REPUBLIC OF RWANDA

MNISTRY OF HEALTH
PO.Box 84 KIGALI

RWANDA COMMUNITY BASED HEALTH INSURANCE POLICY

Kigali, April 2010

Abbreviations

ART	Antiretroviral Therapy
CBHI	Community Based Health Insurance
CPA	Complementary Package of Activities
CMA	Minimum Package of Activities
CS/HC	Centre de Santé/Health Centre
DHS	Demographic and Health Survey
DP	Development Partners
DH	District Hospital
EICV	Integrated living conditions survey
EDPRS	Economic Development and poverty Reduction Strategy
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoR	Government of Rwanda
HMIS	Health Management and Information System
HP	Health Policy
HR	Hôpital de Reference/ Referral Hospital
MDGs	Millennium Development Goals
MINECOFIN	Ministry of Economic Planning and Financing
MINALOC	Ministry of Local Administration
MMI	Military Medical Insurance
MOH	Ministry of Health
NHIC	Rwanda Health Insurance Council
NRH	National referral Hospital
PRSP	Poverty Reduction Strategy Paper
RAMA	*Regime d'Assurance Maladie des Agents de l'état*/Rwanda Medical Insurance Scheme
RWF	Rwandan Francs
VUP	Vision 2020 Umurenge Program

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Foreword

This policy for community-based health insurance answers the will of the Rwandan government to popularize the fundamental axes of the current policy.

This document serves as an update to the first policy that was elaborated and published in 2004, and integrates all the changes that have occurred in the process since then. Indeed, since this time, community based health insurance has gone through tremendous changes, which deserve to be taken into account. Membership has increased considerably, a new law was promulgated and new management tools were developed. All these innovations have contributed to an improvement in service utilization and have generated a positive impact on the overall health of Rwandans and related health indicators.

This new version of the policy for community based health insurance contributes to the fulfillment of the same objectives as the EDPRS and the Millennium Development Goals (MDG). It integrates system experiences but more especially the devices adapted to the challenges with which community base health insurance are confronted at present.
This orientation given to community based health insurance translates the profound will of the State, at the highest level, to guarantee the access to quality care to the Rwandan population, in particular the most vulnerable.

This will bring our health policy, of which community based health insurance is an important part, towards improving the population's access to health services in a fair and equitable manner. In this way the success of the policy for community based health insurance contributes to the economic and social development of the whole nation.

In conclusion, I call upon local authorities, communities and development partners to invest in and work towards the implementation of this policy.

Dr Richard SEZIBERA

Minister of Health

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Introduction

In many African countries, lack of access to health care affects a large proportion of the population. The financial barriers to health care lead to various forms of exclusion: total exclusion or becoming destitute, seasonal exclusion, temporary exclusion or partial exclusion.

The risks of total exclusion from health care or becoming destitute are higher among extremely poor populations. For other segments of the population which depend on weak and irregular incomes (in fact, most of the rural population), the risks of seasonal, temporary and partial exclusion are higher.

Policy options to deal with these disparities in accessing to health care are limited. Among them, alternate mechanisms of community financing based on pre-payment and on risk pooling, such as Community Based Health Insurance (CBHI) have proven to be strong options, reconciling an improvement in the financial accessibility to health care and the necessity to mobilize the internal resources necessary to ensure the financial viability of health services.

In Rwanda, CBHI was identified as a privileged channel for the growth of financial accessibility to health services in both rural settings and in the informal sector. CBHI should in particular allow the most vulnerable and poorest segments of the population to be fully integrated into the health insurance system, thus guaranteeing participation of the whole community and avoiding any stigmatization. As CBHI is a mechanism which aims to limit the exclusion of the most destitute segments of the population from health services, CBHI should play a key role in building and strengthening the foundations for the concept of equity in access to various packages supplied by the health system.

