

ESID Working Paper No. 72

The political path to universal health coverage: Elite commitment to community-based health insurance in Rwanda

Benjamin Chemouni ¹

December 2016

¹ London School of Economics

Email correspondence: b.h.chemouni@lse.ac.uk

ISBN: 978-1-908749-73-4

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 is the community-based health insurance (CBHI), which covers three-quarters of the population. Despite the importance of the Rwandan case, analyses of the history and politics behind the scheme are largely absent. This article fills this gap by identifying the political drivers behind its development. It engages in process-tracing of the critical policy choices regarding the CBHI: the design of the first pilot, the decision to make enrolment mandatory, the policies to ensure its adequate funding, and the strategy of day-to-day implementation. It argues that the commitment to expanding health coverage is part of the broader efforts of the ruling coalition to foster its legitimacy based on rapid socio-economic development in a context of a dominant political settlement. The paper also argues that CBHI was chosen as a solution to expand access to healthcare over other approaches because it was the policy option that was the most compatible with the ruling coalition core paradigmatic ideas of popular participation, individual and national self-reliance.

Keywords: Rwanda, universal health coverage, community-based health insurance (CBHI), health insurance, social protection, political settlement, ideas, health financing, Africa

Acknowledgements:

I thank Tom Lavers for his comments and guidance, Hinda Ruton for his research assistance, Pia Schneider and Philipa Mladovsky and the anonymous reviewers for their useful comments.

Chemouni, B. (2016) The political path to universal health coverage: Elite commitment to community-based health insurance in Rwanda. ESID Working Paper No. 72. Manchester, UK: The University of Manchester. Available at www.effective-states.org

The background research for this paper was funded by the Effective States and Inclusive Development Research Centre (ESID), based at The University of Manchester, UK. This document is an output from a project funded by UK Aid from the UK government for the benefit of developing countries. However, the views expressed and information contained in it are not necessarily those of, or endorsed by the UK government, which can accept no responsibility for such views or information or for any reliance placed on them.

Introduction

Providing affordable healthcare to the population of low and middle-income 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). As a consequence, 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 (WHO 2010; Kutzin 2012).

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 coverage in Sub-Saharan Africa (Twahirwa, 2008; Appiah, 2012; Lagomarsino et al., 2012; Odeyemi, 2014). In 2014, the scheme covered 76.3 percent of Rwandans according to the Ministry of Health,¹ while about 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 generally in line with the findings of the Demographic Health Survey (DHS), which founds that in 2015, 70 percent of respondents were enrolled in the CBHI, and 5.7 percent in another insurance (NISR et al., 2015: 32). CBHI in Rwanda has successfully increased medical care utilisation and decreased out-of-pocket expenses (Saksena et al., 2011; Lu et al., 2012). 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 insurance model.² 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 et al., 2009; Soors et al.; 2010).

Since the 1990s, CBHI have been widely promoted in poor countries as a tool to reduce the financial burden of accessing healthcare (Dror and Jacquier 1999; Preker and Carin, 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;

¹ MoH data : <http://www.moh.gov.rw/index.php?id=3> (accessed 14 August 2015).

² It is the enrolment onto a health insurance that is compulsory in Rwanda, not to CBHI per se. Yet, most people, being poor and in the informal sector, cannot access any other insurance schemes but the CBHI, making *de facto* the scheme compulsory for the vast majority of the population. When compulsory enrolment to CBHI is referred to in the article, it means compulsory enrolment onto CBHI unless another health insurance scheme has been subscribed to.

Hsiao 2001; Preker et al. 2004).³ 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 national health insurance, and more generally 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 low in poor countries and especially in Sub-Saharan (Ndiaye et al., 2007; De Allegri et al., 2009; Soors et al., 2010; Appiah, 2012; Odeyemi, 2014), 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; Saksena et al., 2011; Lu et al., 2012). Analyses of the history and politics behind it are so far absent. This is especially surprising as the scheme features original and polarising characteristics, such as compulsory enrolment, public and private subsidisation, and original channelling of donors' funding into the scheme, which questions the origins of such innovations and the kinds of ideas that supported them. This article contributes to filling this gap by analysing the politics and ideas behind the adoption and implementation of the CBHI.

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 and 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 and Bennett, 2004: chap. 10). Review of policy documents and semi-structured interviews of key informants provide the main sources of data. The interviewees include 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). These interviews were mainly conducted during fieldwork in Rwanda between January and March 2015. The research draws as well on precedent fieldwork conducted on maternal health in Rwanda in 2012 and 2013.

The article first introduces the theoretical framework guiding this study. It then presents an historical narrative of the policy-making process with respect to CBHI in Rwanda, focusing on critical policy choices. Using the theoretical framework, it then moves to an analysis of the political drivers behind the CBHI adoption, design and implementation, focusing on the nature of the Rwanda political settlement and the

³ 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.

significance of the paradigmatic ideas underpinning the ruling coalition. The final section concludes.

Analysing the politics of health coverage: political settlements and ideas

This study is part a broader project comparing elite commitment to social protection in five African countries: Ethiopia, Kenya, Rwanda, Uganda and Zambia (see Lavers and Hickey 2015). The analysis draws on the theoretical framework developed by Lavers and Hickey (2015), which relies on two pillars. First, recognising the centrality of bargaining and contention between political groups in the evolution of the welfare state in advanced economies, the framework uses a political settlement approach to analyse the political drivers of social protection. Political settlement can be defined as 'the balance or distribution of power between contending social groups and social classes' (DiJohn and Putzel, 2009: 4). Identifying the different social groups and their relative power helps in understanding the institutional structure that underpins the distribution of rents under the form of social protection policies. This is because political settlements directly influence institutions, since 'if powerful groups are not getting an acceptable distribution of benefits from an institutional structure, they will strive to change it' (Khan, 2010: 4). Drawing on Khan (2010), horizontal (between elite factions) and vertical (between the elite and the population) repartition of power can be distinguished. Lavers and Hickey (2015: 10-11) hypothesise that in the case of a competitive political settlement, where elite factions excluded from the ruling coalition are powerful and the ruling elite has weak autonomy from its supporters and the population in general, social protection programmes are more likely to be used for patronage to guarantee short-term political survival. Conversely, in a dominant political settlement where excluded elite are weak and the ruling coalition is autonomous from social demands, it is likely to use social protection as a means of legitimation to prevent the emergence of political opposition, reasoning in a longer-term perspective.

