Financial Protection and Access to Health Care Workshop

CBHI Rwanda experiences
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<td><strong>Enrollment</strong></td>
<td>7%</td>
<td>27% - 86%</td>
<td>91% - 76.4%</td>
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| **Premiums**         | Not harmonized in different pilot schemes | Flat fee:  
  - Contribution by the government: 50%  
  - Contribution by members 50%  
  - Subsides for the poorest | Stratifiaction: Premiums according to Socio Economic categories:  
  - Indigents fully subsidized around 25% |
| **Pooling**          | Section levels      | Sections (more than 450)      | Sections (more than 450)  
  - Districts (30)  
  - National Pooling Risk |
| **Benefit Package**  |  
  - Health center (Primary Care)  
  - Limited package at District Hospital level (C section, non-surgical pediatrics services, malaria)  
  - District hospital (Secondary care)  
  - Tertiary health care |  
  - Health center (Primary Care)  
  - District hospital (Secondary care)  
  - Tertiary health care  
  - Patient Roaming |
CBHI: Expanding Coverage practical strategies

- Political will & Local Leader Engagement
- Intensive awareness campaigns
- Attractive benefit package
- Stratification of the population into socioeconomic categories & subsides for indigent
- Financial accountability
Financial Sustainability
Practical strategies

• Increased Resources:
  – Diversification of resources (Population contributions, Government, SHI & PHI);

• Cost containment measures:
  – Control on abuse & over-utilization: Co payment & mandatory referral system;
  – Mitigation of insurance risks:
    • Adverse selection: Enrollment by HH and no Individuals
    • Overbilling: Rigorous bills verification

• CBHI sustainability study scenarios: Revision of premium levels, universal mandatory enrollment
Move of CBHI scheme from MoH to RSSB:

• Rationale:
  – Separation of functions: Providers Vs Purchaser;
  – Improve CBHI management: Financial management and enhanced insurance management skills;
  – Move from fragmented pools to one pool.
Thank you