Mutual insurance companies are designed as a supplement to other existing health insurance systems. These include: i) RAMA (*Rwandaise d'Assurance Maladie*) which currently covers civil servants and other Government agents, and is gradually expanding coverage to private sector workers involved in the formal economy; ii) the health insurance program for servicemen (MMI) which started at the end of 2005 and; iii) other private insurances which are encouraged to develop insurance products in Rwanda.

The unprecedented efforts by the Rwandan Government in the CBHI implementation process to date are a strong foundation for future success. The strong political investment by the Government is justified by the important role that can be played by CBHI in the financing of health services, in population access to health the care as well as in the wellbeing of families and the fight against poverty.

CBHI is strongly anchored in community ownership and management. Not only do communities massively subscribe to CBHI, but they are also involved in their management. A sense of urgency, the continuous involvement at all levels with the intervention of actors from the community, including administration and religious organizations, have played a major role in transforming communities and local authorities into active players in the CBHI system.
A development policy document for CBHI was elaborated in 2004 as a basic tool for the implementation and development of CBHI in Rwanda.

The policy document was based on the following five axes of implementation;

- Setting up management structures;
- Strengthening the legal framework;
- Strengthening the financing mechanisms;
- Strengthening the partnership with CBHI;
- Strengthening national and provincial capacities.

Considering the environmental, socio-sanitary and administrative dynamism in the six years following CBHI development, the orientations of the aforementioned policy deserved to be updated. Following the rapid change and expansion of the Rwandan CBHI scheme, it was necessary to adapt the CBHI policy document to the current context. This revised policy contains new orientations relating to the consolidation of the current success of the system but especially devices adapted to the challenges presently facing CBHI. The implementation and management of the CBHI is under the responsibility of the Ministry of Health (MOH).

1. Situation analysis

Presently, all operational health centers of the country shelter a CBHI section; which presumes 100 % geographic coverage. CBHI is regulated under the law n°62 / 2007 of 30/12/2007 relating to the creation, organization, functioning and management of CBHI and published on March 20th, 2008 in the official gazette.

Population adhesion to CBHI was progressive but the dynamics really started in 2004. As demonstrated in table 1 below, adhesion rates increased rapidly from 7% in 2003 to 85% at the end of June 2008.

Year	**Adhesion rate**
2003	7%
2004	27%
2005	44%
2006	73%
2007	75%
2008	85%
2009	86%

Table 1: CBHI coverage rates (Source: MOH)

As table 8 in appendix 3 shows, very few districts have an average membership rate lower than 75%, showing strong equity in CBHI access among districts. At the same time, utilization of health services increased considerably from 30.7% in 2003 to 85% in 2008 (HMIS).

The growth of CBHI, along with malaria and HIV programs, performance-based financing, community health and quality assurance program, have led to dramatic improvements in key health indicators as shown in the 2007-08 IDHS: i) the assisted deliveries rate rose from 39% in 2000 to 52% in 2008; ii) the infant mortality rate declined from 139/1000 in 2005 to 62/1000 in 2008; the under five mortality rate from 152/1000 in 2005 to 103/1000 in 2008.

2. Policy for the development of the community-based health insurance

2.1. Context

The CBHI system is linked to several key policies in Rwanda.

Vision 2020 summarizes the long-term objectives of the Rwandan Government. It aims to increase the well-being of the population by increasing production and reducing poverty in a context of good governance. To realize this vision, the Government of Rwanda endeavors to develop a proactive and successful health system capable of identifying the health needs of the population and of bringing appropriate answers.

The poverty reduction strategy is the mid-term policy reference framework that guide Rwanda towards attainment of the Vision 2020 objectives, as well as international development objectives, such as the MDGs. An evaluation of the first poverty reduction strategy in Rwanda (PRSP 2002-2007) demonstrated a remarkable improvement in health indicators.