In Rwanda, the political settlement can best be described as a dominant political settlement. Vertical and horizontal power is concentrated in the hands of the Rwandan Patriotic Front (RPF), which dominates a larger ruling coalition. The RPF was created by Tutsi refugees who fled the anti-Tutsi pogroms of the 1950s and 1960s. It was formed in Uganda in 1987 with the objective of allowing the return of refugees to Rwanda, which the two Hutu-dominated regimes since independence have constantly opposed (Prunier, 1995: 35–90). The RPF launched an attack from Uganda in 1990, and gained power in 1994 by stopping the genocide against the Tutsi ethnic group and achieving a clear victory over the governmental army. It gained power in a context of limited popular support. The Tutsi-led RPF ended the genocide against the Tutsi ethnic group to rule over a Hutu-dominated population. Such ethnic discrepancy was magnified by the horrors of the genocide and decades of anti-Tutsi ideology that constituted a central criterion of legitimacy of all regimes since independence (Prunier, 1995.).

Since the end of the genocide, the political settlement in Rwanda has been characterised by the horizontal and vertical concentration of power in the hands of an RPF-led coalition. In terms of horizontal repartition of power, the political opposition is virtually inexistent in Rwanda, for two main reasons. First, from 1994 onwards, the RPF has made sure to give a minimum representation in government to other legal political parties. This practice was later enshrined in the 2003 constitution. The dominant party in parliament (which has always been the RPF) cannot have more than 50 percent of ministerial portfolios. To what extent these arrangements reflect the reality of power is, however, debatable. While some authors underline that these arrangements have participated to a consensual, democratic, and post-ethnic governance in Rwanda (Golooba-Mutebi, 2013), it seems that real power remains firmly entrenched in the RPF, helped by its control of the military apparatus, and supported by a range of military and party-owned large enterprises (Gökgür, 2012; Reyntjens, 2013). Second, the closed political space, and the limits put on media and civil society activities (Reyntjens, 2004; Beswick, 2010), prevent the emergence of alternative political ideas and projects. As a result, the political opposition to the ruling coalition is weak. It is mainly outside Rwanda, constituted by diaspora activists and the remnants of the armed opposition to the RPF that fled into the Democratic Republic of Congo after the genocide.

Power is also vertically concentrated in the Rwandan political settlement. The RPF is generally analysed as a cohesive party, although this cohesiveness has been punctually challenged by the defection of high-level individuals. It is dominated by Paul Kagame who enjoys enormous loyalty from party supporters. The RPF has a considerable autonomy from subordinate groups, giving it great enforcement capabilities. Such capabilities are enhanced by the RPF's tight control of the local administration (Chemouni, 2014).

The second pillar of the theoretical framework is based on the recognition that political settlement analysis inherently relies on interest-based explanations. Ideas are treated at best as instruments used by elites to reach their objectives. Yet, this reductive approach to political behaviour is questionable, especially as ideas are instrumental in shaping preferences in social policy (Schmidt, 2002; Béland, 2005; Weyland, 2009). Furthermore, it ignores the fact that 'any political settlement is likely to be compatible with several different policy approaches' (Lavers and Hickey 2015: 11). To analyse the role of ideas in social protection, it is useful to distinguish between policy paradigms, i.e. mental road maps providing 'a relatively coherent set of assumptions about the functioning of economic, social and political institutions' (Béland, 2005: 8; Schmidt, 2008), problem definitions, i.e. a way of framing and understanding particular social issues, and finally policy ideas, which provide potential solutions to pre-defined social problems. Analysis also distinguishes between cognitive ideas, used to understand reality and how to act on it, and normative ideas that 'indicate "what is good or bad about what is" in light of "what one ought to do"' (Schmidt, 2008: 306, in Lavers and Hickey, 2015). This framework, focusing on the crossroad of interest and ideas, will be used to analyse the empirical material of the Rwandan CBHI presented in the next section.

CBHI: the quest of universal health coverage

Recognising the problem

Since the 1960s, patients have paid user fees for healthcare services in Rwanda. At the beginning symbolic, they increased dramatically in the early 1990s, following the 1987 Bamako African health ministers' initiative, which called for cost recovery. Immediately after the genocide, healthcare became free. This was not due to any government's ideological preferences, but was a pragmatic decision in the context of the post-genocide emergency period. The few state-run health facilities still functioning provided poor quality emergency care to an impoverished population unable to pay for healthcare services. Furthermore, the health sector mainly consisted of an aggregation of NGOs that provided free healthcare.⁴

As soon as the end of the genocide, officials in the MoH were discussing the best way to make the health sector financially sustainable through cost recovery, while improving financial access to healthcare. Drawing on the experience of some staff in the Ministry of Health (MoH), who had lived or studied in Central and West Africa, the Burundian Assistance Health Card (CAM), a national health insurance scheme created in 1984, and some West African community-based schemes were discussed as potential blueprints, but their results were generally deemed unsatisfactory.⁵ This was confirmed in 1995, when the first minister of health after the genocide, Joseph Karemera (in office from 1994 to 1997), undertook a study trip to West Africa to gain knowledge of CBHI schemes, but came back frustrated by their disappointing results.⁶ User fees were progressively re-introduced in 1997, because of budgetary constraints. They resulted in a drop in the utilisation of health facilities (Figure 1 below). Furthermore, donors' assistance to the health sector progressively decreased as a result of the end of the emergency period (1994–98). This spurred the Ministry of Health in 1998 to ask USAID for help to improve financial access to healthcare through health insurance.⁷ USAID readily agreed, as such a request fitted with their existing Partnerships for Health Reform (PHR) project, a global five-year project which began in October 1995 to support health sector reform and, notably, health insurance. In 1998, the consultancy firm Abt Associates, financed by the PHR, assisted the ministry in design, implementation and evaluation of a pilot project.

