

National University of Rwanda
School of Public Health



CAUSES OF INSUFFICIENT COST RECOVERY OF THE
HEALTH CARE SERVICES PROVIDED TO THE
MEMBERS OF THE COMMUNITY-BASED HEALTH
INSURANCE IN RWANDA: Case of Kabusunzu Health Center
from 2009 to 2010

By

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(MPH)

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REFLEXION

“The Lord

Does whatever pleases him,
In the heavens and on the earth,
In the seas and all their depths”

Bible, Psalms 135:6

DEDICATION

To our dear parents Joseph NDATEGWA and NYIRARUFARANGA Pascasie whose destiny did not allow you to see this page,

To my dear wife Henriette MAHIRWE for your inexpressible assistance and understanding,

To our dear children MUCYO Grace, NGOGA Olivier, NGABO Samuel, MUGISHA Benjamin and NEZA Spencer, for so much affection with which you have continuously surrounded us.

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ABBREVIATIONS.

ANMC	Alliance Nationale des Mutualités Chrétiennes.
BIT	Bureau International du Travail.
CBHI	Community Based Health Insurance.
CHW	Community Health Workers.
HC	Health Centre.
CTAMIS	Cellule Technique d'Appui Aux CBHI de Santé.
DHS	Demographic and Health Survey.
DH	District Hospital.
<i>EDPRS</i>	Economic Development and Poverty Reduction Strategy
HC	Health Facilities.
GDP	Gross Domestic Product
RH	Referral Hospital.
HWC	Health Workers Community.
ILO	International Labour Organization.
MDGs	Millennium Development Goals
MINECOFIN	Ministry of Economic Planning and Financing.
MMI	Military Medical Insurance.
HRH	Human Resources for Health.
MOH	Ministry of Health.
MUSA	Mutuelle de Santé
NGO	Non-Governmental Organisation
NUR	National University of Rwanda.
RAMA	La Rwandaise d'Assurance Maladie
WHO	World Health Organization.
WSM:	Web Sémantique Médical.

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SUMMARY

Our study is focused on the causes of insufficient cost recovering of medical care provided to adherents of community based health insurance (CBHI or MUSA) in Rwanda: case of Kabusunzu health center. Kabusunzu health center is one of the country's public health centers, located in Kigali city with a big number of adherents to CBHI. Existence of many unpaid invoices compromising the functioning and sustainability of CBHI. Indeed, until November 2011, the accounting situation notes a debt of more than 59.000.000 Frw due to Kabusunzu Health Center by the section of CBHI (mutuelle de santé).

Our question is to know what are the major causes that hinder the cost recovery of health care provided by Kabusunzu health center to the members of CBHI?

The objective of the study consist of identifying the causes of difficulties in cost recovering of medical care provided by the health centers (HC) to adherents of CBHI with the aim of proposing possible strategies to improve the functioning and sustainability of CBHI.

To achieve this objective, we have conducted a qualitative study. Mainly three techniques have been used: i) individual interviews of 15 people having at least responsibilities in the functioning of CBHI, from HC to Ministry of Health (MoH) passing through primary entities, and those intermediaries including Non Government Organization (NGOs), ii) two focus group, one composed of 7 clients and another composed of 10 community health workers (CHW), iii) at last a documentary technique for taking in account the existing literature on this topic in our country as well in the world.

The study has showed, from literature review that there has been many unpaid invoices compromising the functioning and sustainability of CBHI. Identified causes of difficulties encountered in cost recovering of medical care and services provided to the adherents CBHI are numerous. The more prominent and quoted is the poverty of the population to afford the cost of medical care, the abusive use of the card of health insurance including fraud, falsification and overuse of health services, low contribution of members, the "Adverse selection" by the NGOs, the insufficient motivation of the staffs, the background of paternalism from the colonial period, the quantitative and qualitative insufficiency of staffs, the overcharging of medical services including tests of laboratory, favouritism and the long process in the transmission of the lists of the indigents. Among the proposed strategies and recommendations, it has been suggested the diversification of financing sources (e.g. contribution of enterprises producing tobacco, alcohol, gas stations, transportation companies etc.) to CBHI and the universal coverage of health insurance.

CHAPTER: I. INTRODUCTION

1.1. Context

The social protection in health care has always been a concern to managers of health system in a country.

Article 3 of the Universal Declaration of Human Right states, "Everyone has the right to life, liberty and security" [1]

During the 20th century, all European countries progressively focused on the coverage of social risks of their peoples. A large number of European countries have adopted the Bismarckian system, also called "professional system", because it is funded by labor and social security contributions. Some others followed the Beveridge system, also called "national system". This model is based on universal access to health care and the taxation of health expenditure. [2]

The social protection system covers less than 10% in Sub-Saharan Africa and less than 50% in Latin America and Asia. Overall, the exclusion of social protection in health affects approximately 80% of the population of developing countries. [3]

This led WHO to launch the Alma Ata conference held to Geneva in 1978, which resulted in the slogan "Health for All"; so that the all population receives at least primary health care (PHC) for their participation in the services cost recovery. [4].

However, despite the joined efforts, the universal and fair health care coverage has not been effective yet. The population's socioeconomic conditions and ignorance and the low proportion of national budget allocated to health, and so on, are the causes.

1. 2. Problem statement.

The health system of each country determines the mode of health care coverage to its population. Prof. W. Hsiao argues, "Picking a Payment System is like picking someone to marry. All options are imperfect. The question is what problems are you prepared to live with in the long run "[5].

In addition to Rwanda Medical Insurance or "La Rwandaise d'assurance maladie (RAMA)" originally designed for social protection of the civil servants regarding health, and private insurance schemes, Rwanda has opted for the Community-Based Health Insurance called "Mutuelle de Santé." Many initiatives were taken in the our Country. It is since years 60s

that of initiatives of health insurance based on the community, like the Muvandimwe association of Kibungo (1966) and of the association Umubano mubantu of Butare (1975) began to constitute itself. The health care insurance scheme was established in 1988 to cover primary and referral level health care provided by Murunda Hospital. It was initiated in 1991 in Gikonko health center in Gakoma district hospital catchment area, in Butare Province. However, these initiatives of health insurance based on the community developed more than since the réintroduction of the politics of payment to the act in 1996. (6)

“Rwanda has achieved sustained GDP growth over the last 7 years. Per capita GDP grew from USD 235 in 2002 to USD 291.3 in 2008. In 2008 agriculture contributed 31% to the economy, while services contributed 47.7%, and industry contributed 15.6%. Nearly 80% of the population was reliant on agriculture for family income in 2006. Poverty is widespread as it affects 57% of the population.” [6].

The Law on the establishment, organization, operation and management of the CBHI states the “The property of the National Guarantee Fund of the community based health insurance, come from: 1° grants from the Health Insurance Scheme for Government and Private Sector employees (RAMA) which is equivalent to one per cent (1%) of the monthly income; 2° grants from the Military Medical Insurance (MMI) which is equivalent to one percent (1%) of the monthly income; 3° the allocation which is equivalent to thirteen per cent (13%) of the ordinary annual budget of the Ministry of Health; 4° grants from each of the health insurance companies operating in the country which is equivalent to one per cent (1%) of the monthly income; 5° grants from donors; The Government shall, on an annual basis, review the amount of money to make sure the mutual health insurance scheme runs properly.” [7]

Aware of his right to health care, the population multiplies the disease episodes in seeking treatment even in cases of minor discomfort. And health facilities are overwhelmed as demand for health care exceeds the capacity of the providers. This compromises the availability and quality of care. The waiting queue, complaint from both health providers and patients are vivid.

An activist of human rights argues that “overwhelmed Health facilities, victims of the health insurance success, health centers and personnel are completely overwhelmed. The long queues at health centers and pharmacies discourage patients. They complain of inadequate and delayed services [8].

Moreover, the financial incapacity of the community-based health insurance due to the accumulated heavy unpaid bills from health centers worsens this situation.