Health and poverty are very closely related, as falling ill is one of the biggest risk factors leading to poverty, and, conversely, poverty can be the root of many health problems. Thus, ensuring an adequate standard of health care by setting up a health insurance system which offers coverage against financial, social and health risks connected to diseases constitutes a very important element in the fight against the poverty. This is reflected in the new mid-term strategy (EDPRS, 2008-2012) which has a stronger emphasis on poverty reduction through strengthening economic growth policy with components focusing on the most vulnerable segments of the population. One of the three pillars of this strategy is the Vision 2020 Umurenge (VUP), which focuses on promoting the productive capacities of the most vulnerable by increasing their access to basic social services and means of creating wealth. Covering disease-related risks is part of the social protection framework which has been laid out in the national social protection and social security policy, implemented by the Ministry of Local Administration (MINALOC). The objective is to promote sustainable social and economic development, centered on good management of social risks and good coordination 7of protective actions aimed at vulnerable groups.

In the national health policy (2005-2009), one of the priority objectives is to improve the financial accessibility to health services. CBHI constitutes an important pillar of this objective and allows the promotion of community financing mechanisms, solidarity and risk sharing.

2.2. Organization and management of CBHI

CBHI focuses mostly on people in the non public sector and aims at providing them equitable access to quality health services. CBHI are coordinated at the district level, where each of the 30 districts of Rwanda hosts a *"Fonds de Mutuelle de Santé"*. They are managed by a director appointed by Order of the Minister in charge of health. In each health center, there is a CBHI section managed by an administrator. In every village, cell and sector, there is a mobilization committee for CBHI, consisting of members elected by the population for a two year renewable mandate.

Contributions are made on an annual basis, and are individual, although the whole household is enrolled to avoid the risk of adverse selection. This system takes into account the low

purchasing power of the great majority of the Rwandan population through subsidies provided by the government and development partners. Further, a co-payment (*ticket modérateur*) is asked from enrolled members at the point of use of health services.

In the CBHI system, beneficiaries are covered at all three levels of health service provision:

1) Health centers;
2) District hospitals;
3) Referral hospitals;

Funding sources foreseen in the law to cover the minimum package (CMA) at the primary health care level reimbursed by CBHI sections are:

1) Contributions from beneficiaries;
2) Contributions from sectors;
3) Contributions from development partners.

Funding sources for the complementary package (CPA) at the district hospital level reimbursed by the district risk pool are:

1) Contributions from CBHI sections;
2) Contributions from districts;
3) Contributions from the national risk pool
4) Contribution from development partners

Funding sources for the CPA at the referral hospital level reimbursed by the national risk pool are:

1) The Government;
2) Contributions from RAMA;
3) Contributions from MMI;
4) Contributions from private Insurance companies;
5) Development partners.

In Rwanda, service providers are currently reimbursed in two ways:

Fee-for-service payments. In this case, the provider receives a payment from the mutual after producing an invoice.
Capitation payment. In this approach, the provider receives a fixed amount for each enrolled member for a given reference period (usually annual).

Key actors in implementing the orientations set forth by the CBHI development policy are:

The central government, whose role is to:

- Manage the District risk pool
- Lead development and implementation of the CBHI policy and strategy
- Strengthen the technical and material capacities of district CBHI (by providing support in management and data processing tools, equipments, training modules, sensitization, monitoring);
- Manage the national risk pool and payment of referral hospitals
- Provide financial support to the needy by subsidizing their membership fees into the CBHI system.

District CBHI, whose role is to:

- Manage the district CBHI and strengthen the management capacities of CBHI sections (training, supervision, evaluation, audit);
- Mobilize the populations in order to get them to subscribe to CBHI;
- Supply equipment and furniture to CBHI.
- Validate and pay invoices of district hospitals

Sections of CBHI, whose role is to:

- Manage the mutual health section, including collection and administration of membership fees and payment of health centre invoices
- Fund the salaries of people in charge of the CBHI sections;
- Mobilize the populations in order to get them to subscribe to CBHI;
- Strengthen the management capacities of mobilization committees in villages, cells and sectors (training, supervision and evaluation).