During this period, rendering access to healthcare partially or totally free was never contemplated to increase health facility utilisation, despite some NGOs advocating for such a solution.⁸ The lack of resources made it hard to consider free healthcare (i.e., based on general taxation and donors' support), as confirmed by the results of

⁴ Interview with Maurice Bucagu, Geneva, 23 February 2015, interview with former MoH high official Kigali 19 February 2015, interview with Vincent Biruta, Kigali, 19 February 2015.

⁵ Interview with former MoH high official, Kigali, 23 March 2015; interview with Claude Sakabarage and Louis Rusa, Kigali, 21 May 2015.

⁶ Interview with Vincent Biruta, Kigali, 19 February 2015.

⁷ Interview with Pia Schneider via phone, 7 July 2015.

⁸ Interview with Joseph Karemera, Kigali, 28 January 2015 and MoH high official, Kigali, 19 February 2015.

the 1998 National Health Account (Schneider et al., 2000b).⁹ Besides the financial constraints, lifting user fees was also ruled out for ideological reasons. The Rwandan leadership worried that it would open the door to a culture of assistance and dependency. As put by the then minister of health, Joseph Karemera, pre-payment schemes were already 'appealing to [him] because [they] created solidarity, ownership and self-reliance'.¹⁰ The 1995 Rwandan Health Policy consequently encouraged the population to create CBHI schemes and self-help mechanisms to increase financial access to healthcare (Schneider et al., 2000a: 16).

Devising a solution: the 1999 CBHI pilot

The pilot design was shaped by three main factors. First, although no existing African examples of pre-payment schemes stood out as having the potential to be directly translated into the Rwandan situation,¹¹ the pilot's design was influenced by the experience of an Abt consultant who worked on pre-payment schemes tested at the time in the Copperbelt and Lusaka provinces in Zambia. Individuals enrolled in these schemes paid a monthly sum to a health facility in exchange for free services when the person fell sick.

The second influence on the design of the pilot lies in the ideological preference of the MoH to involve the community in the management of the scheme. Contrary to the Zambian scheme where health facility staff managed the funds, the population would be involved in Rwanda as a result of the explicit demands by the Rwandan authorities.¹² As recalled by an international consultant,

what was important for the Ministry of Health, what they clearly articulated when we had a first meeting with them, is that they wanted to strengthen the community participation [...] to develop the aspects reinforcing the sense of responsibility of the community.¹³

The intent of the MoH was to promote two kinds of participation: first grassroots democratic participation, by increasing the population's oversight in the management and use of funds; and, second, financial participation to avoid the population being passive consumers not 'owning' the scheme¹⁴ because, as stated by Joseph Karemera, former minister of health, 'free things are not put to proper use'.¹⁵

The third influence on the design of the pilot project came from the consultations with the grassroots level. The scheme's features – benefit package, premium and co-

⁹ Interview with Pia Schneider via phone, 7 July 2015.

¹⁰ Interview with Joseph Karemera, Kigali, 28 January 2015.

¹¹ Interview with Maurice Bucagu, Geneva, 23 February 2015, with Vincent Biruta, Kigali, 19/02/2015, with Pia Schneider via phone, 7 July 2015.

¹² Also interview with international consultant by phone, 28 July 2015.

¹³ Interview with international consultant by phone, 28 July 2015.

¹⁴ Interview former minister of health, Kigali, 29 January 2015; interview with Joseph Karemera, Kigali, 28 January 2015; interview with international consultant by phone, 28 July 2015.

¹⁵ Interview with Joseph Karemera, Kigali, 28 January 2015.

payment levels, management structure – were based on the steering committee’s consultation of the population, health staff and local leaders. Fact sheets laying out the advantages and disadvantages of each design option were submitted locally for discussion during several consultative workshops held from February 1999 to July 1999.¹⁶

Past initiatives aiming at decreasing the financial burden of healthcare on citizens in Rwanda hardly influenced the CBHI pilots. Solidarity funds, used to mitigate out-of-pocket expenditure for unplanned events such as illness or funerals, have existed since colonial times. After independence, the most successful community-based insurance schemes were *Muvandimwe* (‘siblings’), which was created in 1966 and included 120 local branches by 1986, and *Umubano mubantu* (‘good relations among people’) in Butare, created in 1975, which included 15 local branches by 1990 (Nzisabira, 1992). The solidarity funds functioning on the eve of the genocide were destroyed in 1994 (Musango, 2005: 53). Similar schemes emerged again after 1996 as a reaction to the reintroduction of user fees. Six existed in 1998 (MoH, 2004: 5), often organised around church-run health facilities. They encountered many operational issues, however.¹⁷ An exception was a scheme created by the *bourgmestre* of the commune of Ruhondo in the North of the country, which achieved a significant enrolment rate. As recalled by Protais Musoni, former Minister of Local Government (2004-09), this initiative ‘created lots of enthusiasm in the leadership’ of the RPF.¹⁸ Yet, this initiative did not influence the pilot, although members of the PHR project steering committee went on a study trip to Ruhondo. It was deemed not participatory enough, as it resembled a commune-managed service, raising a local tax for healthcare. In addition, there was a general reluctance in the MoH to let local governments manage the CBHI, because of the general distrust they elicited following local officials’ dismal role during the genocide.¹⁹

Another potential influence on the pilot could have come from the Social Democratic Party (PSD), since CBHI featured in its political programme for the 1993 elections. Yet, contrary to the claim put forward in other works (Golooba-Mutebi and Booth, 2013: 17; Golooba-Mutebi, 2013: 19), interviews conducted for this research reveal no direct link between the PSD programme and the CBHI. Many of the key policy makers at the time, including Protais Musoni and Joseph Karemera, simply did not know that the PSD included *mutuelles* in its 1993 programme.²⁰ In addition, although two former health ministers, Vincent Biruta (in office from 1997 to 1999) and Jean-

¹⁶ Interview with Pia Schneider via phone, 7 July 2015, with Maurice Bucagu, Geneva, 23 February 2015. Interview with international consultant by phone, 28 July 2015.

¹⁷ Interview with Pia Schneider via phone, 7 July 2015.