With regard to Kabusunzu Health Centre, the accounts reveal a debt of over 59 million RWF that the section of the community-health insurance owes the health center in November 2011. The CBHI service at Kabusunzu Health Centre currently reports that before the health center received more than 200 patients per day whereas before the CBHI, the average was 30 patients per day.

Under these conditions the Health Centre, in addition to the extra effort made to meet the needs of the people, was obliged to compress or eliminate operating expenses, bonus for personnel, and other incentives like New Year and the Labor Day allowances, etc. Due to lack of funds recruitment of more staff to deal with this large volume of work is delayed. [9]

The future of the quality of care and CBHI sustainability for the continuity of health services to the members and staff motivation is doubtful if nothing is done to overcome the situation.

The Government of Rwanda through the MoH has certainly made a lot of efforts in recent years to improve the functioning of CBHI: increasing health centers, building CBHI managers' capacity, increasing the number of health care providers, paying additional membership fees especially to district hospitals, developing legislation providing strategies to improve the financing of CBHI etc.

However, despite these efforts, the CBHIs still encounter many difficulties, such as cost recovery of health care provided to members of this Health Insurance.

In this study, our concern was to know what the major causes that hinder the cost recovery of health care provided by Kabusunzu health center to the members of CBHI, and to determine possible strategies to make CBHIs sustainable toward universal coverage of health insurance.

1.3. Objectives

1.3.1. General Objective

Describe the main causes of difficulties encountered in costs recovering of health care services provided by the HC to the members of the CBHI, in order to propose strategies that can contribute to better functioning and sustainability of CBHI.

1.3.2. Specific objectives

1° Identify the major inherent causes of the difficulties in cost recovering of health care services provided by the health facility to the members of CBHI

2°. Identify strategies for financial sustainability of CBHI.

1. 4. Interest of the topic

1.4. 1. Personal interest

As a member of health committee of Kabusunzu health center, having realized the difficulties in the cost recovery of health care services provided by health center to the members of CBHI, I felt challenged to bring my modest contribution to improve this situation. It is paramount to contribute to safeguarding the viability and sustainability of *Community-based health insurance* for the improvement of the health status of the population. Furthermore, this area has always attracted my attention so much that my diploma paper focused on the financing of public hospitals while bachelor degree research paper focused on primary health care.

1. 4. 2. Scientific interest

A healthy citizen invests his/her efforts in the economy of the country. As we have noticed in the health system of rich countries, Rwandans also need quality health care services for healthy longevity. The system of cost recovery relating to health care services is a major concern in the world in general and in Rwanda in particular. In addition, while Kabusunzu health center faces currently the problem of cost recovery care services provided to the members of CBHI, none study was conducted on this topic in Kabusunzu health center. Therefore, the information collected during the completion of this work will provide a basis for further scientific research on the one hand and it will provide good information for policy makers in their decisions related to the policy on sustainability of CBHI in the catchment's area of Kabusunzu health center on the other hand.

CHAPTER II: LITERATURE REVIEW

2.1. Definition of concepts

1° **Health insurance Scheme:** solidarity system in which persons mutually come together with their families and pay contributions for the purpose of protection and receiving medical care in case of sickness;

2° **Member:** registered person in mutual health insurance scheme who regularly pays the subscription or whose subscription is annually paid for by others;

3° **Contribution:** amount paid for by a member in the mutual health insurance scheme;

4° **Deterrent fee:** amount of money paid for by a member of a mutual health insurance scheme after receiving medical care. It is paid in consideration of a percentage determined by the Minister in charge of health.

5° **Primary care:** acts relating to treatment and immunization carried out at the level of the health centers and at private health establishments that conclude a contract with the mutual health insurance Fund.

6° **Hospital care:** acts relating to treatment and immunization carried out at the level of the hospital.

7° **Co-payment:** A payment made by a beneficiary, usually at the time a service is received, to offset some of the cost of care and reduce moral hazard.

8° **Beneficiary:** The insured or a dependent of the insured entitled to receive healthcare services under the health insurance policy. (3)

9° **Recovery:** Activity consisting of reimbursing the bills of health care services provided for members of CBHI. Recovery of care can be made either in the form of prepayment or as co-payment or from third parties (state subsidies, interventions by NGOs or other public or private organizations).

10° Costs: Monetary value of spending on care delivery. In accounting there are three basic notions of costs that traditionally allow: original cost, production cost and cost of comes back. [10].

2.2. Basic principles of the community-based insurance

According to ILO-STEP, there are seven (11) principles governing community-based insurance:

1°. Solidarity:

It requires that each member of a CBHI pays his/her contribution regardless of their personal risk of illness, age, gender and health status or vulnerability). Solidarity is the pillar of CBHI.

2°. Democratic participation

Membership in a CBHI is voluntary. It should suffer no racial, sexual, social, political, religious, discrimination. All members have equal rights and duties.

3°. Autonomy and freedom

Members of a CBHI take decisions freely without asking the approval of the political or religious authorities and employers. To safeguard this freedom, CBHI should be self-financed hence, ensure a balance between contributions and expenditures.

4°. Non-profit

The CBHI is not looking for profit, yet it must use strict principles of accounting and financial management in its operation to ensure its sustainability.

5°. Development of the individual

Each member of a CBHI has the right to freely participate in decision-making, with dignity and respect for all human dimensions.

6°. Liability of the members.

The liability of a member is required both in the behavior regarding the financial and administrative management and in its attitudes towards the consumption of the health care services.

7°. The dynamics of a social movement

Members of the CBHI are called upon to join efforts individually and collectively in order to defend the interests of the organization. Good synergy would be to create a mechanism for collaboration with other organizations working in different fields. [3].

2.3. Health care financing system in industrialized countries

Historically, Europe was marked by two major trends: the Bismarck laws and the Beveridge Report. In the second half of the nineteenth century, the German Bismarck introduced social reform to help the working population and to provide some redistribution to the workers. "The three basic laws passed in 1883 (health insurance), 1884 (accident insurance) and 1889 (disability and old age), develop a social insurance system that guarantees an income of compensation for loss of income due to the occurrence of a social risk (illness, accident, disability or old age). Social insurance is designed to protect workers. They are mandatory, strongly controlled by the state, but managed by the social partners, and funded by contributions proportionally to wages, shared between employees and employers. Bismarckian system will have a strong influence on the systems in place in countries including Luxembourg, the Netherlands, Austria, Norway, Sweden, Italy, Belgium and France." . [2].

In addition, the Beveridge Report was introduced during the Second World War by offering a new perspective of social protection. "Rejecting both the assistance that social insurance provided for employees, it suggests introducing a uniform and general system of social benefits, funded by fixed contributions and delivering flat-rate benefits. In order to completely eliminate poverty, all citizens should be covered by the system that would pay the same amount for all, regardless of the encountered risk. "This system was successful in the UK, Ireland , Finland, Sweden, Denmark, Italy, Portugal and Spain [2].

Currently, in most developed countries, the trend is to ensure universal health coverage (CMU) for all, that is to say access to care by all. Health care is financed by the taxes of the working population. They are planned in the annual national budget. This is the case of Sweden, where 95% of funding is public. The patient pays only 4% of the costs of health care. It is a decentralized health system in which health is a matter for the municipal administration. It gives people a lot of advantages, namely, good accessibility, equity in health care, quality of care, good cost control, and assistance to the poorest regions, accommodation and care for the elderly and / or disabled. As a result, people live longer while being healthy (the oldest population in the European Union) and reducing the number of hospital beds (40%) and average length of sojourn in hospital [12].

In China, a health insurance plan is made effective in order to solve the problem of the rural population. This plan known as the "Rural Mutual Health Care (RMHC)" recommends coverage of medical consultations and medicine to people in rural China, not only by their contribution but also by involving the contributions of employees living in the cities [14].

The great advantage of the Chinese healthcare system is that the economically strong supplement the efforts of rural citizens whose economic power is low so that all should benefit equitable health care [13].