Communities, whose role is to:

- Participate in the management of CBHI at sector and district level, as well as through their perception of the quality of care.

Health facilities, whose role is to:

- Supply quality services to communities in order to adhere to CBHI standards and policies.

Development partners, whose role is to:

- Provide financial and technical support.

2.3. Goal

The goal of the CBHI development policy is to provide the population of Rwanda with universal and equitable access to quality health services. CBHI complements other existing social insurance systems, such as RAMA and MMI, in addition to private insurance schemes which target workers from the formal and private sector of the economy. To reach this goal, the development policy is based on principles of solidarity and equity. Furthermore, all interventions are aimed at strengthening principles of intersectoral coordination, community participation, decentralization, and partnership.

2.4. Objectives

General objective:

The general objective of this policy is to give guidance which will allow the development and strengthening of the CBHI system in Rwanda, with the larger goal of improving the financial accessibility of populations to health care, protecting households against the financial risks associated with diseases, and strengthening social inclusion in the health sector. To reach this goal, the development policy is based on solidarity and equity principles. Furthermore, all interventions are aimed at strengthening intersectoral coordination, community participation, decentralization, and partnership principles.

Specific objectives:
The specific objectives of this policy are to:

1) Favor the membership in CBHI for people in the non-public sector and rural areas
2) Strengthen the financial viability of CBHI;
3) Strengthen management capacities of the CBHI system;

2.5 Opportunities and major challenges

Opportunities
The positive development of the CBHI system in Rwanda is based on several advantages, namely:

- Strong political commitment by central and decentralized government (CBHI coverage is an important indicator in district performance contracts);
- A decentralized health system;
- An excellent network of health facilities in all districts;

Major challenges
Although the extension of the CBHI system to the national level in Rwanda has been done at a very fast pace, it still faces the following challenges:

- Insufficient funds at both district and national risk pooling level;
- Weak pooling mechanisms;
- Insufficient staff and limited management capabilities;
- Possible abuse at different levels in the system (beneficiaries and providers);
- Large numbers of people in the informal sector with limited capacity to make contributions and who are difficult to identify;
- Moral hazard

3. Strategic interventions

A number of interventions have been put in place to create an environment conducive to the attainment of the CBHI's policy objectives.

3.1. Reinforced implementation of the CBHI law

The CBHI system in Rwanda are presently governed by a specific law. This law clarifies how CBHI are organized and managed, the membership rules, the package of services, the provider payment options and the financing mechanisms. Statutory orders (*"arrêtés"*) have also been elaborated. The next step is to inform all segments of the population about the law and the statutory orders. This will be accomplished through various outreach strategies, including informational meetings at the district level, radios broadcasting, etc.

3.2. Strengthening the financial sustainability, equity and fairness of the CBHI system

A key element for a sustainable community based health insurance system is a contribution system that assures equity and solidarity among its members, as well as the financial viability of the system. At the same time, in order to fully cover the costs of health care for their members, subsidies by the central government and development partners are necessary. Hence, when calculating member contributions, CHBI systems need to take into account the capacity of the population to pay, as well as the cost of health care.

Various studies have demonstrated that a contribution system based on the relative revenues of their members will increase equity and strengthen the financing of the CBHI System in Rwanda. At the same time, it raises domestic resources and reduces dependence on external financing. It has consequently been decided to introduce a system of stratification by dividing members into 3 categories based on Ubudehe[1] criteria. The lowest contribution group will comprise the first and second Ubudehe category. The middle contribution group will consist of the third and fourth Ubudehe category, and the highest contribution group will consist of the fifth and sixth Ubudehe category.

For CBHI contribution group 1, an annual premium of RWF 2000 will be paid. As this group is comprised of the most vulnerable and poor, it is envisaged that their contributions will be paid by a third party, either the GoR or development partners. Contribution group 2 will be expected to pay RWF 3000, and group 3 will pay RWF 7000. Assuming an annual per capita cost of health care of RWF 2900, the CBHI system will generate profits each year generating accumulative reserves of RWF 23, 950 Bn in 2014.