¹⁸ Mary Baines, senior cadres and historical figure of the RPF, was especially instrumental in attracting the attention of the party on the Ruhondo scheme (interview with Protais Musoni, Kigali, 20 February 2015). See also interview with a former minister of health, Kigali, 29 January 2015.

¹⁹ Interview with Pia Schneider via phone, 7 July 2015; interview with international consultant by phone, 28 July 2015.

²⁰ Interview with Joseph Karemera, Kigali, 28 January 2015; with Protais Musoni, Kigali, 20 February 2015; with former minister of health, Kigali, 29 January 2015.

Damascène Ntawukuriryayo (2004-08), were from the PSD, they both denied a link between the 1993 PSD idea and the 1999 pilot.²¹

Among Rwanda's 40 health districts, the districts of Kabutare, Byumba, and Kabgayi were selected as pilot areas because of the interest of their administration to collaborate, their previous demands for technical support regarding financial access to healthcare, the sufficiency of health infrastructure, and the relatively low number of existing pilot projects from international organisations in the district. Two additional districts, Bugesera and Kibungo, served as control cases (Schneider et al., 2000: 15). All schemes had to subsidise the premium for indigent members and each cell-level pre-payment bureau was advised to identify about 5 percent of its members as indigents (Schneider et al., 2000: 25).

The rollout of the CBHI pilot was primarily government-led, as the steering committee was composed in majority of MoH staff. The project proceeded quickly. Sensitisation campaigns began in February 1999, only three months after the start of the project, and the pilot was eventually launched on 1 July 1999. The MoH liaised with the Ministry of Local Government to ensure the collaboration of local officials for sensitisation. In late September 1999, shortly after the beginning of the pilots, the health minister, Vincent Biruta, along with some MoH officials, went on the radio to talk to a national audience about what was being done in the three pilot districts and to answer auditors' questions.

The pilot was a success. In only a year and a half, 8 percent of the population in the pilot districts had enrolled. The scheme increased health facility utilisation and decreased out-of-pocket expenses, although many poor remained excluded from the scheme because premiums were too expensive for them (Schneider and Diop, 2001). Overall, these results convinced the MoH to roll out CBHI nationwide. It also created demands from other health for similar pre-payment schemes.

Expansion and consolidation: toward national coverage

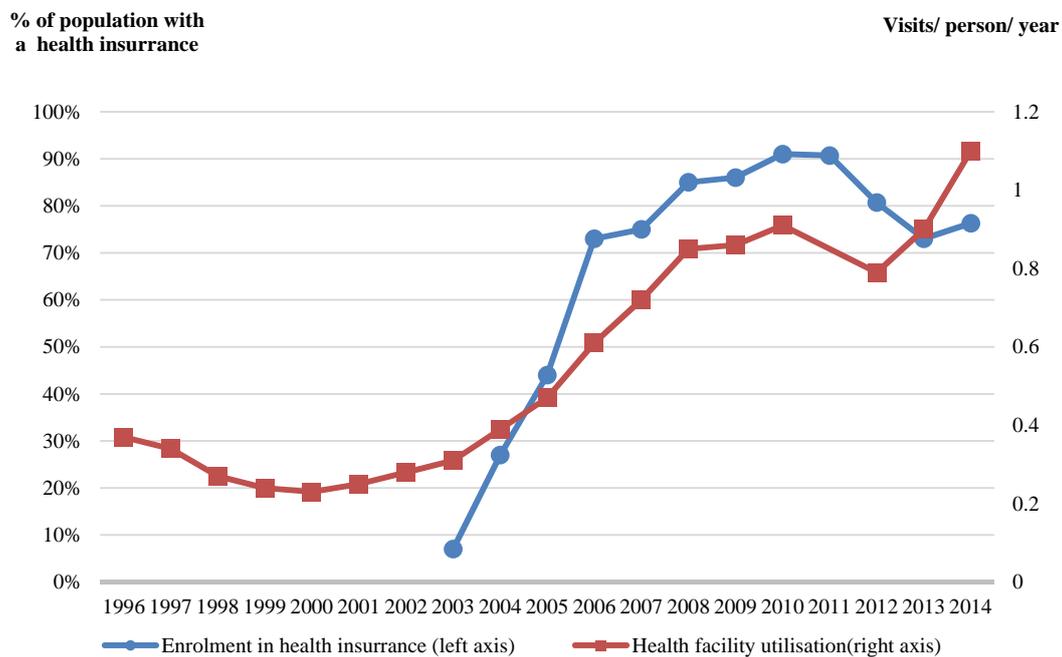
One crucial finding of the pilot, in line with the commune-led experience in Ruhondo before 1999, was that involvement of local government officials to sensitise the population is vital to stimulate enrolment.²² Consequently, the Rwandan government made local officials the mainstay of the expansion of the CBHI schemes. In 2003, MINALOC instructed province governors and district mayors to create *mutuelles* 'as quickly as possible' and stated that 'the creation of the *mutuelles* will be a criterion in their future evaluation' (Musango et al., 2009: 6).²³ CBHIs developed rapidly as a consequence. There were 54 in 2000, 76 in 2001, and 226 in 2004 (MoH, 2004: 4; Soors et al., 2010: 42). As a result, the trend of decreasing utilisation of health facilities since the introduction of user fees was reversed (Figure 1).

²¹ Interview with Vincent Biruta, Kigali, 19 February 2015; with Jean Damascène Ntawukuriryayo 23 January 2015.

²² Interview with former minister of health, Kigali, 29 January 2015; interview with international consultant by phone, 28 July 2015.

²³ Author's translation from the French.

Figure 1: Proportion of population covered by health insurance and health facility utilisation in Rwanda



Source: Compilation from MoH data. For health insurance enrolment from 2011 on, the years are fiscal and not calendar years (e.g. 2011 is 2011/2012).