2.4. System of health care financing in developing countries

In developing countries, after the colonial paternalism that claimed free health care to the population, there was a move to care system paid cash to the act. Given the fact that of disease occurrence abruptly and financial resources (especially of the rural population), is very limited, some countries have adopted the system of mutual health. This is a health insurance system that allows affiliates to pool together their little resources so that they may share the risk related to health care costs. The fight against poverty, under such context, represents a basic challenge to African countries on the one hand, and to all developing countries whose growth rate does not exceed 4 % of the GDP at regional level, because poverty, in general, is not only the individual's or clan's business, but poverty is also national, regional, continental. [14].

In addition, the workshop in Abidjan in 1998, jointly organized by the ILO, GTZ, the ANMC and WSM, on strategies to support mutual health in West and Central Africa and attended by six countries (Côte d'Ivoire, Benin, Burkina Faso, Guinea, Mali and Togo), concluded that the mutual health organization is a quick fix to the problem of financing health care [15].

In sub-Saharan Africa, mutual health or the "Social Health Insurance" is of recent origin but rapidly evolving. Kenya began in 1996, Nigeria in 1997, Rwanda in 1999, Tanzania in 2001 and so on [16]. Neighboring Burundi has chosen a system whereby the civil servants' health insurance is under the direction of the Social Security Institute (SSI). However about 80% of the funding comes from NGOs. This creates a situation of financial dependence [17].

In Benin, a team of researchers addressing the problem of mutual health, made a exploratory study that says that the level of confidence in MHOs (Mutual Health Organizations) is high considering the population [16].

2.5. Community-based insurance schemes in Rwanda.

In Rwanda, from 1960, there appeared health insurance initiatives based on the community, like the association Muvandimwe in Kibungo (1966) and the association Umubano mubantu in Butare (1975). After the independence these initiatives were created in Kibungo, Butare, Gisenyi, Kibuye and Gitarama. These insurances consisted of both patient's transportation in the case he/she was referred and health care services provision. But the unfortunate the events of the 1994 genocide destroyed all traces of these organizations. The initiatives of community-based health insurance intensified with the policy of fee at act in 1996. In fact, from six community-based insurance schemes in 1998, the number of the community-based insurance schemes increased to 76 in 2001 and 226 in 2004. The CBHI has expanded gradually over almost all the national territory. Currently they cover about 85% of the population of Rwanda.

In general, the community-based insurance schemes in Rwanda are organizations with management autonomy and respect the principles of democracy and freedom.

Considering the CBHI organization, the structures of the CBHI are modeled on those of the institutional framework established by the decentralization reforms. The document on the community-based insurance schemes policy provides organs and their functions at each level (CS, cell, sector, district and central level).

In Rwanda, the community-based insurance has opted a policy of family membership with individual contribution. All members of a household must adhere to the CBHI jointly, unless some are affiliated with other insurance. In this case they can optionally join it. The contribution rate ranges from 2000 to 7000 RWF per capita, according to the social categories of the person. [18]

CHAPTER: III. RESEARCH METHODOLOGY

This chapter describes the place of study, methods and techniques of data collection used in this study. It explains the sampling and how the questionnaire was administered individually and in focus group, the procedure of data collection including the pretest, the analysis plan and the ethical considerations of the study.

3.1. Study design

To attain the objectives of this research, we conducted a cross-sectional descriptive study. The qualitative method was useful for identifying the root causes that underlie the difficulties in cost recovering of health care provided by the HC to the members of CBHI and appropriate strategies to address the situation. To describe the phenomenon under study, we collected and analyzed qualitative data.

3.2. Place of the study.

Kabusunzu Health Center is a public health facility located in the Munira I cell, Nyakabanda sector, Nyarugenge District, Kigali City, in the Republic of Rwanda. Founded in 1982, the Health Center serves a target population of 24,799 people in four cells, namely Nyakabanda I, Nyakabanda II, Munanira I and Munanira II.

In addition to the population within its catchment area, the health center also receives people from Kimisagara, Rwezamenyo, Gatsata, Gitega and other clients from all over the country and even neighboring countries.

It consists of many services including consultation, maternity, family planning, antenatal care, immunization, nutrition, dentistry, PMTCT and VCT, TB ward, medical care for people living with HIV and AIDS, laboratory, pharmacy and accounting. The center receives a huge number of adherents to the community-based insurance (16 119 adherents , meaning 65 % of total population of the catchment area). For example, for the month of January 2010, there were 3240 consultation cases [9]

3.3. Sampling strategy

Three techniques were mainly used: i) individual interviews of 15 people having at least responsibilities in the functioning of CBHI, From HC to MoH passing through primary entities, and those intermediaries including NGOs, ii) two focus group, one composed of 7 clients and another composed of 10 community health workers, iii) at last a documentary technique for taking in account the existing literature on this topic in our country as well in the world. An interview guide, specifically targeted to leaders of CBHI, was developed. Similarly, to determine the strategies for the financial sustainability of the CBHI, we collected the views of the aforementioned officials involved in the CBHI management at all levels but also the experience of other countries was considered. The MoH's layer has provided with us legal documentation relating to the CBHI.

The sample by reasoned choice strategy was mainly used; individual interviews included, at health center level, the interview with the head of the community-based health insurance section, the "titulaire" of Kabusunzu HC, a nurse employed in the pharmacy, a lab technician and the accountant of the HC, two nurses and two care providers.

At the hierarchy level, the interview was conducted with the Executive Secretary of the MUNANIRA I Cell, the person in charge of social affairs in Nyakabanda sector, the Director of the health unit and of the CBHI in Nyarugenge District, the Administrative Manager of CBHI and the auditor of Muhima hospital, the representative of the NGO that pays premiums for the poor in the HC, finally the Coordinator of CBHI Technical Support Unit in the MoH. The total number of people interviewed individually is 15. We conducted also two focus groups: one composed of seven clients (three men and four women); the other one composed of ten community health workers (five men and five women). All participants to focus groups were chosen randomly. Details concerning their characteristics are found in the chapter on the results presentation. In total, thirty two (32) people were interviewed. 3.33.5. *Selection criterion.*

- Consent to participate in the study.
- Being involved in the costs recovery of health care provided to the members of CBHI.

3.4. Exclusion criteria

- Refusal to participate in the study
- Not to being involved in the costs recovery of health care provided to the CBHI members.

3.5. Collection procedure and data processing

"Qualitative research is based on semi-structured or even unstructured interview in which the moderator or interviewer uses a discussion guide or an interview guide prepared according to the subject and the target of the study" [19].

We used an interview guide designed for individual interviews with officials at all levels of CBHI. Accounting documents and records, financial reports and CBHI database were consulted.

This clear interview guide was initially developed in English and French and translated into Kinyarwanda and tested in advance. The questions are open to any opinion thereon. We conducted the interview ourselves among those retained people according to the criteria above. Before we began, we introduced ourselves and exhibited the official permission to conduct the investigation. Then we gave a brief explanation of the purpose of the survey, its benefits and risks; we also ensured the respondents that the confidentiality of information would be guaranteed and that they had freedom to participate or to abstain or withdraw at any time without any prosecution.

The opportunity to ask questions was offered to the participants. Permission to take notes during the interview was also solicited from the participants, ensuring them that the information would solely be used by the researcher, followed by signing of informed consent by each participant. The discussion took place in calm and secured environment. The participants were asked probing questions until the topic was thoroughly exploited. After thanking the participants we immediately wrote down the information we collected; primarily in Kinyarwanda, then translated into English. The interview took between 30min and 40min. The software Word and Excel were respectively used for data entry and data processing and Epi Info was used for quantitative data analysis, but t The qualitative data were dealt with manually.

To minimize bias we took care of conducting ourselves interviews.

3.6. Data analysis

"Qualitative research is characterized by an approach that aims at describing and analyzing the humans' and their groups' culture and behaviour from the perspective of studied ones. Therefore, it insists on complete or "holistic" knowledge of the social context in which research is carried out. Social life is seen as a series of connected events to be fully described in order to reflect the reality of everyday life. Qualitative research is based on a flexible and interactive research strategy "[19].

The information gathered, transcribed and faithfully translated into English and coded, were subject to analysis and interpretation. The discussion of results led us to the comparison our findings with literature from books and electronic documents related other health systems.

