioning, but also in the concern to provide the majority of the Rwandan population with modern health services in a sustainable and continuous manner, the Government of Rwanda should – given the low contributing capacity of the population of Rwanda (60% of the population of Rwanda lives below the poverty belt) and per capita GDP is USD 280 – compensate for the contribution per inhabitant in order to facilitate access to a more inclusive package at health centres in hospitals. Based on the current rate of hospitalization risk, this subsidy would be (Frw 1.000*694991) Frw 694.991.000 to assist members of mutual insurance to have access to the inclusive package of care both at health centres and in hospitals. Indeed, given the low financial capacities of the population, the latter cannot pay the basic premium of Frw 1.000 at the level of the health centres.

5. STRENGTHENING THE LEGAL AND REGULATORY FRAMEWORK

Codification of the mutual insurance system in Rwanda dates back to the colonial period under the Decree of 15 April 1958 on mutual help associations. The advantage of this legal framework is the fact that it exists. However, this legal tool has some disadvantages, including lack of specificity in relation to mutual health insurance systems, failure to adapt to the regulatory provisions, lack of anticipation of the federative dynamics of the mutual system, and lack of requisite conditions for establishing mutual help schemes. Finally, the Decree of 15 April 1958 is too general and covers mutual insurance associations as diverse as health associations, accident associations, associations of disabled persons, death associations, social security associations, education associations, and other associations.

The action plan envisaged in the context of the policy is to review the existing legislation and make it more specific to the health insurance and mutual health insurance systems, under a law or presidential order, which would be completed by ministerial implementation orders.

The new provision should elaborate the organization of mutual health insurance societies, the conditions of membership, the administrative and executive organs, the resources and control mechanisms to ensure transparency, the conditions of approval and tax advantages. Finally, the legal and regulatory framework should anticipate on the creation of mutual insurance federations and confederations to facilitate the establishment of self-supervision structures in the context of the mutual help movement in the country.

To that end, the following activities will be carried out:

- Organizing consultative meetings with stakeholders of schemes covered by the 1958 Decree and other existing texts,
- Establishing a technical committee on revision of the legal framework,
- Organizing consultative meetings with existing mutual health insurance structures,
- Elaborating draft legal and regulatory texts,
- Training stakeholders on the legal and regulatory scheme adopted,
- Supporting promoters of mutual health insurance in the elaboration of the constitutions and by-laws of mutual health insurance structures.

6. IMPROVING THE FUNDING OF MUTUAL HEALTH INSURANCE

Funding for mutual health insurance mainly comes from membership contributions. In fact, the population is capable of financing the cost of basic health care and services provided at health centres, at the rate of Frw 1000 per inhabitant per annum. The above estimates showed that annually, with sustained mobilization, the population could mobilize for health care – in the context of mutual health insurance - Frw 6.117.700.800 by 2007.

To facilitate the mobilization of contributions and enhance the premium-paying capacity of the population, a new strategy for granting “mutual health insurance credit funds” by the *banques populaires* was promoted and has proved to be efficient in facilitating subscription and increasing membership of mutual health insurance.

However, there is a problem of access to care at the secondary level. In fact, in the present state of the premium-payment capacity of the population of Rwanda, it is essential that second level health care be subsidized through national solidarity mechanisms and external sources from either donors or international cooperation agencies supporting the health sector in Rwanda.

Concerning potential sources of co-financing of contributions towards health care in district hospitals, a mechanism of national solidarity between the public and formal private paid sectors and the rural world should be put in place. The *fonds des rescapés du génocide* (FARG) mobilizes approximately Frw 348.000.000 per annum. Hence, 2% should be deducted every month from the salary of each public and private sector employee. This will help to mobilize Frw 696.000.000/annum, which is approximately the amount required as a grant for mutual health insurance.

However, considering that workers are already making other contributions (*Caisse Sociale*, RAMA, FARG ...), and given the fact that the recovery by FARG is not total, especially at the level of development projects, and that there is the possibility of an intervention on this dimension by the actors, the solidarity of employees with the rural population must be 1% of the monthly deductions on gross salaries of workers.

7. STRENGTHENING THE FRAMEWORK FOR LOCAL PARTNERSHIPS

Based on inter-sectoral and proximity principles of coordination underlying the program, the activities around this area of intervention facilitate partnerships among existing mutual health insurance structures, and partnerships among mutual health insurance structures and community-based health care organizations, community-based organizations, the *banques populaires* and micro-credit enterprises at the local level.

