ISSN 2348-3156 (Print)
International Journal of Social Science and Humanities Research ISSN 2348-3164 (online)
Vol. 7, Issue 3, pp: (423-432), Month: July - September 2019, Available at: www.researchpublish.com

THE CONTRIBUTION OF COMMUNITY BASED HEALTH INSURANCE ON ECONOMIC GROWTH AND DEVELOPMENT OF AFRICA: A CASE OF RWANDA NYAGATARE DISTRICT

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Abstract: **This study is about the contribution of Mutual Health Insurance on the economic growth and development in Nyagatare District as a case of study. The study was carried out in Nyagatare District and its objective are as follows: To Examine the functioning of Mutual health insurance scheme in Nyagatare District; to find out the impact of improved health status of the people on Economic development in Nyagatare District, to identify the challenges encountered by both mutual health officials and the beneficiaries of mutual health insurance in Nyagatare District. In order to arrive to the findings, the researcher used structured questionnaires and the interview guide to collect data.**

The population of the study was comprised both beneficiaries of mutual health insurance and staffs at the sector and cell levels in Nyagatare District. These questionnaires were given to 30 respondents including fourteen questionnaires (14) which include six heads of households (6); six agents (6) of mutual health insurance and two patients (2) in health centre of Biguhu. Sixteen questionnaires (16) designed to the staffs at sector and cell levels and two nurses (2). A sample of 30 respondents was randomly selected.

Findings revealed that Mutual health insurance plays a big role in the economic development process of the beneficiaries in Nyagatare District through real costs of healthcare services costs minimization. Hence new ventures were to be born through good management of mutual health insurance contributions. At the end of the study, several suggestions were given to the officials and beneficiaries of this policy of MHI scheme and even suggestion for further research was proposed.

1. INTRODUCTION

This chapter is detailed with background of the study, problem statement, objectives of the study, purpose of the study, research questions, significance of the study, organization of the study and conceptual framework of the study.

2. BACKGROUND TO THE STUDY

The concept of community health started way back around 1831-32 during the great revolution in sanitation when cholera tragedy broke up in England. Cholera caused panic and beneficiaries fled the cities and others had died during the medieval plagues. It is a salutary reminder to the rich that they could not be the privileged immunity that pestilence was something Shared by the poor and therefore could be combated communally through community health. In many African countries a considerable proportion of the population faces problems of financial access to essential healthcare services. This holds especially true for the informal sector and beneficiaries living in rural areas. (Barry1965:322).

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

According to WHO (2005) 100 million people every year are driven into poverty due to catastrophic health expenditure. It is imaginable that most reside in resource poor settings such as Sub Saharan Africa (SSA) with very weak modern health care systems and in most cases without any functioning health insurance schemes (e.g WHO, 2003; Carrinetal, 2005). The result is high disease burden that has a risk of propagating a sickly, unproductive labor force. In Sub-Saharan Africa, formal and well-functioning health insurance schemes generally exist for the very few who are employed in the formal sector. For the majority, health care is accessed through out-of-pocket expenditure, which in many instances may lead to suboptimal use of health care services. As a result, expenditure on heath related needs in some countries could be substantially high with visible divergence across the income divide. Households in poorer countries generally tend to spend as much as those living in relatively richer countries, but evidently with worse health outcomes. One of the reasons could be lack of functioning health insurance scheme to protect households from illness related income or expenditure shocks. Formal health insurance schemes for the self-employed and rural farmers are difficult to institute for a number of reasons. Community Based Health Insurance Schemes (CBHISs) are promising alternatives for a cost sharing health care system which hopefully also leads to better utilization of health care services, reduce illness related income shocks and eventually lead to a sustainable and fully functioning universal health care system.

Traditional solidarity organizations exist in a rudimentary form to deal with health related shocks in some parts of Africa and have provided the basis for the movement towards CBHISs that emerged in response to failure by the state and market to provide such services. Ghana, Senegal and Rwanda are among the leading countries that experimented on the idea of CBHISs as a national health program in Africa.

CBHISs in Rwanda are interesting case study for a number of reasons. The first and most important is that the country has scaled up coverage of CBHISs from just around 35% in 2006 to almost 85% in 2008, an exponential growth in a space of two years in the middle of uncertainty on its potential impact on health service utilization and protection from unforeseen health related income or consumption shocks. Such rapid growth and coverage is unprecedented in the history of CBHISs (Mladovsky and Mossialos, 2007). Secondly, CBHISs in Rwanda have been accorded central place by policy makers so that they are integral parts of the country's health program, with a strong administrative and political support for their expansion and functioning. Third, the experiment has attracted so much interest that other countries are considering the Rwandan model as an alternative vehicle for health sector financing and delivery of basic health services.