The ideas are logically arranged following topics related to the objectives.

The analysis is the result of several readings of the data grouped according to the different questions that have a complete understanding of all aspects.

The discussion of results has led to a conclusion of plausible explanations describing the causes of the difficulties identified in the cost recovery of care services provided to the members of CBHI and related recommendations.

3.7. Ethical consideration.

"Ethics is the study of how human action affects other humans, sentient beings, or the ecosystem. Ethical researchers understand that their actions have the potential of causing harm and promoting the potential of good for others (profession, society, natural world.) This means that ethics is the aspect of the study that examines how the action affects other human beings, sensible existence, or the ecosystem. Proponents of ethics understand that their actions have a potential to cause harm or do good for others (profession, society, the natural world.) [20]

Our study has taken into account aspects of ethics commonly used by experienced researchers. After approval of the research protocol by the Technical Panel of the School of Public Health, we were provided with a letter authorizing the research by the authority of that School. Before beginning each interview, we explained the purpose of the interview, about confidentiality and anonymity of participants, the risks and benefits of the study. Participation in the study was voluntary and freely accepted by the interviewee. A written informed consent

form, previously prepared in duplicate was signed by the participant and the investigator. A copy was given to the participant. Thus the confidentiality of the data and of the interviewees was guaranteed.

3.8. Study Limitations

The study addressed only the situation of one health centre, The results of this study are not generalizable to all health facilities of the Rwanda. They are valid only at the Kabusunzu health centre. The data collected are limited between 2009 to 2011. Some respondents tended to forget some facts. Others voluntarily or involuntarily gave false information for political reasons. A check against the question to other participants helped to well circumvent the obstacle.

CHAPTER IV: PRESENTATION OF THE RESULTS

4.1. Socio-demographic characters of all respondents.

Table 1: Distribution of all respondents in general according to socio demographic characteristics (N=32)

Variables	Frequency		Percentage
Sex	F	18	56.25
	M	14	43.75
	14		
	Total	22	100.0
Age	20-29 years	8	25.00
	30-39 years	14	43.75
	40-49 years	6	18.75
	50-59 years	4	12.50
	Total	32	100.00
Marital status	Married	25	78.12
	Single	7	12.87
	Total	32	100.00
Level of education	Primary	6	18.75
	Post-primary	3	3.37
	Secondary	14	43.75
	University	9	28.12
	Total	32	100.00
Occupation	Salary	15	46.875
	Others	17	53.125
	Total	32	100.00

The table above shows that female respondents are the more dominant with has 56.25%, the age group 30-39 years is predominant with 43.75%. Similarly predominant level of education

is mostly secondary with 43.75% of the respondents. Most of respondents are married ,78,12% of all cases. Respondents who have monthly salary are 46, 87%.The table 1 gives more details.

Table 2: Socio Demographic characteristics of clients interviewed .

N0	Age	Sex	Marital status	Level of education	Function
1	21 years	M	Single	Primary 6	shopkeeper
2	25 years	M	Single	Secondary 3	Carpenter
3	30 years	F	Married	Primary 7	Business
4	33 years	M	Married	Secondary 2	Messenger/ Office assistant
5	30 years	F	Single	Primary 6	Housewife
6	20 years	F	Married	Secondary 3	Housewife
7	23 years	F	Married	Primary 7	Housewife

Table 3: Socio Demographic characteristics of community health workers (CHW) interviewed.

N0	Age	sex.	<i>Marital status</i>	<i>Level of education</i>	<i>Function</i>
1	34 years	F	Married	A2	Student
2	58 years	M	Married	A2	ASC
3	54 years	M	Married	A2	ASC
4	28 years	M	Single	Primary 5	Cooperative
5	41 years	M	Married	A2	Private
6	30 years	F	Married	A2	Private
7	37 years	F	Married	A2	Private
8	48 years	F	Married	Primary 5	ASC
9	49 years	M	Married	A2	Private
10	52 years	F	Married	A2	Private

Table 4: Socio Demographic characteristics of individual interviewed

N0	Age	Sex	Marital status	Level of education	Function
1	42 years	M	Married	A0	Public health
2	44 years	M	Married	A0	Manager
3	29 years	F	Married	A0	Manager
4	31 years	F	Married	A0	Social
5	50 years	M	Married	Master	Medical Doctor
6	25 years	F	Single	A2	Manager
7	30 years	F	Single	A2	Nurse
8	32 years	F	Married	A2	Nurse
9	34 years	F	Married	A2	Nurse and pharmacien
10	27years	M	Single	A2	Tech Labo
11	36 years	F	Married	A1	Nurse
12	32 years	F	Married	A2	Nurse
13	44 years	M	Married	A0	Manager
14	30 years	F	Married	A0	Manager
15	46 years	M	Married	Master	Medical Doctor

4.2. Major inherent causes of the difficulties in cost recovering of health care services provided by the health facility to the CBHI members.

4.2.1 Causes related to the CBHI members' responsibility

According to the respondents, the frequency of visits by CBHI members to the consultation services result in an overspending of the available CBHI budget.

The health services are requested based on having a membership card and not the severity of the disease, because the CBHI members want to maximize the consumption of their

contributions. For example, a group of young people during a brawl in a bar, they beat each other saying, "it's nothing since you have your medical insurance card, you will be treated tomorrow."

Other kinds of misuse of the MUSA card mentioned by interviewed are fraud case by non-members, the frequent use of the card and several health facilities, in order to create a stock of drugs to treat others in the future, especially given that the MUSA expire soon. A member or adherent can also pretend being patient by presenting symptoms of his or her own unaffiliated really sick. So a family can pay for a small number of persons but seek treatment for his whole composition.

The members of CBHI didn't still understand the notion of solidarity bound to health insurances, everyone doing everything to maximize the consumption of his/her premium without thinking about the others.

4.2.2 Causes related to the responsibility of the section of CBHI

Respondents noted problems related to insufficient quantity and quality of staff. They point out that the staff of MUSA is insufficient comparing with the large volume of activities. In addition, staff have not received adequate trainings in the management of MUSA, area in which they don't have enough experience. Also, some respondents complained that the MUSA staff do not take enough time to go on the ground to sensitize the population about MUSA.

4.2.3. Causes related to the health facility's responsibility

The clients complained, out of health care providers, the poor quality of reception of patients in health facility even in some urgent cases, especially when the patient does not have a transfer, Interviewed persons talked about also the "swelling of invoices" (surfacturation) by unnecessary tests and medications and sometimes repetitive voluntary and favoritism to meet the patient. "We take advantage of the incompetence of auditors of MUSA section", they said. Some clients decide to go away for medical treatment at Bilyogo health centers led by a Whiteman whereby they are not only welcomed but also receive a good food. In addition to the mentioned poor client services also some medicine are monotonous and ridiculous enough and the late arrival of an ambulance when needed.

Other causes highlighted in the cost recovery of health services such as those raised by respondents are that all Health Centers do not have the same organization of care. For example, some Health Centers do not work at night while the flow of some patients is high at night mostly children and elderly people.

4.2.4. Causes under the responsibility of donors.

According to the CBHI clients, some donors do not comply with their promises. “For example, some bills are not paid while others are delayed to be paid”, they said. This results in the cessation of indigent care and increased health care debts.

Others causes of the difficulties impeding the cost recovery of health care provided to the members of CBHI highlighted by the respondents are mainly adverse selection done by some NGOs. For example, those NGOs pay for a chosen category like children suffering from chronic disease, ignoring the remaining other members of family. NGOs are also charged poor cooperation with the district administration in identifying the needy and payment. The amount can be paid into the account of the MUSA by an NGO without informing the district.

4.2.5. Causes under the responsibility of the Government

The respondents believe that the most important responsibility relies with government authorities. The budget for the MUSA is insufficient compared to the costs of care, wages, materials, etc. The government fails to honor its commitments often, namely the release of additional amounts and this has implications for the MUSA.

Respondents said also that the amount of premium/contribution requested to the families was initially underestimated.