Indeed, the networking of mutual help structures and their federations will ensure efficient distribution of disease risk over a wider population. The intensification of partnerships between mutual health insurance structures and health care organizations will help to improve aspects relating to the quality of care to be provided to members of mutual health insurance, the rational use of care services, price fixing and billing for health care and services, which are all vital elements for perpetuating mutual insurance experiences. Finally, the intensification and monitoring of the partnership with decentralized financial institutions like the *Banque Populaire* will help to enhance the sustainability of this partnership, while avoiding accumulation of outstanding payments in repayment of loans granted to pre-finance membership contributions, but also by institutionalizing this approach, which makes it so easy for the population to join mutual health insurance.

8. STRENGTHENING NATIONAL CAPACITIES

The learning process of the mutual help system initiated in the country will be accelerated and deepened under the program in order to facilitate the accumulation of a vast database and reach a consensus on policy measures, decision-making and evaluation in the context of the development of mutual health insurance. The human resource base will be enlarged in order to strengthen the capacities for implementation, management and monitoring of mutual health insurance.

9. SHORT-TERM ACTION PLAN

During the next three years, the policy will focus on four priority areas of action: (i) developing mutual health insurance, (ii) putting in place the legal and institutional frameworks, (iii) strengthening the funding capacities and (iv) producing and disseminating information to support capitalization of experiences and deepening of the mutual benefit insurance system.

It will consist in supporting, through the development of mutual benefit health insurance, improving existing mutual health insurance systems and extending the schemes to the districts and provinces.

A core of trainers charged with the establishment, management and monitoring of mutual health insurance will be established in each province, in order to support the training and proximity counselling activities of the Districts and mutual health

insurance structures. These activities will also be strengthened through inter and intra-province study tours.

An information and monitoring system for mutual health insurance will be developed right from the first year. It will be completed with documentation of best practices on care and support for the poor, partnerships among mutual health systems, associations and micro-credit, and involvement of mutual health insurance in interventions aimed at combating diseases. Studies will be conducted to support the conception and strengthening of mutual health insurance structures, co-financing of the extension of the benefits package by the State and households. This database will be used in the exchange of experiences, organization of the first national forum on mutual benefit structures and orientation of activities for deepening mutual benefit insurance in the long term.

The annual action plans of the Districts, provinces and the central level, integrating the four priority areas, will be prepared during the next three years. The identification of specific priorities will be done and the executive organ will ensure the conduct of the planning and coordination process, in conformity with the elaboration of the medium-term expenditure framework of the health sector.

9.1. Medium-term expenditure program

The programming of the medium-term expenditure focused on estimation of the resources required to facilitate the establishment of mutual health insurance structures in all Districts of the country, training of local actors on establishment of mutual health insurance, equipping mutual health insurance structures with management tools, training members of the management organs of these structures and monitoring mutual health insurance, and counselling support activities.

The activities aimed facilitating the strengthening and extension of mutual health insurance at the local level are supported upstream through the establishment and equipment of the program with human and material resources at national and provincial levels.

Indeed, this triennial program (2005-2007) will make it possible to accompany the development and establishment of mutual health insurance structures countrywide for the benefit of the majority of the population of Rwanda. It is obvious that at the end of these three years, not only will the mutual health insurance structures have increased their own funding resources through massive subscription by the population (60 - 80%), but also the contributions could be eventually increased to ensure partial and gradual coverage of second level health costs, given the improvement in the living conditions of the population, with the introduction of the PRSP.

The medium-term estimates on expenditure to support the strengthening and extension of mutual health insurance to all the 106 towns and districts of the country are summarized in the table below.

Table1: Programme of Medium-term Expenditure 2005-2007 in Rwandan Francs

ITEM	Source of Funding	2005	%	2006	%	2007	%
Functioning of support unit and provincial branches	Ordinary budget	133.220.000	3%	78.065.200	1%	80.668.756	1%
Purchase of management tools	Ordinary budget + Projects	164.318.000	3%	123.238.500	2%	82.159.000	1%
Support for the functioning Training, supervision, sensitization, Documentation Exchange of experiences	Projects	159.432.000	3%	152.297.800	2%	78.189.574	1%
Contributions from the population	Members	3.861.063.000	77%	5.405.488.200	84%	6.117.700.800	87%
Grant from mutual health insurance structures for access to hospital care	National solidarity Formal sector and rural world + projects	694.991.000	14%	694.991.000	11%	694.991.000	10%
TOTAL		5.013.012.012		6.454.064.716		7.053.091.148	

The estimation of the financial contribution from the population was based on a subscription of 50% of the population in 2005, 70% in 2006 and 80% in 2007.

