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# The political path to universal health coverage: Power, ideas and community-based health insurance in Rwanda

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ABSTRACT

Rwanda is the country with the highest enrolment in health insurance in Sub-Saharan Africa. Pivotal in setting Rwanda on the path to universal health coverage (UHC) is the community-based health insurance (CBHI), which covers more than three-quarters of the population. The paper seeks to explain how Rwanda, one of the poorest countries in the world, managed to achieve such performance by understanding the political drivers behind the CBHI design and implementation. Using an analytical framework relying on political settlement and ideas, it engages in process-tracing of the critical policy choices of the CBHI development. The study finds that the commitment to expanding health insurance coverage was made possible by a dominant political settlement. CBHI is part of the broader efforts of the regime to foster its legitimacy based on rapid socio-economic development. Yet, CBHI was chosen over other potential solutions to expand access to healthcare because it was also the option the most compatible with the ruling coalition core ideology.

The study shows that pursuing UHC is an eminently political process but explanations solely based on objective "interests" of rulers cannot fully account for the emergence and shape of social protection programme. Ideology matters as well. Programme design compatible with the political economy of a country but incompatible with ideas of the ruling coalition is likely to run into political obstructions. The study also questions the relevance for poor countries to reach UHC relying on pure CBHI models based on voluntary enrolment and community management.
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## 1. Introduction

Providing affordable healthcare to the population of low and middle-countries is a persistent development issue. The WHO estimated in 2010 that 100 million people are pushed into poverty and 150 million suffer financial catastrophe because of out-of-pocket expenditure on health services every year (WHO, 2010: 8). Consequently, universal health coverage is a priority on the global development agenda, as demonstrated by its inclusion in the Sustainable Development Goals. Despite the global support for universal health coverage, how to reach this objective in poor countries remains highly debated (Kutzin, 2012; WHO, 2010).

Rwanda has made impressive strides towards universal health coverage, mainly by providing health insurance to the poor in the informal sector through its community-based health insurance (CBHI), the focus of this article. The scheme, also known by its French name, *mutuelles de santé,* has made Rwanda the country with the highest health insurance enrolment in Sub-Saharan Africa (Table 1). In 2015/2016, the scheme covered 81.6 percent of Rwandans according to the Rwandan Social Security Board (RSSB),[1] the public body managing social security services. Furthermore, an additional 6 percent working in the formal economy were enrolled in other health insurance schemes: the RAMA (Rwandaise d'Assurance Maladie), which covers civil servants, the Military Medical Insurance (MMI), and private health insurances. These data are consistent with the findings of the Demographic Health Survey (DHS). In 2014/2015, while the official CBHI total enrolment was 76.5 percent[2], the DHS, focusing only on respondents aged 15–49, found that 70 percent were enrolled in the CBHI (NISR, MoH, & ICF International, 2015).[3] CBHI in Rwanda has successfully increased medical care utilisation and decreased out-of-pocket expenses (Lu et al., 2012; Saksena,

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[1] RSSB Media weekly report of 06/10/2016: http://www.rssb.rw/sites/default/files/media_weekly_report_06-10-2016.pdf (accessed 6 April 2017).
[2] MoH data: http://www.moh.gov.rw/index.php?id=3 (accessed 14 August 2015).
[3] The difference can be due to that fact that the local bureaucracy has an incentive to inflate enrolment numbers (see later in the paper).

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**Table 1**
health insurance enrolment in Sub-Saharan Africa.

| Country | Coverage | Insurance name | Year of reference | Source |
|---|---|---|---|---|
| Rwanda | 81.6% for CBHI. ~87% including other insurances | CBHI (coverage reaches ~87% if MMI, RAMA and private insurances are included) | 2015 | RSSB |
| Gabon | 45% | NHIP (National Health Insurance Program) | 2012 | Saleh, Barroy, and Couttolenc (2014) |
| Ghana | 38% | NHI (National Health Insurance Scheme) | 2013 | NHIA (2014) |
| Senegal | 32% | Different insurance schemes | 2014 | Ministère de la Santé et de l'Action social (n.d.) |
| Burundi | 25% | CAM (Carte d'Assurance Maladie) | 2012 | Ministère de la Santé (2015) |
| Namibia | 18% | Different insurance schemes | 2014 | Abt Associates and USAID (2014: 7) |
| Botswana | 17% | Different medical aid schemes, the biggest being BPOMAS (Botswana Public Officers' Medical Aid Scheme) | 2013 | SHOPS Project (2014) |
| Kenya | 17% | NHIF (National Hospital Insurance Fund) covered 15%, private insurance and CBHI the rest. | 2014 | MoH of Kenya (2014) |
| South Africa | 16% | Private insurances and different medical schemes | 2013 | Republic of South Africa (2014: 61) |
| Tanzania | 10% | National Health Insurance Fund (NHIF), Social Health Insurance Benefit (SHIB), Community Health Fund (CHF), Private insurance | 2008 | Mills, Ally, Goudge, Gyapong, and Mtei (2012) |
| Ethiopia | ~8% | CBHI and SHI | 2015 | Lavers (2016) |
| Nigeria | 3% | National Health Insurance Scheme (NHIS) | 2013 | Dutta and Hongoro (2013) |
| Lesotho | 2% | Different insurance schemes | 2014 | Lesotho 2014 Demographic health Survey (DHS) |