Some of the strong critiques of the program argue that CBHISs have the potential to further alienate the extreme poor from utilizing health services for at least two main reasons. First, the flat premium rate (about $2 USD per year per person)i is considered to be too high for the very poor so that given a choice they would rather defer health care expenditure until it is vitally needed. Secondly, even if extreme poor people become members of CBHISs, they may not fully utilize its provisions since all is not free. There are other layers of expenses to be born such as transport, prescription drugs, and others including the opportunity cost of time, especially for the casual laborers. Thus, in short the CBHISs could be inefficient and iniquitous for the health service that is heavily subsided by funds coming from the treasury as well as international aid. This study attempts to contribute to this debate by providing some evidence on the relationship between membership to CBHISs and key indicators that measure intended outcomes.

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

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

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

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

Community based health insurance schemes have existed in Rwanda since 1960s that community-based health insurance systems, like the association Muvandimwe de Kibungo (1966) and the association Umubano mu bantu de Butare (1975) started to be constituted. However, these community-based health insurance initiatives were further developed only since the reintroduction of the payment policy in 1996 and especially increase during the past five years. Membership rates of Community Based Health Insurance (CBHI) stood at 73% in 2006 and increased since then to reach 91% of coverage in 2010. (The World Health Report (2000). WHO, Geneva.)

Community based health insurance schemes are normally local community initiatives based on concepts of solidarity and risk pooling and involve active participation of group members. They improve equity access to healthcare and health services for the excluded high level of solidarity, trust and finally improve the ability to counter-risk, cover all healthcare cost. In order to enhance healthcare coverage and provide financial protection against impoverishment due to the costs of catastrophique illness, the Government of Rwanda has implemented several financing mechanisms; (The World Health Report (2000). WHO, Geneva.).

In addition to the Community Based Health Insurance Policy, the present policy has been elaborated to provide a comprehensive guiding framework for a National Health Insurance system in Rwanda. In 2010, the Community Based Healthy Insurance policy has been updated in order to be more adapted to the current challenges of illness, infant mortality rate and maternal mortality rates. The new policy was improving population's access to quality health services in a fair and equitable manner. The existing statutory social security system in Rwanda includes the Social Security Fund (pensions and occupational risks); and, for the health part, the RAMA and the MMI. (World Bank (2003), Washington, DC.).

The Nyagatare district has shown a strong interest in strengthening the structure and capacity of public institutions in providing social security through healthcare services. The district is striving to achieve set targets for MDGs despite this being an uphill task considering that economic development level prevailing in the country is still low. In Nyagatare this policy is in and most of them are the client. Financially, the health institutions can develop themselves and auto finance because the payment of the premium at the right time in a collective system, health institutions can procure enough materials and medicines in order to effectively continue serving the beneficiaries.

3. STATEMENT OF THE PROBLEM

According to Hellman and Atim C (1999:143). An estimated 1.3 billion people worldwide lack access to effective, affordable healthcare, while millions of households worldwide every year face financial ruin as a direct result of large medical bills. To reduce such large medical bills there is a need to share the bills through community based health insurance. With the help of community based health insurance schemes, health costs are minimized and these costs would be invested in profitable ventures/investments to reduce poverty.

However; there is this policy of community based health insurance, in Rwanda, beneficiaries are still being pushed to pay their medical insurance contribution and this causes the above problem of large medical bills in case they feel sick without medical insurance. Hence poor or inappropriate healthcare service in Rwanda and in Nyagatare district in particular. Basing on the above problem, the researcher intended to examine, «The contribution of Rwandan health insurance (Mutuelle de santé) on socio-Economic development of Rwanda.

4. OBJECTIVES OF THE STUDY

The specific objectives of the study were:

i. To find out the effect of community based Mutual health insurance scheme on people's socio-economic development in Nyagatare district,

ii. To identify the challenges encountered by mutual health insurance scheme in Nyagatare district.

iii. To identify the possible solutions to the challenges faced by community based health insurance in Nyagatare.