ANNEX 1: Role of local actors in the development of mutual health insurance

Bungwe District/Byumba Province

Three mutual health insurance structures were established in Bungwe District in the framework of the establishment of pilot experiences in 1999: mutual health insurance structures of Bungwe, Kivuye and Manyagi. At the end of the first pilot year (June 2000), Bungwe mutual health insurance had 8.710 members, while those of Kivuye and Manyagi had 1.160 members and 2.360 members respectively. Like the mutual health insurance structures of Byumba health district, the three structures experienced significant loss of membership and low level of subscriptions during the second semester of 2000 and the first semester of 2001.

These trends were not unique to mutual health insurance structures of Bungwe District; they were also observed in several mutual health insurance structures of the health district. They motivated the initiation of surveys by Byumba health district to ensure better understanding of the factors associated with the decline in participation. Several problems were identified as part of the factors contributing to the loss of membership and decline in the number of subscriptions, notably: limited quality of health services, perception of sudden establishment of mutual health insurance structures, low level of appropriation by the administrative authorities who perceived mutual health insurance schemes as yet another purely medical and health program, impoverishment of the population and difficulties associated with the collection of contributions. To resolve these problems, several strategies were elaborated, including the Bungwe District initiative under the leadership of the District Mayor.

The initiative created these institutional bridges between mutual health insurance structures, the *banque populaire* and constituted associations, of which the Mayor of Bungwe District offered to personally ensure the monitoring. Households of the units and sectors are motivated to form associations recognized by Bungwe District; a contract is signed between recognized associations and the *banque populaire* of Bungwe District to finance the contribution from members of each association in mutual health insurance, thereby enabling members of associations to subscribe as a group, to enjoy coverage by the mutual health insurance without a waiting period, and to reimburse the loan granted by the bank on the basis of monthly deductions under relatively soft terms.

Since the introduction of this initiative in Bungwe District in October-November 2001, subscription to Bungwe mutual health insurance increased from 7.120 members at the end of September 2001, to 11.640 at the end of December 2001, to 16.020 at the end of December 2002 and to 19.722 at the end of December 2003. At the level of Kivuye mutual health insurance, the number of members increased from 940 at the end of September 2001, to 3.390 at the end of December 2001, to 3730 at the end of December 2002, and to 5.046 at the end of December 2003. Finally, at the Manyagi mutual health insurance society, the number of members increased from 1.140 at the end of September 2001, to 4.550 at the end of December 2001, to 2950 at the end of December 2002, and to 6.327 at the end of December 2003.

The Bungwe local partnership is based on the mutual benefits each of the stakeholders derives from it. It facilitates access of households to the benefits of mutual health insurance and the credit from the *banque populaire*. It contributes to increase the pool of members and the financial capacity of the mutual health insurance. It strengthens the financial intermediation capacities of the *banque populaire* through the deepening of networks of community-based associations with which it maintains continuing contractual relations. Finally, it is beneficial to the District through the deepening of the local associative movement based on mutual help and solidarity values.

ANNEX 2: Role of partners in support for mutual health insurance

Initiatives on coverage of vulnerable groups in mutual health insurance

Catering for orphans. Many organizations are providing aid to orphans, including the offer of health care and treatment. The mechanisms put in place by the mutual benefit structures enable these organizations to pay for the subscription of orphans and their adoptive family to cover health care costs. Hence, Food for Hungry International (FHI) managed to cater for 400 families that have adopted orphans in Kivumu mutual health insurance in Kabgayi health district. Similarly, at the level of Rilima mutual health insurance in Bugesera health district, World Vision caters for 700 orphans by paying their subscription to the mutual health insurance scheme; another NGO, a member of Compassion, is also participating in catering for the coverage of orphans through the same scheme.