Source: author's compilation. Countries with the highest health coverage according to ILO Social Security Inquiry were selected but data have been systematically verified. If it could not, countries have been removed (Gambia, Sudan, Djibouti). Additional countries with low enrolment numbers have been added as a way of illustration. Only the main insurance names are mentioned.

Antunes, Xu, Musango, & Carrin, 2011; Wang, Temsah, & Mallick, 2017). The scheme has evolved from a pure form of voluntary CBHI to one based on obligatory enrolment and subsidies from the formal sector, thus paving the way to a national health insurance model. Before the scheme became compulsory in 2006, it was already recognised as one of the rare successes of wide CBHI coverage in Sub-Saharan Africa (De Allegri, Sauerborn, Kouyaté, & Flessa, 2009; Soors, Devadasan, Durairaj, & Criel, 2010).

Since the 1990s, CBHI has been widely promoted in poor countries as a tool to reduce the financial burden of accessing healthcare (Dror & Jacquier, 1999; Preker and Carrin, 2004). CBHI has three main features: it is based on pre-payments for purchasing healthcare, separating direct health payment from utilisation, it is controlled by the community, and it relies on voluntary membership (Atim, 1998; Hsiao, 2001; Preker et al., 2004).[4] CBHI is one of three main financing strategies to reach universal health coverage. The two others being social health insurance (SHI), which is a compulsory system gathering resources for healthcare from employee payroll taxes and managed by a public or quasi-public organisation, and tax-based financing, whereby money is collected through general taxation of the entire population and finances healthcare through the general government budget.

CBHI seems a particularly suitable solution to improve access to health services in low- and middle-income countries where the size of the formal sector is small, preventing payroll deduction for social health insurance, and the creation of a tax-base robust enough to finance universal health coverage. Yet, despite the global interest in CBHI, population enrolment in these schemes remains stubbornly low in poor countries, and especially in Sub-Saharan Africa (Appiah, 2012; De Allegri et al., 2009; Ndiaye, Soors, & Criel, 2007; Odeyemi, 2014; Soors et al., 2010), making Rwanda a conspicuous exception.

Despite the importance of the Rwandan case to inform the debate about achieving universal health coverage in poor countries, the literature remains focused on the scheme's technical and managerial aspects (e.g., Musango, 2005; Lu et al., 2012; Saksena et al., 2011; Wang et al., 2017). While social protection involves shifting resource allocation and is consequently an eminently political process (Graham, 1995; Barrientos & Pellissery, 2012), analyses of the history and politics behind the Rwandan impressive CBHI expansion are so far absent. This is especially surprising as the scheme features highly original and polarising characteristics, such as compulsory enrolment, public and private subsidisation, and massive donors' funding. This raises questions about the origins of such innovations, the kinds of ideas that supported them, and the lessons that can be drawn from this experience. This article contributes to filling this gap. By analysing the politics and ideas behind the adoption and implementation of the CBHI, it seeks to understand why the policy took the shape that it did in Rwanda, and why it was successful at being scaled-up.

The study constructs a historical narrative of the scheme, using process tracing of the crucial decisions that gave the CBHI its current form. Process-tracing can be defined as the investigation of the "decision process by which various initial conditions are translated into outcomes" (George & McKeown, 1985: 35). Analysis based on process-tracing often requires detailed historical analysis. This ensures the validity of the causal mechanism identified, while ruling out possible alternative hypotheses (George & Bennett, 2004: 205–232). Sources of data include review of policy documents and semi-structured interviews. The paper draws on a wider research on state effectiveness in Rwanda which involved a nine-month fieldwork conducted in 2012 and 2013, and included more than 150 interviews. Another fieldwork between January and March 2015 was the occasion to conduct further interviews. They include interviews of high-level politicians (eight interviews, including interviews of four former ministers of health), governmental technical staff within government, mainly from the Ministry of Health (16 interviews), staff from international organisations involved in the CBHI design, funding and implementation (five interviews).

The article first introduces the theoretical framework guiding this study. It then presents a historical narrative of the policy-making process with respect to CBHI in Rwanda, concentrating on critical policy choices. Using the theoretical framework, it then

[4] For simplicity's sake, the Rwanda scheme will be referred as 'CBHI' throughout the article, although the scheme was not a pure form of CBHI from 2006 onwards, when it became compulsory.

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