In addition, to strengthen the financial sustainability of the CBHI, an increase on VAT on the consumption of alcohol and tobacco will be introduced.
Furthermore Rwandans, who desire to access premuim services by paying 10,000Frw or more, will be encouraged to do so.

3.3. Strengthen management of CBHI system

Under the current organizational structure the central level management will be strengthened and reinforced by the Rwanda Health Insurance Council (RHIC). RHIC will serve as an independent advisory council to both the CBHI and to the newly-created Rwanda Social Security Board (RSSB). The national risk pool will continue to validate and reimburse referral hospitals. Further, it will also manage and reimburse invoices from patients that seek care outside their home districts (patient roaming). District CBHI will remain responsible for the validation of district hospital invoices and the coordination of patient roaming within their districts. Invoices of health centers will be validated and paid by CBHI sections. A schema with an overview of the organizational structure can be found in annex 1.

Building management capacity in CBHI involves many dimensions. All levels of the CBHI system need to be strengthened, whether it is the MoH at central level or CBHI at the district or section level. Capacity building will be articulated around the following strategies:

- Development of a capacity building plan for CBHI;
- Provide sufficient and competent human resources to the different components of the CBHI system;
- Provide equipment to CBHI at district and section level;
- Train staff from the MoH and from districts and CBHI sections;
- Provide technical assistance and study tours and exchange between CBHI;
- Revitalize the CBHI committees in the villages, cells and sectors
- Set up a system of performance-based premiums for CBHI staff and for members of CBHI committees;
- Institutionalize systems of internal and external audits at all levels
- Strengthen financial and administrative management mechanisms in district CBHI and sections of CBHI

[1] Ubudehe is a community-based targeting mechanism that categorizes the Rwandan population according to their revenues and vulnerability

- Install upgradeable management software which can take into account the evolution of CBHI and accepted Rwandan health standards.

3.4. Strengthening the management of patient roaming

Beneficiaries can be treated in any health facility in the country. Mechanisms to facilitate the refunds of invoices in cases involving the mobility of access for beneficiaries will be strengthened.

These are mechanisms allowing the refund of health care invoices between sections in the same district, or the refund of invoices for health care services received by a member of a CBHI in a district other than the one with which he is affiliated.

3.5. Strengthening community participation and ownership

Community participation has been an important tool to ground CBHI in the country and to keep the system responsive to the needs of the community. Tools to support community participation in the management of CBHI (statutes, internal regulations, community participation modules) have been provided to the CBHI. The involvement of community actors is going to be strengthened in the following areas:

- In all the implementation process and management of CBHI. This refers mainly to the participation in the conception, in the sensitization, in the establishment and in the monitoring and evaluation;
- In the identification and coverage of the most vulnerable. The Ubudehe approach will be used to identify indigents. In subsidizing the needy, the CBHI committees have to make sure that socio-economic categories are taken into account and that the most deprived are considered first as is the case in the Ubudehe methodology.
- In monitoring health care quality.

3.6. Intensification of the sensitization and information

Continuous sensitization and information of the population remains the main tool to mobilize populations and bring them towards enrolling in CBHI. Sensitization will be done gradually at both the local and national levels, using several channels. Messages on the rights and the responsibilities of beneficiaries, as well as on the advantages of becoming a member of a CBHI, will be broadcasted regularly by various organizations and through radio commercials, television programs, and awareness meetings at the districts level. Leaflets and posters on CBHI in health facilities and other public institutions will also be widely disseminated.

3.7. Strengthen a dialogue framework between CBHI actors

This dialogue is a forum for exchange and information-sharing about the system in order to favor the cross-fertilization of experiences on CBHI, the connection between different actors involved in the CBHI system, the opportunities for partnership, and consensus building on the strategic orientations for the development of CBHI in the country. If actors of the CBHIsystem are better informed about the variety of experiences with CBHI, they will be better prepared for change and adaptation of their own CBHI in light of best practices learned from their peers. Through these results, a national dialogue framework would contribute to the flexibility of CBHI which is essential for their institutional viability.