5. RESEARCH QUESTIONS

The study was guided by the following research question:

i. What is the effect of community based Mutual health insurance scheme on people's socio-economic development in Nyagataredistrict,

ii. What are the challenges encountered by mutual health insurance scheme in Nyagataredistrict.

iii. What are the possible solutions to the challenges faced by community based health insurance in Nyagatare.

6. METHODOLOGY

The study adopted survey design. Mouley (1983) and Kerlinger (1983) observes that survey design is used to gather data from a large population at a particular point in time with the intention of describing the nature of current existing situation in order to plan for the future. The survey design, despite being used for both exploratory and preliminary studies allows the researcher to gather information, summarize, and interpret the information for the purpose of clarification (Orodho 2004). Survey design was employed in the study because it enabled the researcher to gather information from the respondents on the contribution of community based health insurance on economic growth and developmentin Rwanda. Data was collected using questionnaires and interviews.

7. SAMPLING PROCEDURE AND SAMPLE SIZE

Stratified random sampling technique was used to determine the sample size because it gives equal opportunity to all subjects in the population to be selected in the study. A sample size of 13 schools was selected from a target population of 26 secondary schools. This comprised of 2 Girls schools, 2 Boys' and 9 mixed secondary schools on the proportional basis. This was 50% of the target population according to Jacob and Rasariah (1972). It was considered adequate in giving results since all categories of schools were included in the study (Kothai, 2003; Kerlinger 1986). Simple random sampling was used to select school from the specific category. Purposive sampling was used to select health workers.

8. DATA ANALYSIS

Data analysis involved both qualitative and quantitative procedures. In qualitative analysis, information collected was transcribed into written texts by combining the notes taken and then organized into various themes. Quantitative data was grouped according to the research questions and analyzed through percentages and frequencies, and presented in tables.

9. FINDINGS AND DISCUSSIONS

The findings/results of the study were presented as follows:

The contribution of mutual health insurance towards economic development.

In order to determine the contribution of mutual health insurance towards economic development, frequency counts and percentage scores were used to analyze the responses on itemsThe economic development goes hand in hand with an improved health of the beneficiaries through mutual health insurance and the following are the points that justified this contribution:

i. Mutual health insurance contributes in finding ways to keep healthcare costs down by negotiating reduced tariffs and fixed fees per day of hospitalization.

ii. It contributes to the health sector's allocation efficiency.

iii. The MHI contributes to the extension of social protection to the rural and informal sectors.

iv. It helps to poorest of the poor, do not have gainful occupations and cannot work and afford the financial contributions through government intervention.

v. It provides the opportunities for all members to access healthcare which results in reduced mortality rates which hinders the economic development.

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vi. It provides equitable and equal access to quality healthcare for children and women who mostly suffer from different illnesses and this promotes the economic status of households.

The points outlined here above imply that MHI contributes a big to the economic development processes. If each point is to be analyzed at the own, it is shown that this policy of MHI contributes significantly to the economic development by reducing expenses which are incurred on healthcare costs, efficiency allocation of health centres, providing to the poor healthcare services and equitable access to quality healthcare for children and women because these are most vulnerable exposed to different illnesses such as Malaria. Through a successful MHI, the economy gained healthy HR and the excess to real costs on healthcare services can be invested in new ventures to generate or make more income. Hence these reserves are used to promote the economic development of the beneficiaries.

The indicators of economic development brought about by MHI.

In Nyagatare district, there are some indicators of economic development which result from mutual health insurance policy implementation. These indicators are:

i. Reduced illnesses and mortality rate among the beneficiaries,

ii. Above 70 percent or 23 respondents of the beneficiaries have opened the accounts in BPR and umurenge SACCO as financial institutions and do save,

iii. The outlook and behavior of the beneficiaries are also improved,

iv. Infrastructure development, such as health centres, schools, water sanitation and cooperatives.

v. Income is increased because of increased economic activities.

From the points above which indicate MHI's contribution on the economic development, tangible and physical evidences are shown while moving around the sector, though few beneficiaries still against with this policy of CBHI (sects like «Abagorozi» which born from 7th Day Adventists and «Temoins de Jehovah».