Also, the proportion of budget called "pooling list" for the payment of bills of hospitals is irregular and insufficient to meet expenses, benefits (health care, staff salaries, equipment, etc.), the use of funds for the MUSA by the district for other purposes. They also said that those who are supported by the FARG suffer from late payment; they feel like apart to care for a long time. It does not consider the level of poverty of the population especially for families that appear to lower category while financial support to the MUSA is insufficient.

4.3. Strategies for improvement of the health care costs recovery.

4.3.1. Strategies in terms of membership.

For behavior change of its membership, some strategies are proposed by respondents: wariness regarding the use of MUSA and taking tough action against fraudsters.

Respondents proposed also community mobilization to gather the members in the tontine "known as ubudehe, Special to the MUSA and create jobs to strengthen the financial capacity of the local population. They add that people should get used to pay the card MUSA and not always having the hands extended toward the donors for external support. They want a broader interest to members for awareness on the proper use of health services knowing that it is their own company. To this purpose, the increase of contribution required and double-checking system at MUSA section and at health center for a good compliance of the card is compelling.

4.3.2. The section of CBHI

Respondents suggested that CBHI provide the qualified and sufficient personnel, appropriate trainings to staff in place to enhance their knowledge and regular monitoring to have competent auditors able to cancel the invoices which not comply and serve to FOSA. This would allow the section of MUSA unit to discharge debts vis-à-vis health center and it is in turn to pay for drugs and materials needed to provide quality services to members. An extra effort is required to MUSA staff for regular field visits, together with the authorities in view of the basic awareness of the accession of the whole community in the MUSA area and updating of the family record with evidence. Some respondents argued for an incentive award to the staff of MUSA, others require a careful revision of the premiums to increase the coverage of catchment's area and minimize the outsiders.

4.3.3 Strategies for Health facility

Under health centers respondents suggested the staff to improve their customer care of patients, to double vigilance in monitoring compliance of the MUSA card to avoid fraud, train staff on the management of client files/records and professional awareness of prescription drug claims and laboratory tests.

It is suggested to provide a permanent medical doctor at the health center, Particular emphasis should be on strengthening the nursing staff by recruiting others, disciplinary transfer and

those dry up the image of the health center often hostile customer when booking to customers. Participants recommended the nursing staff's observation of professional ethics in billing and treatment, avoid favoritism.

In addition, they advocated for the creation of appropriate database to prevent fraud, regular monitoring of section MUSA and improving the transfer system by increasing the number of ambulances and direct admission of an emergency by the district hospital. . More health centers should increase community awareness on use of health services and have the accurate database to prevent fraud.

4.3.4 Strategies with regard to donors

For NGOs, the respondents recommend to establish the system of payment for the needy supported bills to avoid the accumulation of unpaid bills to the detriment of vulnerable people. In return, “donors should quickly and completely fulfill their commitment towards the poor people and support all health centers by giving them the same benefits”, said the respondents. They offer pre-payment system, to honor their commitments on time for the sponsor to the poor families, maximize payments to the poor people, and avoid financial support for the extension work within health centers and good collaboration with the district authorities.

4.3.5 Strategies in relation to the Government.

A series of suggestions made by respondents are addressed to the government. This is particularly looking for more financial partners to support the MUSA project, the provision of materials and wages to motivate workers to MUSA and the additional budget to pay health care bills. They interviewed expressed the wish to revise upward co-payments, co-operation between MoH and the local population while establishing contribution of members, to create a MUSA pharmacy as RAMA for government agents. Establish the effective system would seek treatment anywhere there is regular monitoring and operation of MUSA on the countrywide.

Respondents want the government to adopt the system of universal health care so that a member can get medical treatment everywhere in the country, to provide the supplement budget to support the community's contributions, Many of the participants recommended to the government to harmonize drug list for MUSA clients as is the practice for RAMA, good work collaboration between central level and decentralized structures, written instructions and

compliance with the law, working with the public in setting the new rate of contribution of MUSA clients. Some others suggested the following: regular monitoring of policy of MUSA by MoH, the availability of the budget, the week dedicated to MUSA and not the slogan or routine, MUSA payment for all family members and not one person in a family. Finally, they pleaded for release of money to the poor people on time to avoid interruption of care services to them, provide attractive salaries to workers of MUSA and adequate materials, the additional payment for health care bills, simplification of process of transmitting lists of needy people to their donors, look for other partners to cover the gaps and avoid suddenly pooling list.

4.3.6. Other strategies

Other strategies identified by respondents include the wishes of the membership of the entire population in the MUSA, the regular adjustment of the project and the refusal by MUSA, care of cases of injured especially in the drunken brawl.

They suggested that all health centers have their own autonomy, continue to give the health membership cards to people living with HIV and AIDS and to practice its commitment and comply with the policy. They recognition that the availability of MUSA policy is the solution to the community needs. It has many advantages including the fact that clients seek medical treatment on time, easy membership, reduction of diseases, and the demystification of the taboo once called witchcraft. Respondents believe that if government support was effective it would be done with the debt problem. They came again on the proposal for the energetic mobilization of the community to adhere to any MUSA, the creation of jobs for affiliate people, free to take insurance at its option depending on financial capacity of each and everyone. They also suggest the consistency of financial capacity for health centers because some section of MUSA has no debt, while others have a very huge. Finally, they proposed the strict control and monitoring of inputs and outputs to determine why the MUSA fail to pay the debts and provide to all health centers the same responsibilities and packages of tasks, regular adjustment of project is also the most important.

CHAPTER V: DISCUSSION OF RESULTS.

The above results led us to a discussion of key points that hamper the cost recovery of health care services provided to the members of the CBHI as well as key strategies outlined to address the situation.

5.1. Major causes of the difficulties in cost recovering of health care services provided by the health facility to the CBHI members

All started by noticing that there existing huge unpaid bills to the detriment of Kabusunzu Health Center. . It is true that the cost recovery is a concern in most countries of the world in general and in developing countries in particular. The newspaper “le soir” coming back to the article entitled "the cost of health care gets heavier" published on September 28, 2009 in “Carrefour Santé” said: "This is the norm in Belgium, as in all industrialized countries: the expenses on health care are increasing at a faster rate than revenue from payroll taxes that finance the social security system. Hence the resort, since 2008, by to an alternative financing supplied by tax revenues. "[21]

A group of researchers, members of the Health Economics Unit of the Ministry of Public Health and Social Affairs of the Central African Republic, currently focusing on the recovery system of health care costs conclude: "Concerning the functionality of the existing health care cost recovery systems, especially the organizational dimension, many levels of development are to be achieved in order to make it even better and efficient. Of course, a possible restructuring of these systems will help health facilities to recover to a certain extent the various operation costs. But as the health facilities do not have all the parameters; it would be risky to set this limit in terms of figures» [22]

The financial records review led us to realize that the amount of money owed to Kabusunzu Health Center by the CBHI for the health care provided for its members is more than 59 million RWF, the equivalent of about 98 000 USD while at Muhima hospital the value of unpaid bills is up to 454 792 535 000 RWF, the equivalent of 757.898 USD. [23]

One of the most cited reasons is financial incapability due to population’s poverty. The demographic and Health intermediate surveys jointly conducted in 2007-2008 by Ministry of Health, National Institute of Statistics of Rwanda and USAID released in 2009 showed that:

"Although efforts are regularly made to develop the service sector and to stimulate investment in industry, agriculture still occupies a prominent place in Rwanda's economy. Data from the General Census of Population and Housing (RGPH) of 2002 show that more than 8 in 10 people are employed in agriculture with 81% of men and 93% of women (SNR, 2005). The agricultural sector is, however, the major constraints due to a production system characterized by small farms with an area less than 1 hectare, simple technology and low investment"[24].

In addition, the report by a multidisciplinary national team of Rwanda about poverty says: "If the economy experienced a sustained improvement between 1995 and 2001, with GDP growth rates above 6% per year, Rwanda remains one of the poorest countries in the world (with a GDP per capita of 250 USD in 1997). In 2001, the incidence of poverty was 60% across the country and 66% in rural areas, where the majority of the population lives "[23] However, at present, according to the Ministry, of Health the GDP increased from 250 USD per capita in 1997 to 565 USD per capita in 2011.

