

## Considering Healthcare Insurance to Uninsured Individuals in Rwanda

Sandra Marie Grace Musabwasoni<sup>1\*</sup>, Abe Oudshoorn<sup>1\*</sup>

University of Western Ontario, London, Ontario, Canada

Correspondence email: mmusabwa@uwo.ca

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### Abstract

**Introduction** Rwanda healthcare insurance coverage aims to help Rwandans with access to healthcare. However, some individuals face difficulties with obtaining healthcare insurance. This paper provides a critical analysis of policy factors hindering the attainment of total coverage.

**Methods** A critical policy analysis framework devised from discourse theories by Taylor informed this paper.

**Results** This paper illustrates the context and antecedents associated with the issue of uninsured individuals. The paper highlighted competing factors and discourses contributing to persistent gap in healthcare insurance coverage in Rwanda. An example of factors is a limited income of individuals assigned to the second Ubudehe category.

It further identifies the nature of the issue and corresponding economic and social consequences, along with priority action steps required to attain total healthcare coverage.

**Conclusion** To address the issue of uninsured individuals, the Government of Rwanda should target segments of population with the lowest rates of coverage, regardless of their income.

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**Keywords:** Rwanda, Healthcare coverage, uninsured, Ubudehe category

### Introduction

The issue of individuals facing difficulties with healthcare insurance, referred to as uninsured individuals, hinders progress in healthcare insurance coverage in Rwanda. This may contribute to the delay in the attainment of a total coverage of the whole population envisioned by the Government of Rwanda. In Rwanda, healthcare is delivered through a multi-tier system starting from community level of health workers to the national referral hospitals. The multi-tier system facilitates healthcare delivery across a densely populated country with limited resources and geographical barriers. Community-based healthcare insurance (CBHI), referred to as *Mutuelle de santé*, started in 1998 with the aim of allowing Rwandans access to healthcare, and covers the majority of the Rwandans (i.e., 94% of the total population).[1] Although, the CBHI has been widely successful in improving access, improvement is required to ensure complete coverage of the whole population. In this regard, CBHI and La Rwandaise d'Assurance Maladie (RAMA) were merged and integrated into the Rwanda social security board (RSSB).[2] This integration intended to enhance the efficiency of delivering services; however, it has not bridged the gap regarding full healthcare insurance coverage.

Aside from RAMA, which provides insurance for civil servants through contributions from monthly salaries,

Military Medical Insurance (MMI) is another public healthcare insurance for military forces, law enforcement and their families. Employees of private institutions and wealthy families subscribe to private health insurance services provided by insurance companies. Yet, a part of the population remains uncovered by neither public nor private healthcare insurance, especially among individuals with low economic status who do not qualify for public subsidies. This paper sought to critically analyze the situation of uninsured individuals through the community-based healthcare insurance (CBHI) and suggest actions to address the issue of uninsured individuals.

### Methods

Using a critical policy analysis framework devised from discourse theories by Taylor, [3] where the author stresses some criteria for approaching education policy research in critical and political ways. Following these two ways, the author links the contexts, texts and consequences of education policy. The author stipulates again that policy texts need to be analyzed within their context in relation to their impact on policy pitches in the broadest sense. In conclusion, the author reveals that politics of discourse can be very useful to those involved in the various arenas of education policy making while encouraging concerned ones to go in the same way. Therefore, this paper articulated the analysis of the policy context and

the debates around the CBHI in Rwanda. Specifically, the analysis traced the context and antecedents which sustain the situation of uninsured individuals, along with discussion about competing factors and consequences in relation to total coverage of the whole population intended by the Rwandan CBHI policy.

## Results

In Rwanda, healthcare related costs are mostly covered by healthcare insurance, which comprises public and private insurance schemes. Nonetheless, not all of the population is currently covered; which implies that uninsured individuals have to purchase their insurance privately. The policy stipulates that, individuals classified in the lowest income classification, denoted as the first *Ubudehe* category, receive free access to CBHI coverage. This low-income group is exempted from co-payment of 10% required for the CBHI insurance scheme. [4] While Rwandans are assigned to *Ubudehe* categories based on income, the subscription process to healthcare insurance is still voluntary; and individuals in higher categories pay a premium. This implies that some individuals who have modest or high income may not subscribe to healthcare insurance since they are not eligible to a public subsidized one. This situation is more prevalent among individuals classified into the second *Ubudehe* category, which requires citizens to pay a small fee to be insured. These individuals are disqualified from full public subsidized healthcare insurance, and many face difficulties to pay into the public scheme at the second *Ubudehe* category. Some Rwandans, assigned to the second *Ubudehe* category, express concerns for the fitness of the categorization process for reflecting true individual's economic status. [5]

Conversely, individuals classified into the third and fourth *Ubudehe* categories are mostly covered under other insurance schemes, including RAMA and MMI subsidized through their employment. This demonstrates the vulnerability of individuals assigned to the second *Ubudehe* category as they neither qualify for public subsidized coverage nor have sufficient means for paying their subscription to CBHI. Therefore, a better understanding of this gap in healthcare coverage requires considering criteria for accessing public subsidized health insurance, which is based on income classifications, *Ubudehe* categories.

