

Analyzing Challenges Associated with the Implementation of Community Based Health Insurance (CBHI) in Rwanda

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Received Date: May 05, 2017; Accepted Date: June 14, 2017; Published Date: June 20, 2017

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Abstract

With the aim of achieving the fourth, fifth and sixth Millennium Development goals, since 2000 Rwanda has been striving to put much effort in reinforcing the Community Based Health Insurance scheme (CBHI). The scheme is known to be covering the largest percentage of the poorer population. Its implementation had recorded success from year to year, whereby the trend went from 1% of coverage in 2000 to 91% in 2010. However, the quick recovery of Rwanda and the success in achieving global goal of healthcare for all, there are undocumented facets of health system management that need to be documented (health care standards and poor services offered to people under CBHI policy and the mismanagement of CBHI funds). Through various documentations (local newspapers, researches), this study has addressed the roots of the above healthcare ethical issues and strategies to mitigate the extent of the problem. Firstly, Rwandan education system should train more nurses and doctors in order to increase the number of workforce in Rwandan health system. Secondly, put in place incentive mechanism to retain the existing health professionals and attract the new ones working in rural areas. Thirdly, offering more ethics related training programs to nurses and other health facilities' staff who deal with patients. Finally, Rwandan government with other key stakeholders should rethink CBHI structure by formalizing relationship between CBHI sections at local level and the national board in charge (RSSB) as a well-structured institution in order to avoid a bizarre and recurring mismanagement of CBHI funds.

Keywords: Ethics; Healthcare; Community based health insurance; Health system; Public funds; Rwanda

Introduction

With the aim of achieving the fourth, fifth and sixth Millennium Development Goals, since 2000 Rwanda has been striving to put much effort in reinforcing the Community Based Health Insurance scheme (CBHI) commonly known as Mutuelle de Sante (MUSA) in French. The scheme is known to be covering the largest percentage of the poorer population. Only two other health insurance schemes were in parallel functional; namely the one for public servants and other formal institutions (RAMA), and other for military health insurance scheme (MMI). However, the two latter categories cover a small number of people who, most of them do not figure in the category of vulnerable groups.

With the political will of the government leadership in place committed to uplift lives of poor communities, CBHI policies were introduced since 1999. Its implementation had recorded success from year to year, whereby the trend went from 1% of coverage in 2000 to 91% in 2010. However the trend did not continue as it was before. Since 2010, CBHI coverage has started declining slowly by slowly from 91% to 63% in 2015. One of the factors that was claimed to have caused such a drop down is the increase of subscription fees in 2010 from 1.5\$ to 3, 5 or 12\$ based on national socio-economic stratification [1].

Increased CBHI national coverage has resulted to a high rate of use of medical care, hence tremendous success in almost all health indicators over time. For example, under-five mortality rate dropped down from 196 deaths per 1,000 live births in 2000 to 76 deaths in

2010. Infant mortality rate declined from 107 deaths per 1,000 live in 2000 to 50 deaths in 2010 and maternal mortality ratio went down from 1,071 deaths per 100,000 lives in 2000 to 540 deaths in 2008 [2].

However, the quick recovery of Rwanda and the success in achieving global goal of healthcare for all, there are undocumented facets that ethically need to be addressed. The two main challenges identified are those associated with the health care standards and poor services offered to people under CBHI policy, while the only entry point is the health center as gate keeper [3].

Secondly, the mismanagement (fraud and embezzlement) of CBHI contribution (mostly poorer family) either maximum out-of-pocket from CBHI users or third party payment as additional support from different stakeholders, has made the issue more complicated by affecting the supply chain process of drugs and medicines (The East African).

Research Question and Methodology

In this report, I analyzed the following questions: what are factors that are at the origin of the above mentioned issues (low package of service with poor customer care of the provided services and CBHI funds mismanagement)? What could Rwanda do to minimize possible risks associated with these challenges?

This study is examining the two issues through existing literatures using especially newspapers and other researches. Note that in most cases the reality at grassroots is known by the civil society representatives, in this case local, regional or international newspapers or researchers are the source of information to investigate what is

really going on to ensure those issues are addressed in the benefit of those who are poorer.

Generally, this issue has been documented in regional and local newspapers and fewer researchers, but at the low extent as more researchers are only focusing on researching factors that led Rwanda to high outcomes in improving healthcare. Some of the unprofessional cases in medical care documented either at health center or hospital level, are related to misconduct, undervaluing the patients, ineffective manner of treatment against CBHI holders.

Discussion Findings

Bitterness and irritating conversation with patients: Beyond the low service CBHI users have been offered, it was noted that in some health facilities they are not treated with the minimum dignity. The lack of minimum care with harsh language has been leading to shocking atmosphere between nurses and patients or theirs. "There was a mother who took her sick baby to the hospital asking for drugs and the nurse said 'Go away, when your baby dies, I will deliver another one for you'; the nurse is still working at the HC; unfortunately the baby died." a CBHI user said [4].

Failure to assist patients: The worst situation is when health centers in rural areas who could serve CBHI holders who make a big percentage of rural population are not reliable. Sometimes nurses are absent at their workplaces. Their clients are the one bearing the burden at end of the day. "To some of the remote health centers, you can go and find no one to receive you, said a CBHI user in rural area" [4].

Waiting queue without any update information: Even where those who are at their workplace, quality service is almost ineffective and in some places patients spend the whole day without being given the service or being provided with clear information of what is going on. Note that health centers are the gate keepers for CBHI policy. In that case, a patient can't be received at the hospital without being transferred by the health center. "Patients complain that they get to get to the health center as early as 6:00 am but get to noon without any hope of seeing the nurse to attend to their problem as they queue on the long line of waiting as Claudine Musabyimana a patient at health center explained" [5].