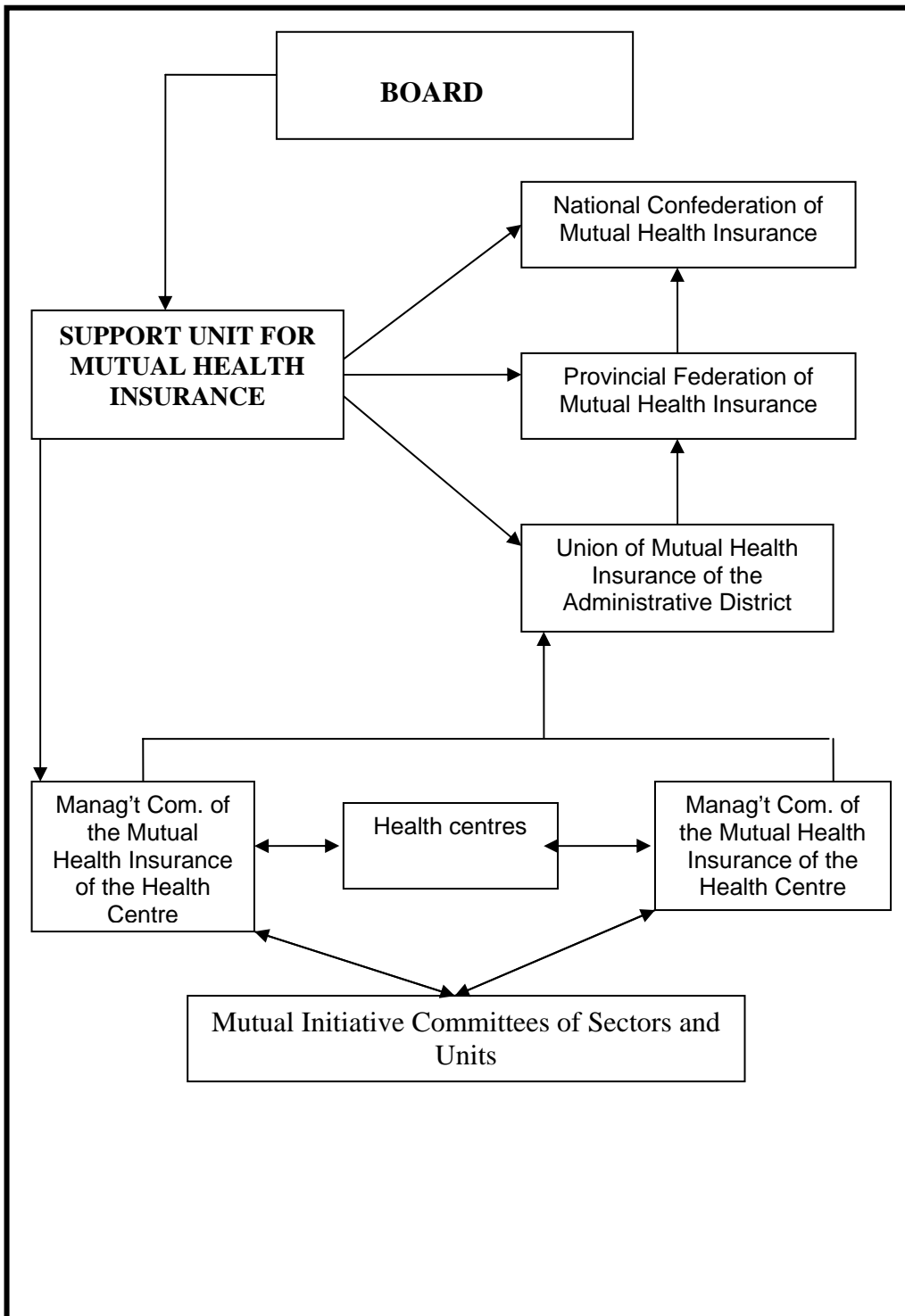
Catering for poor people. The NGO Caritas became famous very early in catering for poor people through subscription to mutual health insurance. In the mutual health insurance of Save, in Kabutare district, Caritas has been catering for poor people since 2001. It also caters for the poor in parishes in Kivumu mutual health insurance in Kabgayi health district. At the level of Rilima mutual health insurance in Bugesera health district, Caritas is catering for 613 poor people, including 363 for whom Caritas has covered their entire contribution; for the remaining 250 poor persons, the NGO pays part of the subscription based on a matching rate of 50%-50%, whereby the beneficiary contributes half of the annual premium and the NGO, the other half. Finally, in the Nyamata mutual health insurance in Bugesera health district, Nyamata Solidariti, an Italian benevolent organization pays the subscriptions of poor persons in the Gakurazo, Nyamata, Mayange and Mwogo health centres.