With regard to increasing subscription into CBHI, awareness raising activities entail the local leaders' commitment to increasing their local insurance rates to meet the central government's vision of total healthcare insurance coverage. However, local leaders' efforts encounter barriers related to the income bracket just above the cut-off, which limits prospects of acquiring healthcare insurance among Rwandans in the second *Ubudehe* category. [6] This calls for revisiting the

process of assigning categories and offering citizens opportunities for appealing when they feel the category assigned to them is not accurate.

## Discussion

There are many competing factors and discourses contributing to the persistent gap in healthcare insurance coverage in Rwanda. One of predominant factors is the limited income of some individuals assigned to the second *Ubudehe* category. [7] Besides subscription to the healthcare insurance system, co-payments can also be a challenge to healthcare coverage. For example, CBHI covers 90% of total health service costs while RAMA pays 85% of costs.[8-9] This denotes that while attaining 100% coverage is an important first step, it is not the only step in guaranteeing access to healthcare services. Instead, steps towards the attainment of 100% coverage would include ensuring that co-payments are not a barrier to healthcare.

Geographic variation is another important factor in a country with a primarily rural population. The Rwanda demographic and health survey[10] indicated that Rwandans who are covered with health insurances in rural areas is 78.2% while urban areas have achieved 81.4% coverage. The same survey showed that the lowest rates of coverage are met in rural areas. Connecting this with the preceding points in relation to income brackets and access to healthcare insurance coverage, there is a correlation between poverty and rurality within the Rwandan population. Uwamariya[5] linked rurality to low rates of CBHI, which in turn are associated with higher rates of individuals seeking healthcare from traditional healers. Clear associations between poor health outcomes and uncertified traditional treatments in rural areas were also established in other research.[11] Subsequently, uncertified traditional treatments may cause more harm than good in terms of facilitating drug resistance or causing other harms.

Economic growth of any country correlates with the health status of its population. Health and well-being allows the population to participate in the economic development pursuing personal and family betterment through education and social activities. Conversely, those who face illness related to the lack of healthcare access are both personally impacted through their inability to work, resulting in caregiver burden. This has a negative economic effect on the families and the local community. It is unsurprising that rural communities with lower insurance coverage also experience higher rates of poverty; which in turn serves as a barrier to the healthcare insurance coverage. Arguably, it should not be necessary for an individual to fall into the lowest *Ubudehe* category and to receive coverage for care when income is serving as the barrier to access. In a perverse way this may serve as incentives for retrograding into

poverty among those who have some level of financial support. The health consequences relating to insurance obtainment are not simply a personal issue, but are rather broader community and social issues, and require a population level approach to be permanently addressed.

## Conclusion

To address the issue of individuals who remain without health insurance in Rwanda, there is a need for sustainable resolutions. These resolutions require a full agreement on extending access to healthcare for all.

Public healthcare insurance must cover all vulnerable populations, thereby close gaps in healthcare coverage. To this end, we recommend that all individuals in both the first and second *Ubudehe* categories would be insured 100% for health services in public healthcare facilities. Furthermore, individuals in the third category and fourth category should continue to be insured, a minimum of 85% of total costs, as they have the means to meet co-payments. In addition, it is well noted that individuals funded through the RAMA/RSSB, MMI and other private insurances have the same quality of services which would be meaningful if individuals funded through the CBHI should have the same quality of services as their counterparts funded under the insurance schemes stated above. We recommend the full merge of public insurance funds, including CBHI and RAMA, in order to sustain the accounts and enhance the viability of funding during the recommended change. Neither of these recommendations limit personal access to further coverage based on choice, and people who desire extra insurance for private purposes can and should obtain it separately. Should these recommendations prove a strain on current public healthcare insurance funds, taxes could be raised for consumable products, such as alcohol and tobacco. Subsequent revenues can serve not only to provide funding for public health insurances, but also discourage unhealthy personal behaviours.

Rwanda's commitment is to have 100% health coverage for its citizens. While healthcare insurance coverage has considerably advanced in Rwanda, this should not mean that we cease to pursue improvements. To address the issue of uninsured individuals and achieve complete coverage as well as provide the highest level of access to care, regardless of income, the Government of Rwanda should target segments of the population who have the lowest rates of coverage. This would mean eliminating co-payments for the second *ubudehe* category and ensuring that all citizens are properly categorized.

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