4.3.8. Health expenditure of the beneficiaries before and after joining MHI

Health expenditure of the beneficiaries in Nyagatare district before this policy of mutual health insurance was very high. The beneficiaries were usually fallen sick and stay at their home because of the lacking and insufficient of financial means for them to go to the health centre for their healthcare. They normally used to cure themselves using traditional methods. They also used to the witchcraft/traditional doctors when they fallen sick. This practice works as a source of conflicts among the beneficiaries and the resources of the beneficiaries were spent buying wrong medicines or drugs. The costs of healthcare were very high while health services were very low.

With the introduction of MHI and after its sensitization among the beneficiaries in Nyagatare district, these join mutual health insurance. From the time, health expenditure of the beneficiaries were low compared to the bills of health costs before beneficiaries joining the MHI because of costs risk sharing nature of CBHI. With MHI beneficiaries' behavior were changed. The beneficiaries' health expenditures were reduced at a big proportion and these costs were used by households for other purposes. However, still the beneficiaries claim that these costs were somehow high; there is a big change or gap between the situations before and after the beneficiaries joining these MHI schemes.

Distribution of respondents about willingness to pay (WTP)

Table 9.1.: Distribution of respondents about willingness to pay (WTP)

Nature of response	Number of respondents	Percentage (%)
Yes	11	69
No	5	31
Total	**16**	**100**

Source: Primary data 2012

According to the table above, 11 respondents or 69% argued that the beneficiaries are willingly to pay their premiums, while 5 respondents or 31% are not willingly to pay. This big percentage or numbers of those who are willingly to pay,

justify the success of this government policy. At the other hand this percentage of those who pay but not willingly, local authorities and their neighbors contribute a big to sensitize them to pay their contributions. At this issue of paying mutual health insurance contribution, through community works, jobs are mostly given to those who do not have the was to pay and their due contributions were taken as the advance before being paid.

Problems hinder MHI from contributing a hundred percent on economic development processes.

Table 9.2: Problems hinder MHI to contribute a hundred percent on economic development

Problems	Number of respondents	Percentage (%)
Lack of contribution fees	3	19
Poor health services	3	19
Limited services provided by MHI	5	31
Few health centres	2	12.5
Lack or inappropriate infrastructure	0	0
Low contribution in % / person /year	0	0
High contribution	2	12.5
MHI verse other health insurances	1	6
Total	**16**	**100**

Source: Primary data 2019

According to the table above, 5 respondents or 31% argued that low coverage/package of services provided by MHI was a big problem that hinders MHI to contribute a hundred percent on economic development. This is because some beneficiaries pay this contribution while continue to pay in other health institutions for health services at high costs when they are supposed to pay only between 200Rwf and 250Rwf on each visit at health centre.

Lack of contribution fees and poor health services come at the second with 19% each, while high contribution and few health centres range at the fourth place with 12.5% scores respectively, then MHI compared to other health insurance ranges at last position with 6% scores. These problems can have its source either from beneficiaries when the family members are of a big numbers as shown in the table 7.

Where best solutions to the problems hinder MHI can be gotten.

Table 9.3: Provider of the best solutions to the problems hinder MHI

The best answer providers	Number of respondents	Percentage (%)
Government	8	50
Mutual health as insurance institution	5	31
Other organization	3	19
Total	**16**	**100**

Source: Primary data 2019

From the table above, 8 respondents which represent 50% of the whole number of respondents was satisfied that the government should be the good provider of the best solution to the problems that hinder mutual health insurance from performing as it expected. Five respondents which represent 31% of the whole sample were arguing that MHI as institution of health service provider is the good provider of the best solutions to the problems hinders mutual health insurance from performing as pretended or expected. The 3 respondents which represent 19% of the whole number of respondents argued that other organizations should be the providers of the best solutions to the problems hinder MHI for it not performing as it was expected.

A big number of respondents on the idea that government should be the provider of the best solutions imply that the government as the policy maker should renew this policy for effective contribution to the beneficiaries' economic improved status and hence mutual health insurance contribute to the economic development in Nyagatare district.

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International Journal of Social Science and Humanities Research ISSN 2348-3164 (online)
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10. SUMMARY OF RESEARCH FINDINGS

Findings have shown that 35.5% of respondents are in age range of 30-42 and they are the majority. 21% lie in range of 42-54, while 19.5% lie in the range of 18-30 and 17% of respondents are in range of 54-66, only 7% of respondents are in the range of 66 and above. The findings shown that the majority of respondents are males while the female gender were minority; 60% were males and 40% were females. Also findings have shown that 50.5% of respondents are married and they are the majority. 42.5% were single while only 7% of respondents are widows and widowers.