In parallel, CBHI attracted the attention of the top leadership. Presidential advisors regularly consulted the MoH to enquire about the last developments of the scheme.²⁴ It became a national priority: CBHI was integrated into the 2002 Poverty Reduction Strategy Paper (PRSP) and mentioned in the RPF programme for the 2003 presidential elections.²⁵ It consequently benefited from the support of the whole executive branch of the government. Concretely, the MoH did not have to compete with other agencies for funds. As recalled by a consultant who worked regularly on the CBHI from 1999 to 2011, ‘the ministry [of health] never had to demand resources to scale up the *mutuelles*. It is rather the presidency or the ministry of finance that made the budget available to the ministry’.²⁶

Nonetheless, the CBHI schemes remained a collection of patchy interventions initiated by different actors (churches, local governments, opinion leaders) with variation in the organisation, the care package and the amount of the premium and co-payments. Interventions at hospitals were not covered (MoH, 2004: 7). Recognising both the good results of the CBHI and their limits, the government laid out a series of principles in the 2004 *Mutuelles* Development Policy. Subscriptions were standardised at 1,000RwF (1.7USD at the time) per person per year, although

²⁴ Interview with international consultant by phone, 28 July 2015.

²⁵ Interview with former member of the RPF executive committee, Kigali, 30 March 2015.

²⁶ Interview by phone, 28 July 2015; see also interview with Maurice Bucagu, Geneva, 23 February 2015.

some donors argued that it was too high.²⁷ At this rate, however, relying only on population contribution was not sustainable. Furthermore, the scheme remained unaffordable for the poorest, which decreased the equity and limited its expansion. Consequently, the 2004 policy stated that ‘a national solidarity mechanism between the formal public and private salaried sector and the rural world should be put in place’ (MoH, 2004: 17, author’s translation from the French), laying the basis for the subsidising of the CBHI by the formal sector’s insurance schemes. The policy also recognised the need for the government to support the CBHI schemes financially and subsidise them for the poorest.

This commitment, apparently difficult to implement in the short run given its cost, materialised in 2006 thanks to funding from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM). The previous year, the country coordinating mechanism (CCM) team for GFATM-funded projects in the MoH, composed of MoH and donors staff, had submitted an innovative application to a GFATM call for proposal. Instead of asking for funding for vertical interventions on particular diseases, the CCM successfully applied for funds to subsidise the CBHI for the poorest under the form of a ‘Health System Strengthening’ project. It became at the time one of only three ‘Health System Strengthening’ projects ever approved by GFATM (Kalk et al., 2010). In January 2006, \$34 million were made available to the CBHI for the next five years (Kalk et al., 2010). The Global Fund accepted this unconventional project because the CCM argued convincingly that to effectively fight the diseases on which the GFATM focused (HIV, tuberculosis and malaria), financial access to healthcare for the poorest had to be improved.²⁸

The success of the application came as a surprise and created tensions between donors and the Ministry of Health. Initially, as laid out in the proposal, a consortium composed of the German cooperation GTZ, UNDP and the Rwandan first lady’s Protection and Care of Families against AIDS (PACFA) were to manage the money (CCM Rwanda, 2005: 15). When the grant submission proved successful, however, the MoH decided against the consortium, in order to manage most of the funding by itself. The rationale was to strengthen national capacity, and to limit overhead costs of the members of the Consortium (Kalavakonda et al., 2007: 18). On the donor side, concerns were raised about the capacity of the MoH to manage the amount of money and implement the project.²⁹ Despite frictions, the MoH did not change its position and as a consequence UNDP withdrew from the process, while GTZ was only awarded about 1 percent of the total budget. Only the first lady’s PACFA retained the funding that was agreed on initially.

²⁷ Interview with CCM member, Kigali, 20 January 2015, with Jean Damascène Ntawukuriryayo 23 January 2015; with former donor through phone, 20 March /2015.

²⁸ Interview with CCM member, Kigali, 20 January 2015; with former donor through phone, 20 March 2015.

²⁹ Interview with CCM member, Kigali, 20 January 2015; with former donor through phone, 20 March /2015; with former MoH top official, Kigali, 23 March 2015.

The award of the grant had two main consequences for the CBHI. First, by paying the membership fees for 1.57 million Rwandans and the co-payments for 1.35 million of them (Kalk et al., 2010: 95), it boosted the coverage of the CBHI dramatically and increased equity in accessing healthcare.³⁰ Yet, 14 percent of the poorest Rwandans still had to pay the co-payment when seeking healthcare, which was often prohibitive at hospital level. But, overall, the funding proved crucial in the expansion of the Rwandan CBHI. It also created a precedent as GFATM provided further funding in subsequent grants. Second, the grant made mandatory health insurance enrolment enforceable, a measure impossible to implement without subsidising the CBHI for the poorest.

Making CBHI enrolment compulsory

The decision to make the CBHI compulsory was taken by ministerial order in 2006 and was subsequently enshrined in the 2007 CBHI Law that states that ‘every person who resides in Rwanda shall be obliged to join the mutual health insurance scheme’.³¹ The need to justify local officials’ heavy-handed practices of boosting enrolment apparently explains why the mandatory nature of the CBHI was specified in a ministerial order instead of waiting for the law to be passed.³²

Four main factors explain why the bold and polarising decision of making health insurance enrolment mandatory was taken. First, Jean-Damascène Ntawukuriryayo, who had been minister of health since September 2004, was frustrated by the slow progress of *mutuelle* enrolment. Second, it was clear to the MoH that low enrolment jeopardised the scheme’s financial sustainability, notably through adverse selection, with people in good health less likely to enrol (MoH, 2004: 9), a common source of difficulties of CBHI schemes in Africa (De Allegri et al., 2009). Third, Minister Ntawukuriryayo had been inspired by his experience as a student in Belgium, where health insurance was mandatory.³³ Finally, the GFATM grant subsidising health insurance for the poorest meant that compulsory enrolment for everyone could materialise.

Many donors were against compulsory enrolment, which they considered too authoritarian.³⁴ Yet, the MoH did not change its position. As recalled by the minister of health of the time, Jean Damascène Ntawukuriryayo:

I had to fight with the Americans, the Germans, the Belgians, all those that were involved in the *mutuelles* because I was completely changing the

³⁰ The poorest were identified by the community itself, and verified by the districts.

³¹ Article 33, Law N° 62/2007 of 30 December 2007 Establishing and Determining the Organisation, Functioning and Management of the Mutual Health Insurance Scheme. In practice, individuals that already subscribed to a health insurance did not have to join the CBHI.