Another factor that accompanies poverty, raised by respondents is the ignorance of people. It is true that Rwanda scores a significant rate of low level of education.

The demographic survey mentioned above reveals the following situation: "Concerning the education level, the results still show a gap between women and men: indeed, 22% of women have no education against 15% among men aged 15-49. Only 12% of women and 15% of men have achieved a secondary education or more. In addition to these gender disparities there are important geographical differences: in rural areas, 24% of women and 17% of men have no education against 13% and 9% in urban areas "[24].

Poverty and ignorance result in misuse of the CBHI card (over-requesting, false or borrowed cards, vagrancy, etc...) The document of the national community-based insurance policy, identifying the major challenges of community-based insurance, acknowledges such abuses as well. "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" [6].

The same document confirms the points of view of the interviewees who consider the amount of requested premium as unrealistic and even think that the CBHI project was not well studied; they say the following:

‘There are also major challenges with the financing mechanisms of the CBHI system at different levels. The financing of primary pools still relies mainly on the contributions of households who are relatively poor, and cross-subsidization from richer groups needs to be improved. Current contribution policies under the CBHI system are based on a flat rate for all income groups. The current flat membership fee with regressive burden on the households’ budget is too high to enable poor households to pay their premiums themselves. The financial sustainability of CBHI is also threatened by the rigidity of contribution levels which have not been changed since 2005: the membership fee of CBHI, which was established at RWF 2,000 per person based on a costing of health care level conducted in 2003, is outdated, and needs to be adjusted to reflect today’s real costs’ [18].

However, the amount to be paid by a CBHI’s member should take into account the capacity of the population to pay based on UBUDEHE Classification, according the lately revision. This revision foresees specifically the amount to be paid in: the first category is two thousand Rwanda francs (2000 RWF) per person per year, the second category is three thousand Rwanda francs (3000 RWF) per person per year, the third category is seven thousand Rwanda francs (7000 RWF) per person per year and the partners who support vulnerable peoples will paid three thousand Rwanda francs (3000Rfw) per person per year. We hope that this recent reform will contribute to solve partially the problem of costs recovery of health care provided to members of CBHI. (8)

Regarding the insufficiency of partnership between district and ONGs that the respondents have revealed, the document on the CBHI policy acknowledges that there is a great weakness in help to the poor. ‘Although internal sources of funding have been identified, the national and district risk pools are under-funded as a result of weak contributions of potential sources and weak administrative capacity for resource mobilization. The current mechanism is highly fragmented. In this context, poorer sections and districts are at much higher risk of bankruptcy and are unlikely to achieve financial sustainability’ [25]

As for adverse selection, the Ministry of Health of Rwanda provides the following clarification: "To avoid adverse selection at the time of membership, most CBHIs have adopted the mode of family or household membership, that is to say that all members of a household must always adhere to the CBHI and not individually. Thus the determination of

the premium contribution is made such that the family membership is privileged. "It adds," Still for avoiding adverse selection, other complementary measures are taken by the CBHIs, including the establishment of a waiting period of 1 to 3 months depending on the CBHI. Finally, where the mechanisms of subsidization to the vulnerable and / or the poor are involved, the CBHI often carry out advocacy with funding agencies so that they subsidize the family unit rather than the child or vulnerable adult "[18].

The interviewed CBHI staff members complained of lack of motivation and benefits. When we speak of motivation we mean not only financial rewards but also the satisfaction of the importance of the program and the chance for success and the work environment. A WHO team composed by Bruno Meessen, Jean-Pierre I Kashala and Laurent Musango, focusing on compensation based on the results in order to increase the productivity of the staff members in public health centers(contracting in the District of Kabutare in Rwanda) yielded the following result: "the changes to the contracts structure led to improved performance of health centers: specifically, the establishment of contracts based on the results for the payment of the health personnel resulted in large increases in productivity of the staff. "[26]

Speaking of motivation, Marc Luoma, IntraHealth International wrote: "A successful health staff needs clear professional expectations, updated knowledge and skills, adequate materials and equipment, constructive criticism and a careful supervisor. Providers also need motivation, especially when other performance factors are not met. In fact, highly motivated individuals are often able to overcome obstacles such as poor working conditions, the feeling of insecurity or lack of equipment. Given the challenges currently met in human resources for health (HRH) in most developing countries (Joint Learning Initiative, 2004), helping the providers achieve optimal productivity, despite such obstacles, is possible only if one increases their motivation "[27]

The habits of relying on a paternalism of a donor or an NGO is the state going back to the colonial and post colonial period and continues up to date. The respondents are indignant with the fact that even individuals with enough financial capacity to pay the premium prefer to be assisted by a donor, hence reducing the resources available to the public finances of the States.

Boubou Cissé, Stéphane Luchini and Jean-Paul Moatti explain in an article entitled, Cost Recovery and demand for care in developing countries, published in a French journal in

economics in 2004, that “Until the late 1970, the majority of developing countries (many of which are newly independent nations) provided public health services almost freely for their people. This choice is partly a reaction against the colonial system that excluded most of indigenous from all health care (Tizio and Flori, [1997]), but also by application of the political promise to provide all with an access to health care." They keep saying, " In the early 1980s, the international economic crisis greatly affects developing countries (DCs), especially African countries. Due to macroeconomic constraints, these countries are faced with difficulties pertaining to the implementation of the stabilization and structural adjustment programs that have direct impact on social spending (Guillaumont and Guillaumont-Jeanney, [1994]). Budget limitations that resulted were immediately converted into an increased lack of financial resources allocated to the health sector, and thus a progressive deterioration of services in this domain. Faced with reduced public funding of health systems in developing countries, those responsible for their health services were compelled to seek new financial resources to pay the existing recurrent costs "[28].

Another obstacle that rose during the interviews with the respondents in our study is the quantitative and qualitative inadequacy of health care workers, who perform a large volume of activity. As a corollary to this, a long queue of patients suffering from long waits, the shortened consultation time, hence unsatisfactory welcome, and inattention that can result in wrong treatment. The customers feel discouraged!

The Central African Republic Ministry of Health in its strategic plan wrote: "The quantitative deficit of staff in rural areas is compounded by the lack of quality. The few specialists, surgeons and most midwives, without considering the nursing attendant, are only found in Bangui. In poor and difficult to access areas, health staff is not motivated to carry on their activities" [29].

Emmanuel Habiyakare, in his article published in SIFIA Great Lakes, argues:” The overwhelmed health facilities, victims of the medical insurance successful, health centers and staff are completely overwhelmed. The long queues at the health centers and pharmacies discourage the patients. They complain of inadequate and delayed services. "Health care providers give priority to emergency cases resulting from accident or fever," said a nurse at Gitega health center, Kigali. Hospitals also are overloaded. Often, two patients are required to share one bed. "This influx is due to the fact that nowadays most of the Rwandan population can be treated thanks to the solidarity of the community-based health insurance," said an

official of the technical unit to the CBHI support at The Ministry of Health. According to the Ministry, "each health center, which initially received about thirty patients a day, receives a hundred now." Today, 85% of 10 million Rwandans have joined this insurance against 27% in 2004. Since four years ago, every Rwandan has been obliged to subscribe to the health insurance "[6].

It is obvious that in these conditions, it would be unusual to expect a warm customer welcome. Often the principles of patient's legendary rights to access to quality care, choice of caregiver, his/her own and family's information, decision-making, prior consent, confidentiality, dignity, religious assistance and recourse are violated. Whereas, it is well known that warmly welcoming a patient constitutes a half of his /her treatment.