People living with HIV. Save and Matyazo mutual health insurance are examples where the subscription of associations of PLWHA was facilitated by getting the religious congregations supporting them to pay their premium for two years. At Matyazo mutual health insurance, two associations with a total of 282 members are covered by the scheme.

Officials of the health centres report that PLWHA have high level of care consumption and declare their status to ensure that they receive adequate care and support. Fear of stigmatization of PLWHA in these two mutual benefit societies are allayed by the fact that only the nursing staff are aware of their status, which they keep to themselves by virtue of the confidentiality of patient-nursing staff relationship.

The offices of the two mutual benefit societies are quite aware of the subscription of PLWHA, but have accepted them. In fact, as a result of the reimbursement of care provided by the health centres through poll tax, over-consumption of care by PLWHA is absorbed by the health centre, to the extent that in the medium term the subscription of PLWHA has no financial impact on the mutualists. In the long term, however, tension could arise from the subscription of PLWHA to mutual benefit societies if the health centres received no grants to absorb the care of PLWHA and tended to pass on the extra cost of providing care and treatment to PLWHA to all the mutualists through readjustments of the premiums or co-payments.

ANNEX 3: ORGANIZATIONAL STRUCTURE OF MUTUAL HEALTH INSURANCE



ANNEX 4: DETAILS OF THE TRIENNIAL BUDGET (2005-2007)

Year	2005	2006	2007	Total
A. TECHNICAL SUPPORT FOR MUTUAL HEALTH INSURANCE				
I. Investment				
Rolling stock	30.000.000			
Office furniture	12.600.000			
Computer hardware	7.500.000			
Reproduction equipment	5.600.000			
Projection materials	2.000.000			
Sub-total Investment	57.700.000			57.700.000
II. Personnel				
One Public Health Expert	4.800.000	4.944.000	5.092.320	
One Health Economist	4.800.000	4.944.000	5.092.320	
One Monitoring and evaluation Expert	4.800.000	4.944.000	5.092.320	
One Jurist	4.800.000	4.944.000	5.092.320	
One Secretary – Accountant	3.000.000	3.090.000	3.182.700	
2 Drivers	2.880.000	3.009.600	3.143.088	
Sub-total Personnel	25.080.000	25.875.600	26.695.068	77.650.668
III. Goods and services				
Electricity	3.600.000	3.708.000	3.819.40	
Maintenance of vehicles and insurance	12.000.000	12.360.000	12.730.800	
Maintenance of computer hardware	800.000	824.000	848.720	
Maintenance of reproduction equipment	200.000	206.000	212.180	
Communication	840.000	865.200	891.156	
Office Supplies	9.000.000	9.270.000	9.548.100	
Fuel	11.880.000	12.236.400	12.603.492	
Sub-total Goods and Services	38.320.000	39.469.600	40.653.688	118.443.288
Total A	121.100.000	65.345.200	67.348.756	253.793.956
B. PROVINCIAL COORDINATION				
Year	2005	2006	2007	Total
I. INVESTMENT				
Motorcycles (12)	15.000.000			15.000.000
II. FUNCTIONING				
Maintenance of motorcycles	2.400.000	3.000.000	3.600.000	
Fuel	9.720.000	9.720.000	9.720.000	
Total Provincial Coordination B	12.120.000	12.720.000	13.320.000	38.160.000
Total A+B	133.220.000	78.065.200	80.668.756	291.953.956

C. Strengthening the operational capacities of mutual health insurance.

Management tools for mutual health insurance	164.318.000	123.238.500	82.159.000	369.715.500
Training on management and monitoring of mutual health insurance	32.000.000	24.000.000	24.000.000	80.000.000
Sensitization on mutual health insurance	75.000.000	75.000.000	75.000.000	150.000.000
Documentation and dissemination of best practices	10.000.000	10.000.000	10.000.000	30.000.000
Inter and intra-provincial study tours	13.572.000	13.572.000	13.572.000	40.716.000
Counselling support for mutual health insurance	28.860.000	29.725.800	30.617.574	89.203.374
S/Total C	323.750.000	275.536.300	160.348.574	759.634.874
Support for access to hospital care: grants from mutual health insurance	694.989.000	694.989.000	694.989.000	2.084.967.000
Total A+B+C+grant	1.018.739.000	970.525.300	855.337.574	2.844.601.874