³² Interview with international consultant by phone, 28 July 2015.

³³ Interview with Jean Damascène Ntawukuriryayo 23 January 2015.

³⁴ Interview with CCM member, Kigali, 20 January 2015; former MoH top official, Kigali, 23 March 2015; with former donor through phone, 20 March 2015; with former MoH top officials, Kigali, 19 February 2015.

original concept [of voluntary enrolment] and they were not expecting that. [...] I made them understand that no one could do something out of my guidelines.³⁵

Mandatory financial participation was not only a policy choice, but also a matter of principle. For instance, even when a donor could pay for the whole population in a given region, the MoH refused. As explained by Ntawukuriryayo:

If someone did not follow my guidelines, they could leave with their money. It happened with MSF Belgium who was operating in the North, in Burera, where they wanted to pay the *mutuelles* to everyone. I told them that [this] was strange, since all these people were not indigent. One has to pay only for the people in need. It became a big deal [...] I told them they should not take our people hostage, not get them used to being fed, and when they are going to leave, they will let them with nothing.³⁶

More generally, donors regularly put the question of lifting user fees – partially or totally – back on the table, invoking notably the examples of Uganda.³⁷ By the time of the CBHI scale-up, the global ideological context regarding user fees had shifted. Whereas in the late 1990s, user fees coupled with pre-payment schemes were not questioned, the push for lifting them became *en vogue* in the mid-2000s, in the wake of the poverty-reduction strategies (Ridde et al., 2010). The Rwandan government has always categorically refused to consider lifting user fees partially or totally, because it thought that this would prove unsustainable and would support dependency on foreign aid in the long run.³⁸ As put by Jean Damascène Ntawukuriryayo:

My approach was to say that I don't want anything for free [...], if there is always somebody to give me things for free, at any time this person can decide to stop. If he/she stops, what happens to me? [...] To me and my government, it is about taking our responsibilities: not always await that you give me something and I take it. [...] That is why we chose the *mutuelles*.³⁹

The refusal to lift user fees and the decision to make enrolment mandatory has clear roots in the RPF ideology, already visible in the discussion surrounding the 1999 pilots. First, mandatory enrolment has been anchored in the ideological importance for the RPF of *kwigira*, relying only on oneself. Undoubtedly, the CBHI is dependent on donor funding, but the idea was to create a system that in the long run could decrease this dependency. This is because dependency was seen as dangerous for

³⁵ Interview, Kigali, 14 January 2014.

³⁶ Interview, Kigali, 14 January 2014.

³⁷ Interview with former MoH officials, Kigali, 9 January 2014; with Jean Damascène Ntawukuriryayo 23 January 2015; with former donor through phone, 20 March 2015.

³⁸ Interview with former MoH official, Kigali, 9 January 2014.

³⁹ Interview, Kigali, 14 January 2014.

the country. As summarised by an informant through a saying in Kinyarwanda: *Ak'imuhana kaza imvura ihise*, 'the assistance comes after the rain'⁴⁰ – in other words, it is necessary to rely on one's own strength to tackle difficulties, as help rarely comes when needed. Second, mandatory financial participation has been justified ideologically because, according to the RPF, no one should get anything for free, i.e. with no visible act of payment. As explained by former Minister of Health, Joseph Karemera, the RPF 'doesn't believe in people being only recipients' because 'free thing destroy the mentality of the people'.⁴¹ Overall, as summarised by former Minister of Health, Vincent Biruta, compulsory CBHI was also 'a manner to work on mentalities. What matters is the contribution'.⁴²

On the government side, mandatory enrolment was supported unanimously. The ratification by the parliament of the 2007 law was facilitated by the fact that the National Assembly's speaker, Vincent Biruta, had been minister of health and heavily implicated in the *mutuelles* pilots. Furthermore, many MPs were happy that a solution to financial access to healthcare had been found, as many were frequently solicited by their extended family to pay for health fees.⁴³

Ongoing issues and professionalisation of the scheme

The rapid expansion of CBHI in Rwanda has been accompanied by difficulties, still ongoing. Managerial capacities of the staff, although improving, were limited. The auditing capacity of the MoH had been low, which created important opportunities for overbilling by health facilities (OAG, 2011).⁴⁴ Furthermore, high enrolment has been difficult to maintain, as demonstrated by the recent decrease of CBHI subscription. Although the causes of the decline are not clear, several factors have been raised in interviews to explain it. Enrolment numbers have been inflated by some local officials, as uncovered by a recent audit.⁴⁵ Effort of mobilisation might also have been lower than before, partly because of the priority given to local economic development as part of Second Economic Development and Poverty Reduction Strategy (EDPRS 2) adopted in 2013. Without continuous efforts from the local officials to ensure yearly renewal of *mutuelle* subscription, the enduringly high level of CBHI premiums and the improving, yet limited, quality of healthcare hinder spontaneous voluntary enrolment.

Efforts by the government to tackle these issues have led to the decline of the *mutuelles'* community-based character. The government has given an increasing role to professionals at the expense of the community in the scheme management. The 2007 CBHI Law, for instance, did not retain the management model proposed

⁴⁰ Interview with former member of the RPF executive committee, Kigali, 30 March 2015; similar point in interview with Joseph Karemera, Kigali, 28 January 2015.

⁴¹ Interview with Joseph Karemera, Kigali, 28 January 2015; similar point in interview with former MoH top officials, Kigali, 19 February 2015, with former minister of health, 29 January 2015.

⁴² Interview in Kigali, 19 February 2015.

⁴³ Interview with former minister of health, Kigali, 29 January 2015.

⁴⁴ Interview with donors, Kigali, 3 April 2013; and with MoH officials in the health financing department, Kigali, 3 April 2013.

⁴⁵ 'How probe uncovered the rot in "Mutuelle de Sante"', *The New Times*, 3 February 2015.

in the 2004 policy, which largely involved the community in the national institutions managing CBHI. At district level, members of the board of directors of the mutual health insurance fund were all appointed by ministerial order. As a consequence, the WHO noted that ‘this limited representation of *mutuelles* members is unlikely to promote the feeling of community ownership of the schemes’ (WHO, 2009: 61). Similarly, the national audit committee included no member from civil society. However, the 2007 law maintained an important role of the community at the branch (i.e. health centre) level. The management and property committee, in charge of approving the branches’ budget and action plan, and concluding contracts with medical care institutions and pharmacies, was composed of CBHI enrollees elected by the population.