One of the causes that hinder the payment of bills is their being questioned by the debtors including the MoH and NGOs for overbilling. In this regard the Ministry of Health considers that "Relations with health care providers are also a major concern for the financial sustainability of the CBHI system. In many CBHI schemes, financial sustainability has been threatened by over-prescriptions, which have raised concern about the appropriateness of provider payment modalities. Major challenges include: overuse, over-prescription and over-charging of acts by providers; and the misappropriation of funds in some sections. "[6]

A representative of NGOs is worried about long process for the funds transfer. Here is how policies as described in the Health Policy in Rwanda: _ "All the poor are identified at the cell level by community health workers and members of health committees. This list of the poor is approved by members of the health committees of the health centers and is posted at the health facility. The list is reviewed every six months. A budget for the indigent's care is added onto the budget of the Ministry of Health and the latter is used to pay the bills of health facilities. Nowadays, with the process of community-based health insurance in the country, all the indigent are identified at the cell level and each administrative district in its financial plan, provides a budget for the care of the identified indigents "[6]. This long process is likely to discourage the donors' good will.

5.2. Strategies for improvement of the health care costs recovery.

Collaboration with districts, sectors, cells and the consultation of the population to fix the new rate of the contribution.

About this collaboration, Jean Jacques R , in her research on causes of failure organizations, said: “A great deal of resentment is aroused when management announces a change and then mandates the specifics of implementation. Employees need to be involved in two ways. First, their input and suggestions should be solicited when planning the change. Secondly, after a change has been committed to, they should be involved in determining the means. Leadership needs to communicate, "Here's what must happen. How do you think it can best be done?" [30]

The collaboration between leaders and population is procedure very important in change, since the planning, execution until assessment of the community's program. Robert Chin by the way of this issue: “ The educational problem then shifted to inducing people to comply with immunization procedures based on research finding. This appeal to a combination of research and education of the public has worked in many areas of new knowledge-based thinking technologies where almost universal readiness for accepting the new technology was already present in the population.”[31]

Backing of the politics of the creation of jobs, of tontines, cooperatives and other income generating activities for heightening the financial capacity of the population leaving struggle against poverty.

The economic development and poverty reduction strategy 2008-2012 of the Rwanda stipulates: “Rwanda's Economic Development and Poverty Reduction Strategy(EDPRS) provides a medium-term framework for achieving the country's long-term development aspirations as embodied in Vision

2020 and the MDGs—namely, economic growth, poverty reduction, and human development.

Intended as an operational tool, the EDPRS is supported through

detailed sectoral strategic plans and is the country's main mechanism for mobilizing and allocating public expenditure resources. The EDPRS promotes three flagship programs:Sustainable Growth for Jobs and Exports; Vision 2020 Umurenge;⁷

and Good Governance. Although emphasis is squarely placed on promoting economic growth in Rwanda, the strategy also includestargets for effective environmental management, slowing populationgrowth, and improving health ?” [6]

The regular follow-up of the strict implementation of MUSA policy. The policy of CBHI provides: “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.” [6]

However, as the shows respondents them some official instructions are contrary has this politics coming from top. They mentioned an example according to continue use the old card for last year. It belongs to the hierarchical processes to apply the politics strictly as conceived by the MINISANTE.

However it is necessary to note that according to the recent revision of contributions in CBHI, the annual premium is per person per year but adherence to the CBHI on the membership of all members of the family. It will probably contribute to the resolution of this problem of cost recovery (7)

Maintain and availability of budget "pooling risk at the appropriate moment to avoid the unpaid invoice accumulation and the interruption of cares to paupers. A major challenge faces us today is to restructure our social insurance programs that will guarantee a future financial stability. Alternatives to an increase in the tax rate include increasing the insurance mostly premium enrollees have to pay and increasing required cost sharing by increasing existing deductible and co-insurance payments. In United States of American, the role in health care financing continue to increase while at our country wants to decrease it. We read through Ansel M. and co-authors “The government ‘s role in financing of health care services has increased steadily and significantly since inauguration of Medicare in 1965. Prior to the enactment of Medicare, the public sector accounted for only about 25 percent of total health care expenditures.

By 1990, the government ‘s share had risen to almost 41 percentage, and it has continued to increase. In 2001, government financed 45 percentage of health care services provided in the United States.” [31]

The role of government should be maintained especially for the “pooling risk” in order to avoid inequalities in the access to health cares among the population.

Simplification of transmission process of pauper lists to sponsors of funds.

The policy of good governance extolled by Rwanda privileges the delegation and decentralization of power. Consequently, the MOH should make so that verification and transmission of the vulnerable’s list be done by districts. “Different people participate in

strategy development at the functional and business level. Business strategy is the responsibility of general Manager of business units. That manager typically delegates the development functional tactics to subordinates charged with running the operating areas of the business” [32]

Attractive salary, sufficient materials and adequate training to the staff of MUSA;

Commenting the theory of the hierarchy of the needs Maslow specifies that the differences in the needs and the desires among the employees can be the result of the differences of conditions economic and social of basis, of education, of the interests, of the capacities and faculties, of the past experiences. One of three principles of motivation is the principle of the ROBERVAL balance that constitutes to place for example in one tray of the balance what the agent gives: expertise, the merit, will, and that one would call the "inputs". In the other what the organization gives to the agent the salary for example, that means the "outputs". The result is the next one: if there is unbalance, the tendency for the agent is search of the compensation outside of the system. Other important is principle of equity. “Inequity occurs when person perceives that the ratio of his or her outcomes to inputs and the ratio of a relevant others outcomes to inputs are unequal “ [33].

The government would give equal opportunity to all workers and the criteria used would not discriminate

Foresee the stern measures going until fines to the profit of mutual fund and confinement against the fraud and the falsification of adherence cards and to be heedful and rigorous in the control of adherence card;

The article 62 of law establishing and determining the organization, functioning and management of the mutual health insurance scheme according the member who fraudulently uses a member’s card stipulates: “Shall be liable to the payment of a fine of between five thousand Rwandan francs (5.000 Rwf) and twenty thousand Rwandan francs (20.000 Rwf): 1° an affiliated member who shall lend his or her card to a non member or one who shall use an expired card; 2° an affiliated member who uses another fraud which may cause bankruptcy to mutual health insurance scheme.” [7]

Respect of the professional deontology concerning invoicing and treatment.

“A corporate approach to ethics requires that ethics is integrated into all aspects of our work,; achieving standards of excellence in the performance of our work, in serving clients, good leadership and effective teamwork, responsible dealings with other agencies and government.” .” [34]. In this case health staff has the responsibility and publicly accountability

to serve their clients with empathy. In Oath of Hippocrates the physician take commitment to consider for the benefit of his or her patients, and abstain from whatever is deleterious and mischievous. The nurses also should must be as Florence Nightingale who was considered their pioneer in the nursing professional.

Improvement of the costumer care increasing the system of transfer notably for emergencies. The costumer care is on of the key to maximize the profit. “Chit wood says the company ultimately had to drop that customer. Set expectation too high and the result an unhappy customer. Set expectation too low, however , and you can’t charge as much because the customer doesn’t perceive that the value is there. When expectation are set appropriately, the customer is willing to pay the right price and, if the value is there, is willing to pay more. Marketing communication, the, can help achieve greater profits.” [35]. Developing costumer care in institution is developing the promotion of production and without costumer relationship Management the enterprise is vowed to the disappearance.

Sensitization of the population for the rational use of services and the mind of auto responsibility; The communication is the oxygen of the group and fuel of the actions. The communication help to make share the values and the interests, exchange information on topics of common interests and to inform on events and introduce some actions on the learners and the collaborators of a group of training or work

to make converge the point of view, the opinions of a work group, of where efficiency. In community or the group, the communication plays a role as the blood in the organism. It is therefore important that actors of CBHI can put effort on the sensitization of population so that this one can appropriate of their health Mutual.

Institution of prepayment problems, maximization of payment to paupers and to avoid the inimical section. We think that the population doesn't always expects on the external Fund. Help would have to decrease rather progressively as foresees it the Politics of CBHI. “Developed in 2000, Rwanda's Vision 2020 elaborates a national long-term vision in terms of goals and objectives to be achieved by the year 2020. By that year Rwanda should: be a middle-income country; have halved the percentage of people living in poverty; raise life expectancy to 55 years; and have reduced its aid dependency. It expects to reach these goals by means of seven strategies/pillars, which include decreasing population growth, increasing access to education and improving the health of the people. This document serves as the basis for the elaboration of national and sector plans in the medium term”. [6]

CHAPTER VI: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion.