Actors who should be the driving force behind this dialogue include the MOH, the technical working group on CBHI, the extended team, representatives of CBHI administrators, administrators of sections of CBHI, non-governmental organizations, and development

partners who support the CBHI system in Rwanda. The national dialogue framework will be coordinated by the MOH with the help of the technical working group on CBHI.

3.8. Strengthen the partnership between CBHI and health facilities

Health facilities are key partners of the CBHI system. CBHI have several assets to contribute to health promotion. They contribute to the improvement of health care supply, notably by mobilizing resources and stimulating demand. Development of a good partnership is one of the angular stones to build quality and maintain this demand. Good partnership generates solidarity between CBHI and health facilities. CBHI and health facilities must be bound by a partnership contract in which each of the parties finds its advantage. A good partnership between a health facility and a CBHI contributes to the provision of quality services to members of the CBHI.

To strengthen the partnership between CBHI organizations and health facilities, a model of understanding containing key elements on which there is a consensus was elaborated for CBHI. Mechanisms to monitor the partnership and the good applicability of this model of contract will be established.

3.9. Participation of CBHI in the promotion of preventive activities

CBHI systems have to be involved in the promotion of preventive activities. The more they promote preventive activities, the more they decrease the risks linked costly health services consumed by members of CBHI. Fields of interventions in this process of CBHI promoting preventive activities are multiple and varied. A monitoring table showing the state of preventive activities managed by CBHI will be established.

3.10. Strengthening research and publications on CBHI

Research is one of the important pillars of any health system. Therefore, research will be conducted in numerous aspects of health financing; with a focus on examining how to improve the CBHI system, and looking for evidence of problems which could hamper CBHI development.

Publication of findings, which is a tool to spread good practices, will be boosted. A particular emphasis will be put on the strengthening of a web site which has recently been created for CBHI.

3.11. Strengthening the monitoring and evaluation system

The monitoring and the evaluation of the district CBHI sytems are aimed at assessing their state of development, the possible constraints they are facing, and the ultimate causes of these constraints.

In monitoring and evaluating CBHI in the country, the following indicators will be used:

1) Indicators on the memberships;
2) Indicators on services;
3) Indicators on financial health;
4) Impact indicators on the health of beneficiaries.

Management tools for measuring these indicators will be established and the CBHI management system will be computerized. The staff in charge of monitoring and evaluation at all levels of the system will be clearly identified and given responsibilities.

Capacity building in this field will be strengthened to allow for an effective management of CBHI in the country.

Monitoring and evaluation will occur at both the national and local government levels. Modern information technology will be the tool and the privileged facilitation channel for this activity and at all levels.

At the national level, the MOH will be responsible for the monitoring and evaluation of the CBHI system. The MOH organizes the monitoring and evaluation of CBHI through supervision trips, through the analysis of regular reports coming from CBHI, and through specific studies and research.
Results from regular evaluations will be used to take effective measures aimed at strengthening the system and for assisting the economic planning unit to make short and mid-term projections. Stronger coordination between sectors and between various levels of the Government is necessary when it comes to the system of identification of the most vulnerable (Ubudehe), a system which is managed by MINALOC.

At the district level, the CBHI managers are responsible for monitoring and evaluating the activities of both the CBHI and their sections. They also help facilitate the monitoring and evaluation work of MOH.

The section managers, along with the steering committee, are responsible for the monitoring and evaluation of planned activities that are executed at both the section and committees (sector, cell and village) level. The section also has the responsibility of facilitating the monitoring and evaluation work organized by higher hierarchical levels.

Conclusion

The objectives of the development policy of CBHI are clearly defined and well shared. They strongly reflect the ambition of the Rwandan government towards promote the accessibility of quality health care to all Rwandans, particularly the most destitute.

