Universal health coverage in Rwanda: a report of innovations to increase enrolment in community-based health insurance

Andrew Makaka, Sarah Breen, Agnes Binagwaho

Abstract

Background Rwanda's community-based health insurance programme (Mutuelle de Santé) has been the focus of several large studies and much debate in global health policy. Comprehensive insurance reform enacted in mid-2011 transformed Mutuelle de Santé to a system of tiered premiums to make it more financially progressive and sustainable. Many governments in sub-Saharan Africa and south Asia have studied Rwanda's approach, particularly mechanisms to achieve high coverage, which exceeded 90% by 2010. We assessed the effect of different community-based initiatives on Rwanda's progress towards universal health-care coverage and increased use of health services.

Methods We reviewed Rwandan interventions developed for villages that have enabled the scale-up of Mutuelle de Santé. We reviewed data from the Ubudehe database (proportion of people in each wealth category across districts), the Community Based Health Insurance database (coverage across districts), the preliminary National Health Accounts 2009–10 (out-of-pocket spending as a proportion of total health expenditure), and the Demographic and Health Survey 2010 (contacts per year and out-of-pocket spending).

Findings Over the first decade, national Mutuelle de Santé covered more than 90% of the population, has reduced out-of-pocket spending for health from 28% to 12% of total health expenditure, and increased service use to 1·8 contacts per year. A wealth categorisation programme (Ubudehe) was originally developed as a basic community target scheme, and modified after the 1994 genocide to enrol the most vulnerable citizens into national social protection programmes. It was then adapted to enable communities to assess the socioeconomic status of each citizen to provide a more progressive tiered premium collection system that includes full subsidies for members of the two poorest sub-categories. Ubudehe ratings account for income, household assets, and ability to work and each person is assessed collectively by the members of their village. Additionally, local leaders and 45 000 community health-care workers were incentivised to support individual enrolment in Mutuelle de Santé by inclusion of district coverage levels as a key indicator in their performance-based financing scheme. Finally, a household cooperative savings mechanism (Ibimina), which was developed by one rural district, has spread throughout Rwanda, with several districts reporting that up to 40% of premiums are being fully pre-paid 3 months before the start of the next financial year. Districts that use Ibimina have reduced administrative costs for Mutuelle de Santé programme management, and increased participation in decision making by village residents.

Interpretation As universal health coverage becomes a global health priority, countries should learn from community-level interventions to break down both financial and geographical barriers to access.

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Ministry of Health of the Republic of Rwanda, Kigali, Rwanda (A Makaka BA, A Binagwaho MD, S Breen MSc); **Overseas Development Institute, London, UK** (S Breen); **and Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA, USA** (A Binagwaho)

Correspondence to: Andrew Makaka, Ministry of Health, PO Box 84, Kigali, Republic of Rwanda
makaka.andrew@gmail.com

Contributors

AK developed the concept for the study and analysed and interpreted data. SB wrote and revised the report. AB provided guidance and edited the report.

Conflicts of interest

We declare that we have no conflicts of interest.