From the findings, the majority of respondents have Secondary level education and are represented by 40.5%, Primary level is 32%, and O'Level is 14.5%, Bachelor's degree is 9.5% of the respondents while the illiterates' beneficiaries are 3.5% of the respondents. The major's source of information on MHI are local authorities and are 64% of the respondents, Neighbors are source of information of 21% of respondents while 14% of respondents their source of information are Radios. The major motivator of beneficiaries to join MHI is the government authorities and this is represented 71%of the whole respondents. Findings have also shown that 72% of respondents each family has at least 3 and above children, while 14% of respondents have at least one child and only 14% have no child that's because they are single. Findings have shown that all respondents contribute 3000Rwf in mutual health insurance.

With the observation that I made, among the beneficiaries there is a vulnerable group poor whose contribution is 2000Rwf and since are poor, the government contributes for them. Some beneficiaries such as Teachers, Nurses, Soldiers, Policemen and Authorities are in others health insurances such as RAMA and MMI. Findings have shown that the majority of respondents' perception on the value of amount contributed in mutual health insurance is medium and this represented 64% of the total respondents, while 29% of respondents were argued that MHI premium are high, then only 7% of respondents were satisfied that these premium are low.

Only 43%of the whole respondents are happy with the health services offered by MHI, while 57% of the respondents which are the majority are not happy with the services offered by MHI, this is because of low package of health services provided by this insurance. 86% of respondents argued that their collaboration with mutual health insurance is at least good, while 14% are claiming that their collaboration with health services provider through this policy of CBHI was poor. Nevertheless, there some are specific problems that beneficiaries of mutual health insurance face.

These problems are; Non-covering of health service costs due to low level of risk sharing between sick beneficiaries and health beneficiaries, Poor quality of health services, Benevolent nature of membership of mutual health insurance, Inadequate management capacities of some mutual health insurance contributions by mutual health committees, Over-utilization of the services by beneficiaries who solicit healthcare services, Premiums are fixed, not according to the real costs of healthcare, but the contributing capacity of the beneficiaries, Some among beneficiaries suffer the wrong stage or class and do not contribute accordingly.

From the study some solutions to problems that beneficiaries of mutual health insurance face have been proposed for them to get better health services. For instance: The investment in new ventures of a share of mutual health's contribution for purposes of making profits for supporting beneficiaries' contributions in future time, more health centres have to be built in order to avoid overpopulation in one health centre and long distance walked by the beneficiaries of mutual health insurance. Some beneficiaries' mindset about mutual health insurance should be changed for the beneficiaries profiting from effective risks sharing among those who are suck and those who are healthy.

Beneficiaries' contribution capacity should be raised through community works given to those who cannot easily get the contribution per year, the management of these mutual health contributions should be efficacy and timely controlled to avoid its losses as well as the misuses, the role of partners in support for mutual health is to be pointed in creating initiatives on coverage of vulnerable groups, for them to get mutual health insurance. The study shown that there is a contribution of mutual health insurance towards economic development as shown in the following points:

Mutual health insurance contributes in finding ways to keep healthcare costs down by negotiating reduced tariffs and fixed fees per day of hospitalization, it contributes to the health sector's allocation efficiency, MHI contributes to the extension of social protection to the rural and informal sectors, it helps to poorest of the poor, do not have gainful occupations and cannot work and afford the financial contributions through government intervention, it provides the opportunities for all members to access healthcare which results in reduced mortality rates which hinders the economic

development. It provides equitable and equal access to quality healthcare for children and women who mostly suffer from different illnesses and this promotes the economic status of households.

In Nyagatare district, there are some indicators of economic development which result from mutual health insurance policy implementation. These indicators are: Reduced illnesses and mortality rate among the beneficiaries, above 70 percent of the beneficiaries have opened the accounts in BPR and umurenge SACCO as financial institutions and do save, the outlook and behaviour of the beneficiaries are also improved, infrastructure development, such as centres, schools, water sanitation and cooperatives, income is increased because of increased economic activities. About 69% of the whole respondents argued that the beneficiaries willingly pay their premiums, while 5 respondents or 31% are not willing to pay.