The community character of the scheme has further faded away in the 2015 CBHI Law, as a result of an attempt to improve the management of the scheme. In 2014, the government leadership retreat decided that the Rwandan Social Security Board (RSSB) would manage the CBHI. The rationale was that, as the management body for pensions and civil servants’ health insurance, RSSB had a better experience in fund management than the MoH. The arrangement also created economies of scale, eased auditing and increased risk-pooling by centralising the funds of the CBHI in RSSB, instead of money being partly managed in each *mutuelles* branch. Consequently, as a result of constant efforts of the government to streamline the CBHI functioning and prevent mismanagement, the scheme gradually lost its ethos of popular ownership.

Attempt to increase equity and financial sustainability

Another issue for CBHI since its creation lies in the financial sustainability of the scheme and its equity. In 2007, when the *mutuelles* law was passed, the CBHI was financially balanced at district level, but ran alarming deficits at hospital levels (WHO, 2009: 71). Moreover, the scheme’s fairness was questionable. The flat rate premium of 1,000RwF per individual benefited the wealthiest (WHO, 2009: 67).

As a consequence, the MoH adopted two measures. First, it created in 2009 a National Guarantee Fund to financially support CBHI. The fund was financed by the MoH, contributing to 13 percent of its ordinary budget, and by grants equivalent to 1 percent of the income from all health insurance companies of the country, including the civil servant health insurance (RAMA) and the military insurance (MMI). Second, the MoH adopted the principle of stratification of premiums according to beneficiaries’ wealth in its 2010 CBHI policy, implemented in 2011. The goal was to make *mutuelles* subscription progressive while maximising resources mobilisation. Premium stratification is difficult, since the population enrolled in the CBHI mainly works in the informal sector and is consequently hard to categorise according to its wealth. The MoH decided to rely on a wealth classification exercise regularly carried out since 2001 for the *ubudehe* programme. *Ubudehe* is a social protection programme under the responsibility of the Ministry of Local Government that involves the classification by community of households according to their wealth, in order to

differentiate social interventions. Households identified as the poorest benefit from cash transfers and enrolment in public works. The MoH harnessed this initiative to modulate the premium of the *mutuelles*. As a result, 24.8 percent of the population was classified as indigent (category 1) for whom *mutuelles* fees of 2,000 RwF were paid by the state and donors. People in category 2 (65.9 percent) paid 3,000 RwF/person, and the richer in category 3 (0.64 percent) 7,000 RwF/person.⁴⁶

The accuracy of this classification process has been questioned. Recent evidence indicates it is not very participatory or transparent (Gaynor, 2014: S53-54; Sabates-Wheeler et al., 2015). Especially worrying is the total absence of correspondence between households' categorisation in *ubudehe* and the results of the Integrated Household Living Conditions Survey 3 (EICV 3), which measures household consumption (Sabates-Wheeler et al., 2015). This may also indicate that local authorities can decide arbitrarily who gets *mutuelles* subscription for free, along with plenty of other benefits associated with the lowest *ubudehe* category. Yet, while elite capture might occur at the local level, there is no evidence that it is the result of a systematic, centrally devised strategy of patronage. On the contrary, the central government displayed commitment to solving the issue. It publicly recognised the problem during the 2014 leadership retreat, which resulted in pressure on MINALOC to devise a new classification for *ubudehe*. In addition, the community classification exercise was complemented by a household questionnaire in an attempt to provide more objective measures of poverty (Lavers, 2016).

Day-to-day implementation

Exploring the policy design of the CBHI is not enough to explain the dramatic enrolment in the scheme. For instance, although enrolment in health insurance is also mandatory in Ghana, as in Rwanda, it seems to be a mere declaration of intent (Witter and Garshong, 2009; Jehu-Appiah et al., 2011: 158) and the country has not succeeded in reaching similarly high coverage.⁴⁷ Analysis of the CBHI expansion in Rwanda consequently requires understanding the role of the local bureaucracy in maintaining high enrolment rates.

The CBHI enrolment has been first facilitated by the numerous sensitisation channels at the disposition of the national and local governments. This includes official speeches following the monthly community work *umuganda*, community radio, churches, markets, cooperatives or women associations.⁴⁸ In addition, the tight networks of 45,000 community health workers operating in each of the 14,744 villages (*umudugudu*) of Rwanda, are crucial for sensitisation and detection of

⁴⁶ The *ubudehe* classification is done in six categories, merged in three for the CBHI. *Ubudehe* categories 1 and 2 are CBHI category 1; 3 and 4 are CBHI category 2, etc. Subscribers to RAMA, MMI and other private insurance represented 4.7 percent of the total population.

⁴⁷ In Ghana, 38 percent of the population is covered by health insurance in 2013 (NHIA 201: 5).

⁴⁸ Interview with two officials in the MoH health financing department, Kigali, 3 April 2013; and with officials in the maternal and child health department, Kigali 7 June 2013.

individuals who did not pay the *mutuelles*. Michael Mann's concept of 'infrastructural power' can be of use here. It is defined as 'the capacity of the state to actually penetrate civil society, and to implement logistically political decisions throughout the realm' (Mann, 1984: 113). In Rwanda, the high degree of infrastructural power, underpinned by a dense, decentralised administrative structure, numerous channels of information, and a tight network of community health workers, and facilitated by a high population density across the country,⁴⁹ was significant in ensuring high enrolment.