This determination is shown by the implication of local authorities in the improvement of the coverage by CBHI and the involvement of development partners in the development of CBHI. The challenges are certainly numerous, but the adherence and participation of Rwandans in the development of this policy will favor its success.

Annex 1 Organizational structure

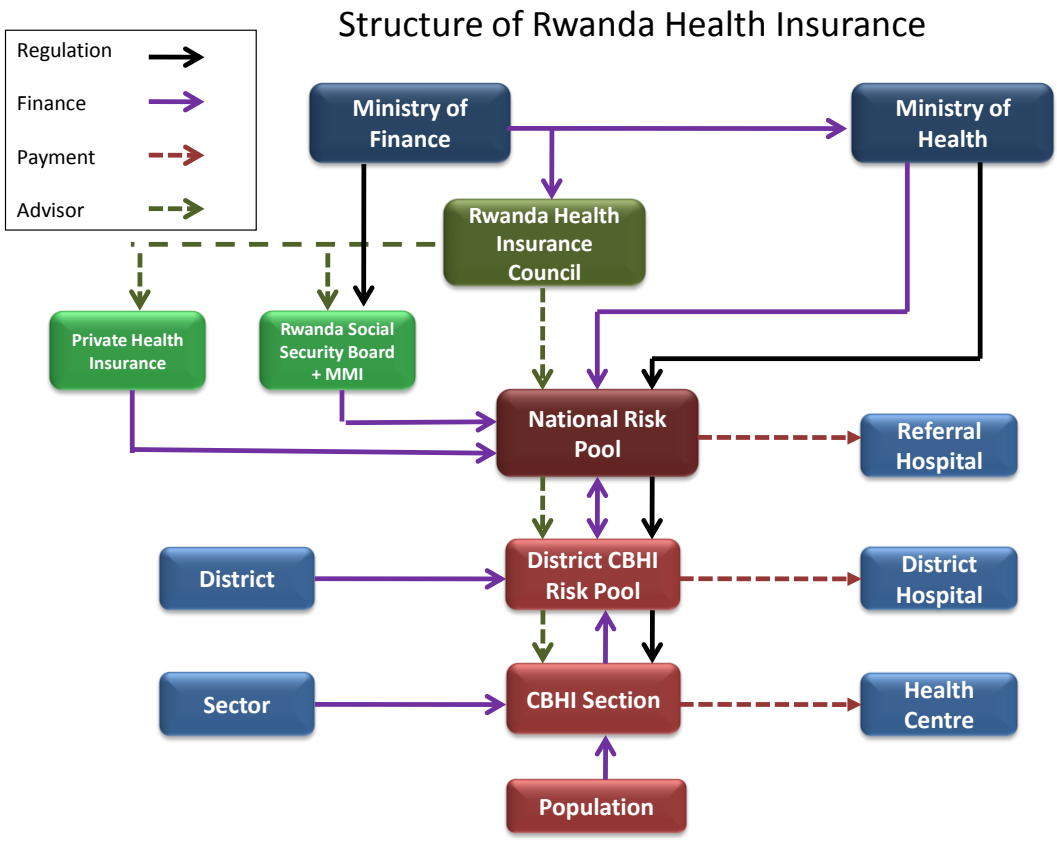

Figure 1: New structure of Rwanda Health Insurance System

Annex 2 Stratification and financial gap analysis

POPULATION					
	2010	2011	2012	2013	2014
Total pop	**10,329,517**	**10,598,085**	**10,873,635**	**11,156,350**	**11,446,415**
Population CBHI	**8,883,385**	**9,326,315**	**9,786,272**	**10,152,278**	**10,530,702**
Group 1 (Ubedehe 1 + 2)	2,300,797	2,415,516	2,534,644	2,629,440	2,727,452
Group 2 (Ubedehe 3 + 4)	5,170,130	5,427,915	5,695,610	5,908,626	6,128,868
Group 3 (Ubedehe 5 + 6)	1,412,458	1,482,884	1,556,017	1,614,212	1,674,382