In general there is an atmosphere of disrespect, careless and ineffective manner of dealing with patients' cases. The result would be a feeling of dissatisfaction on the side of clients. With their level of mindset, they would turn even to witchdoctors or unregistered medical dealers.

According to Athanase [6], community based health insurance holders (CBHI) respondents in Ruganda sector/Health Center Biguhu were at 57% dissatisfied, first by low coverage or package of services offered by CBHI and some drugs are not included by this insurance type. Secondly, the poor service provided to the beneficiaries under this policy and general image of customer care through which the healthcare services are delivered is not good.

In addition, a low number of nurses at health center handling a big number of patients on queuing system bring about disorders in health service delivery. This issue was discussed in the parliament trying to solve the issue related to poor coordination in the delivery of healthcare across the country, tackling issues such as overcrowding in referral hospitals [7].

The issue of poor health service goes in parallel with the mismanagement of CBHI money. The issue of fraud and misappropriation of CBHI funds has been claimed in many cases in various districts. According Audit Report of the Auditor General, At least Rwf96.4 million (138,471\$) for CBHI was embezzled in five districts of the Eastern Province (Audit Report, OAG, 2015). Moreover, a shortage estimated at above Rwf2 billion (\$2.9 million in CBHI funds) in only Western Province [8].

Furthermore, According to a Ministry of Health report, CBHI was characterized by mismanagement and delayed subscriptions; which had fallen from 73% in 2014 to around 63 percent, meaning that more people were remained uncovered and a lot of premiums went uncollected [9]. Resulting to further analysis of causes, local government officials have been arrested over fraud and embezzlement of CBHI premiums following government investigations into the scheme. This came after shortage in funds triggered an assessment audit that unearthed major shortfalls and inconsistencies in CBHI funds as explained above.

According to literature, there are factors associated with misconduct in medical care that would be at individual, organizational (health facility) or policy level. Firstly, a long-term shortage in human resources in health system may create a lack of ethics in medical care. The risks of making errors in medical care is significantly increased when work shifts were longer than twelve hours, when nurses worked overtime, or when they worked more than forty hours per week [10]. In the same regard, level of demands of people for healthcare and level of controlling and mastering the imbalance between demand and service providers is another factor that worsens working conditions at health facility.

Secondly, it was noted that knowledge of what you do and how to do it is very significantly vital in terms of preventing health staff to make unethical practices. Skill requirements of a minimum package of health interventions and low standards of conduct at workplace [11].

Finally, other motivation factors such as management style, incentive strategies, organizational structures and salary scales between health workforces are also associated with the level at which ethical codes are applied and observed at workplace [12].

By linking some of the elements that could be at the origin of issues in medical care (above mentioned) with the case of CBHI holders in Rwanda, I would say that there is a relationship that could not be ignored between work settings and conditions, and workers' conduct at health facility. In this regard, little is known due to the reasons that most of researches in health sector in Rwanda examine the success, but there are cases behind the curtain that should be re-examined.

Generally, due to Limited health workers, the distribution of workforce in health sector is estimated for one Doctor/16 046 people and one nurse/1227 people [13]. However, Hospitals and HCs in rural areas face this challenge at high magnitude because it is practically hard to recruit qualified staff due to life conditions in rural area. The number of people allocated to a nurse almost doubled when it comes to rural areas with an average of one nurse/2219 people.

"I don't understand the routine here; we queue longer to get everything that is why some of us wake up early. We therefore call for the expansion of the HC and hiring of more Nurses to attend to all patients," said CBHI holder [14]. "Doctors and nurses working in the rural areas are not satisfied and insult the patients, become bitter to patients, because they're stuck in the rural areas. CBHI holder [15].

Low incentive mechanisms such as salary scales and other benefits lead to lack of motivation at workplace, which results to a situation whereby work is only formality of obeying terms and conditions in the employment contract. However, ethics goes beyond complying with the law. Rather making actions and practices that are morally right and non-harming. "If our salary were increased, we would work better and, moreover, be extremely happy while at work." A nurse in a rural area, "We have friends-lawyers, economists, and others - and when we talk to them, we hear what they earn, and find that they earn much and work little". Doctor in a rural district claimed [4].

Conclusion and Recommendations

Some of the recommendations that Rwandan Ministry of Health and other stakeholders advocating for disadvantaged communities should deal with in order to minimize the magnitude of these factors that could be at the origin of the unethical practices in medical care for CBHI users (mostly poorer people with limited opportunities) are the following:

Firstly, Rwandan education system should train more nurses and doctors in order to increase the number of workforce at HC level and District hospitals and reduce the burden of having a big number on the shoulder of a health professional (doctors and nurses). Secondly, as a way to retain the existing health professionals and attract the new ones working in rural areas, Ministry of Health should put in place incentive mechanisms so that more qualified staff would be willing to stay in.

Thirdly, apart from recruiting and retaining them, there is a need of offering more ethics related training programs to nurses and other health facilities' staff who deal with patients. A specific attention should be put on one most important aspect. Health centers are the gate keepers through which CBHI users start asking any health service. Thus, health professionals and other staff at the health facility (administration, finance...) will be conscious of their position.

Finally, Rwandan government with other stakeholders associated with this policy should Rethink CBHI structure by formalizing relationship between CBHI sections at local level and the national board in charge (RSSB) as a well-structured institution in order to avoid a bizarre and recurring mismanagement of CBHI funds.

As a human rights element, health facilities should be provided healthcare with application of human rights principles while managing CBHI policy to stay away from any kind of disrespect and misconduct while treating patients from disadvantaged category of people. A Human Rights-Based Approach requires that special attention be given to disadvantaged individuals and communities.

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