Health insurance policy is hindered by some problems and these are: Lack of contribution fees, Poor health services, and Limited services provided by MHI, Few health centres, High contribution, and MHI verse other health insurances. For the above problems which hinder MHI, 47% of the respondents argued that the government is the good provider of the best solutions, 29% of the respondents shown that MHI institution could be the good provider of the best solutions, while 24% of the respondents claimed that the implication of NGOs should contribute a good solution.64% of the respondents on perception of the amount contributed argued that the premium is medium. 57% of respondent on whether are they happy or not, argue that they are not happy with services package offered by MHI, while 64 argued that its collaboration with MHI institution was good.

11. CONCLUSIONS

The development of Rwanda's first Health Financing Policy marks an important step in the evolution of the health sector. The present policy for developing mutual health insurance was elaborated by the Government of Rwanda with a view to centralizing the potential and especially meeting the increasing social demand for the extension of mutual health insurance. Hence the functioning of MHI in Nyagatare district was shown significance vis-a-vis to beneficiaries and the staffs along the sector. In fact, establishing mutual health insurance across the country was to ensure that the population of Rwanda, particularly those in rural communities such as those of Nyagatare district and the informal sector have equitable access to quality healthcare services. Mutual health insurance is therefore intended to complete existing social and private health systems.

Basing on findings of this study, it is shown that improved health status of the beneficiaries has a significant effect on the economic development processes in Nyagatare district. The policy offers an instrument to build and manage partnerships for community health. It is crucial that the coordination and monitoring of the implementation of this policy at the sector, health centre and community levels be effective. In light of the above facts this study has examined the contribution of Rwandan health insurance on the economic development of the beneficiaries in Nyagatare district. Although mutual health insurance has the contribution on improvement of healthcare services and economic development in Nyagatare district through decrease in real costs of healthcare services.

Among the main factors hampering beneficiaries' enrolment in CHI in the developing world, there are the problems with the affordability of premiums, the trust in the integrity and competence of the managers, the attractiveness of the benefit package and the quality of care that is offered by the providers. In many instances, risk pooling remains limited because of the small size of the CHI member population and going to scale remains a huge challenge. In that respect, it is appropriate to further explore the feasibility of creating CHI federations in which funds get pooled.

Also the packages of services given to their members are not effectively given because of increase of services and number of beneficiaries. The CHI thus still has a long way to go if it wants to strongly contribute to health system performance. As is shown, CHI, under certain circumstances, can well be an attractive strategy to improve beneficiaries' access to healthcare. Therefore the major to improve this policy must be taken by the ministry of health and other partners in health sector.

12. RECOMMENDATIONS

Basing on the findings of this study carried out in Nyagatare district on the contribution of Rwandan health insurance in the economic development of Rwanda especially in Nyagatare district, the following are the recommendations given to the officials and the beneficiaries of mutual health insurance in Nyagatare district:

Invest in new ventures of a share of mutual health contributions should be prevailed for purposes of making profits for supporting beneficiaries' contributions in future time in promoting its economic development.

More health centres should be built with equal capacity of delivering health services in order to avoid overpopulation in one health centre and long distance walked by the beneficiaries of mutual health insurance as shown by the researcher in findings of this research.

The grassroots leaders and the entire community should be trained to change some beneficiaries' mindset about mutual health insurance policy, for the beneficiaries profiting from effective risks sharing among those who are suck and those who are healthy because, it has been remarked by the researcher that some beneficiaries pay the annual contribution forcibly.

Beneficiaries' contributions capacity should be raised through community works given to those who cannot easily get the annual contribution or/and sensitize them on paying for themselves before any kind of aid is given to them.

Some mutual health insurance staff should be sensitized on improving healthcare services given to the beneficiaries and control the management of these mutual health contributions to avoid its losses as well as misuses which are persistently observed.

The role of partners in health sector should be encouraged in supporting mutual health in creating initiatives on coverage of vulnerable groups, for them to get basic healthcare costs.

The beneficiaries should be sensitised on the role of contributing on time because when they use to contribute at late time, medical services could be also late and poor and this results in unsatisfaction. Hence, creates the conflicts among MHI beneficiaries and the executive community of the government policy which includes that of MHI scheme.

The beneficiaries should be aware of their problems concerning healthcare services they are given by mutual health insurance service provider,

Those who don't want to contribute claiming that they don't fall sick should change their behavior because MHI is collective rather than individuals separately.

The beneficiaries should raise their saving habit for them to enhance future scarce of liquidity money to be used in different transactions including contribution of mutual health insurance which is one among the problems that hinder mutual health insurance.

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