Table 2: Population projections for CBHI membership

Cost of healthcare

In order to analyze the financial implication of CBHI stratification, the total costs of providing health care at all levels has been calculated for 2010-2014 based on the following assumptions:

Population: 10.4m in 2010 with 2.6% growth (NISR population estimates: medium scenario)
Utilization rate: annual increase of 4% till 2014, based on previous growth
General increase in prices: Annual increase in prices of 15%

Considering these estimations and assuming streamlined and efficient management, per capita health care costs have been estimated at RWF 2900.

	2010	2011	2012	2013	2014
Total Population Mutuelles	**8,883,385**	**9,326,315**	**9,786,272**	**10,152,278**	**10,530,702**
Total cost of health care RWF millions (assumed at RWF2900 per	**25,762**	**30,535**	**34,572**	**38,699**	**43,313**

Table 3: Annual projected health care costs

Financing Scenario

Contribution group 1 pays a premium of RWF 2000, group 2 RWF 3000 and group 3 RWF 7000. The total population contribution to CBHI in this stratification scenario amounts to RWF 34,236,565,784 in 2010.

Financial contributions from premiums 2010

Contribution from Premiums 2010 - 2014					
Population	25 397 597 710	26 663 933 745	27 978 950 478	29 025 363 225	30 107 275 666
GoR	4 601 593 429	4 831 031 018	5 069 288 684	5 258 880 081	5 454 903 391
Total contribution	**29 999 191 140**	**31 494 964 763**	**33 048 239 161**	**34 284 243 306**	**35 562 179 057**

Table 4: Revenues from premium contributions for stratification 2010-2014

Revenue and financial gap with annual per capita health care costs of RWF 2900

FINANCING					
Contribution from population	25 398	26 664	27 979	29 025	30 107
Contribution from third party to cover indigents	4 602	4 831	4 831	5 259	5 455
Contribution from other insurance companies (5% premiums)	917	1 009	1 110	1 221	1 343
Contribution from VAT (1%)	-	1 424	1 615	1 776	1 954
Contribution from co-payment	3 341	3 772	4 070	4 391	4 738
Total Financing	**34 257**	**37 700**	**39 605**	**41 672**	**43 597**
Total cost of health care (assumed at RWF2900 per capita)	**25 762**	**30 535**	**34 572**	**38 699**	**43 313**
Financing Gap (Scenario 2)	**8 495**	**7 164**	**5 032**	**2 974**	**284**
Accumulated reserves (RWF Bn)	8 495	15 660	20 692	23 665	23 950

Table 5: Financial gap analysis for stratification

Annex 3 Membership rates 2009 by districts

Name of the Heath mutual	Number of beneficiaries	Membership rate
BUGESERA	291 331	**91**
GATSIBO	319 752	**94**
KAYONZA	244 128	**97**
KIREHE	256 097	**93**
NGOMA	194 679	69
NYAGATARE	260 217	85
RWAMAGANA	230 214	87
BURERA	377 228	98
GAKENKE	324 633	84
GICUMBI	410 093	95
MUSANZE	280 067	76
RULINDO	295 501	98
KARONGI	328 052	98
NGORORERO	308 229	91
NYABIHU	273 746	85
NYAMASHEKE	339 348	87
RUBAVU	280 958	80
RUSIZI	342 587	86
RUTSIRO	260 141	82
GISAGARA	254 799	81
HUYE	175 202	55
KAMONYI	294 799	94
MUHANGA	299 869	87
NYAMAGABE	309 141	92
NYANZA	264 857	98
NYARUGURU	238 914	86
RUHANGO	253 710	86
GASABO	288 476	75
KICUKIRO	209 490	84
NYARUGENGE	213 300	75
TOTAL/MOYENNE	8 419 560	86

Table 6: Average membership rate by district at end 2009 (Source: MOH)

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