This study was motivated by the fact that, based on financial reports and accounting records, it was noted the large unpaid invoices for the members of the Community –Based Health Insurance (CBHI) of the Kabusunzu Health Centre , with the prejudice of the functioning of this Health Facility.

Indeed, until November 2011, the accounting situation notes a debt of more than 59.000.000 Frw due to Kabusunzu Health Center by the section of CBHI (mutuelle de santé).

Thus, the objectives of this study were to:

1. Identify the main causes of the difficulties encountered in the cost recovery of health care provided by the health centre to the members of CBHI
2. Propose strategies for the improvement of this situation

To do this, we conducted interviews with various persons involved in one way or another in the Organization of CBHI, including members/adherents, care providers and managers from the Health Centre to the central level of the Ministry of health.

The main causes identified by the interviewed as being at the base of the difficulties encountered in the cost recovery are numerous. The most prominent and most cited are 1) the poverty of the population to meet the cost of the health care, 2) misuse of CBHI card including fraud, falsification and the high frequency of medical consultations, 3) too low amount of requested premiums , 4) adverse selection by NGOs, 5) lack of motivation of the staff employed by CBHI, 6) insufficient quantitative and qualitative personnel, 7) overbilling of nursing or medical acts including laboratory tests, 8) the long process in the transmission of the lists of the indigents etc...

The chapter devoted to the presentation of the results provides list of all identified causes. It followed a series of strategies/suggestions to improve this state of things of which the most essential are translated into recommendations in the following section.

6.2. Recommendations.

At the end of our study, it seems to give our modest recommendations and suggestions that we believe necessary to improve the system of cost recovery, to some institutions which have responsibility of CBHI in our country.

6.2.1. To the Government Ministry of Health.

- Maintains and availability of budget "pooling risk" at the appropriate time to avoid the accumulation of unpaid invoices and the interruption of health care to the indigent.
- The simplification of the process in transmission of the lists of the indigents to the donors
- The attractive salary and others materials and adequate training for personnel of CBHI;
- Severe measures including imprisonment against fraud and the falsification of the CBHI membership cards.
- Moreover, the Ministry of health could consider in the future a single institution of Health insurance with compulsory adhesion to all the inhabitants of the country, funded by various sources of funding mentioned above.

6.2.2. To Nyarugenge district.

- Strengthening the policy of the creation of jobs, tontines, cooperatives and other activities generating income to enhance the financial capacity of the population in the spirit of fighting poverty.
- Diversification of sources of funding for the Health Insurance and the universal coverage to ensure fairness and equity to all the inhabitants of the country and avoid selective care within the same country.
- Among the potential sources of funding, it must think about the contribution of companies which product or contribute in some dangerous products such as tobacco, alcohol, gas stations, transport companies etc...
- Fraud and the falsification of adherence cards.

6.2.3. To the health facilities.

- Respect of professional ethics in billing and treatment,
- Be vigilant and rigorous in the control of CBHI membership card;
- Improvement of the quality of reception given to the CHBI members;
- Sensitization of the population for the rational use of the CBHI services and the spirit of auto responsibility.

6.2.4. To the Non Governmental Organizations (NGOs).

- Avoid adverse selection while paying for the indigents.

This study is only a drop of a sea and has no claim to have exhausted, all forms of health cost recovery systems analysis in all its complexity. This is even true that our study addressed only the situation of a single health centre, the results of this study are not generalizable to other health facilities. They are valid only at the Kabusunzu health centre. Therefore further studies would be needed to bring more information to this problem in the country. Thus, we suggest a more extensive study, at the national scope, which would determine the causes of non-recovery of the costs of health facilities in the context of CBHI in Rwanda, and propose possible solutions.

We hope nevertheless that our findings will provide with different interested parties including decision makers, some precious information and will contribute to the resolution of problems of cost recovery of health care services provided to the members of CBHI.

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APPENDIXES

ANNEXE 1. CONSENT FORM.

My name is MUKUNDWA NTAKIRUTA Denis, I work at Kigali Health Institute and I am a student at the School of Public Health, University of Rwanda. I am doing a research on the issue of recovery of cost of health care provided to members of the community-based insurance in Rwanda. The objective of this research is to identify problems related to difficulties regarding cost recovery by Health Facilities and contribute to the development of strategies for effective and sustainable functioning of CBHI in the Kabusunzu HC.

You have been selected for this study and I invite you to participate, if possible, for you are among the beneficiaries of the results. These results will help us to make recommendations for proper management of our Community-based insurance.

I would like to ask you a few questions divided into three categories: the first part concerns the information about how costs for care provided to members are recovered, the second part will be devoted to the identification of major root causes of difficulties related to cost recovery for health care provided by health center affiliated with the Community-based insurance. The last part focuses on search of strategies of community participation for effective cost recovery and sustainability of CBHI. Your name will appear nowhere. Your answers are completely confidential and no reference will be made to you. The questionnaire will be kept in sealed envelope. The only people who will have access to the information are my supervisors who are also required to maintain confidentiality.

If you feel uncomfortable with a question, you are free to not respond. Your participation is completely voluntary and you have the right to not answer questions or to not participate at all.

Thank you for agreeing to answer these questions even though we are not able to financially reward you for your time. By completing this questionnaire you have contributed in one way or another in serving many people in this community, which will benefit better services in the future when they seek any health services at the health facility. You can drop out any time you prefer without incurring any prejudice The interview will take approximately 25 minutes.

1. The researcher's contact (for information on the survey)

Denis MUKUNDWA NTKIRUTA
NATIONAL UNIVERSITY OF RWANDA
SCHOOL Of PUBLIC HEALTH
Tel: 0788468121

2. The Committee of Kigali Health Institute (for any ethical issue).

Dr Kato Ndjunwa
Kigali Health Institute
Faculty of Allied Sciences
Office Tel: (+250) 572172

3. Contact of the Supervisor (for information on the study)

Nzayirambaho Manasseh, MSc, PhD.
SPH / NUR cell phone (250) 785 255 388

Do you have any questions? Are you willing to participate in this study?. (Yes). . . . (No)

Thank you for your decision to participate in this research.

Consent statement

I have received and understood the necessary information about the study mentioned above. I realize that all the information I will provide in this context will remain strictly confidential. It is understood that I have the right to withdraw from the study at any time without incurring any prejudice.

I agree to participate in this meeting that will last for about 25 minutes.

Signature

Date

Investigator's signature

Date

ANNEXE 2: INTERVIEW GUIDE DESIGNED TO THE MANAGERS AND TECHNICIANS

1. In your opinion what are the causes of these difficulties?
 - a) Causes pertaining to the responsibility of the members;
 - b) Causes pertaining to the responsibility of the section of CBHI.
 - c) Causes pertaining to the responsibility of donors.
 - d) Causes pertaining to the responsibility of the health facility.
 - e) Causes pertaining to the responsibility of the Government.
 - f) District Hospital
 - g) Other cause
2. What are the strategies you may propose to guarantee the CBHI sustainability?
 - a) Strategies regarding CBHI members
 - b) Strategies regarding CBHI section
 - c) Strategies regarding the donors
 - d) Strategies regarding the Health facilities
 - e) Strategies regarding the Government
 - f) Strategies regarding the District Hospital
 - g) Strategies regarding other factors

ANNEXE 3: INTERVIEW GUIDE TO CUSTOMERS FOCUS GROUP AND COMMUNITY HEALTH WORKERS

1. In your opinion, what are the difficulties that impede the CBHI functioning?

- a. Difficulties pertaining to the responsibility of members.
- c. Difficulties pertaining to the responsibility of donors.
- b. Difficulties pertaining to the responsibility health facilities.
- d. Cases pertaining to the responsibility of the Government.
- e. Other cause

2. What are the strategies you propose to make permanent the CBHI?

- a. Strategies in terms of membership.
- b. Strategies in terms of health facilities.
- c. Strategies with regard to donors.
- d. Strategies in relation to the Government.
- e. Strategies in relation to other factors.