Yet, what pushes local officials to use the powerful tool that the Rwandan local state machinery constitutes? The answer lies mainly in the strong pressure applied on local governments. As mentioned above, as early as 2002, *mutuelles* enrolment was part of local government evaluation. Currently, the most conspicuous pressure comes from the *imihigo* system, or performance contracts, solemnly signed since 2006 between district mayors and the president of the republic. CBHI enrolment always features as an objective in those contracts. The target is invariably of 100 percent membership across all districts, whereas other targets in *imihigo* are usually adapted according to the districts' situation, which reveals the government's commitment to quickly reach universal health coverage. Officials can also rely on a conducive legal framework to boost enrolment. The 2007 and 2015 CBHI Law allowed the fining of non-enrolees (between 5,000 and 10,000 RwF, i.e. \$6-12). They provided for stronger deterrence for 'any person who incites others to refrain from enrolling into community-based health insurance scheme' (i.e. a fine of between 50,000 and 100,000 Rwf).⁵⁰ Furthermore, the laws stipulated that an individual can benefit from health coverage *only if all* members of his/her household are enrolled.

This strong pressure on local officials to maintain high *mutuelle* membership has led to the use of swift, if not at times harsh, methods, including, arrest, confiscating livestock, banning entrance to local markets, or denying administrative documents to the non-bearers of *mutuelle* cards.⁵¹ In one instance, local officials did not hesitate to steal money from a community health workers' cooperative in order to pay the *mutuelle* for the population and keep the enrolment rate high.⁵² In another, officials forcefully took a proportion of the income given in the form of cash transfer or public work revenue to individuals from the *ubudehe* category 1 (the poorest) to pay CBHI subscription, although the subscription is theoretically free for them.⁵³ Such behaviours are officially forbidden, yet some officials considered them as inevitable, given the strong pressure they faced from the centre. As explained by a district vice-mayor, 'it is their role in Kigali to get concerned by human rights and stuff like this. But it is not them on the ground [doing the work]. They don't understand that for the

⁴⁹ 460 people/km² (source: World Bank, accessed from <http://data.worldbank.org>, 11/02/2016).

⁵⁰ Respectively, articles 63 and 25 of the 2007 and 2015 CBHI Laws.

⁵¹ Interview with district vice-mayor, 12 June 2013. See also 'Locked out of market over *mutuelle* cards', *The New Times*, 28 February 2007; 'Rwanda: No one should be forced to pay *mutuelle* – premier'. *Rwanda Focus*, 15 February 2013.

⁵² Interview with MoH official, Kigali, 16 January 2014.

⁵³ Private communication.

peasants, the *mutuelle* is viewed as a tax'.⁵⁴ The pressure is such that some local officials have not hesitated to simply tamper with CBHI enrolment data. A glaring example of the phenomenon was revealed by the resignation and arrest in late 2014 and early 2015, widely covered by the media, of three district mayors and several other local officials over inflating the *mutuelles* enrolment numbers.⁵⁵

Yet, the pressure on local officials regarding CBHI enrolment also creates less expeditious and more creative strategies. Some local governments have encouraged people to create savings associations (*ibimina*) to pay their *mutuelle* cards, or pushed agricultural cooperatives to pay the *mutuelles* of, or at least lend the required money to, its members.⁵⁶

Overall, the dramatic expansion of Rwandan CBHI has been accompanied by the gradual loss of its ethos of community participation, so dear to the MoH during the design of the 1999 pilot. The greater role of the state in the scheme's management, along with the pressure of local officials on the population to enrol, has made the scheme evolve from a genuine CBHI to what now resembles compulsory national health insurance. This dynamic, however, explains why the scheme overcame the common obstacles to health insurance expansion in Sub-Saharan Africa that constitute limited enrolment, insufficient funding, adverse selection and managerial problems (see De Allegri et al., 2009).

Explaining elite commitment to CBHI

Politics and health coverage expansion

This section uses the theoretical framework presented above to shed light on the political dynamics underpinning the expansion of health coverage in Rwanda. To begin with, political settlement analysis is useful to probe into the government's ability to roll-out the scheme. First, the concentration of horizontal power (i.e. power between elite factions) in the settlement has been conducive to the rapid expansion of the CBHI. It has facilitated centralised decision-making. The Ministry of Health led the reform and was fully supported by the presidency and the Ministry of Local Government that pushed its agents to maintain high enrolment rates. The legislative branch was also unfaltering in its support of the CBHI, although harsh implementation could have been exploited by some politicians to challenge the government. This is because parties in Rwanda, sometimes described as satellites of the RPF (e.g. Longman, 2011: 40), all belong to the ruling coalition and never challenge the leadership's political choices or ideological preferences. Two ministers of health pivotal in the CBHI rollout, Vincent Biruta and Jean-Damascène Ntawukuriryayo, although both members of the PSD party, never sought to distance themselves from the overarching RPF vision. Acting like technocrats, they worked in

⁵⁴ Interview with district high official, 12 June 2013.

⁵⁵ 'How probe uncovered the rot in "Mutuelle de Sante"', The New Times, 3 February 2015.

⁵⁶ Interview with MINALOC high official, Kigali, 4 February 2013; with district vice-mayor, 12 June 2013. See also 'Rwanda: How Ibimina spurred health cover remittal', The New Times, 3 January 2014.

the same line as their RPF predecessors. It is significant that, when asked if there were any links between the CBHI and the PSD programme of 1993, Vincent Biruta, instead of claiming the primacy of the idea for his party, said that contending that such a link existed would be playing politics.⁵⁷ Overall, the virtual absence of elite factions challenging the RPF-led coalition domestically allowed the government to quickly seize on a policy initiative and implement it without engaging in lengthy bargaining in order to secure support. The alternative discourses regarding CBHI policy choices have come from donors, not from the political opposition.

Second, the vertical repartition of power in the political settlement, mainly concentrated in the hand of the RPF, has given the party great autonomy vis-à-vis social demands, making it easy to maintain user fees and to enforce compulsory enrolment. It also enabled the RPF-led coalition to set CBHI as a redistribution mechanism between the formal, wealthier and mainly urban sector and the rural areas. In 2015, the contribution of civil servants' and militaries' insurances, along with private health insurances, to the CBHI has been increased from one to five percent of their revenue.

In this context, the large policy space provided by the nature of the settlement could be fully used by the RPF to deter any future challenge to its rule. Such deterrence has taken the form of a legitimization project based on quick socio-economic development. Securing legitimacy has been a prime concern, given the extraordinary vulnerability of the RPF when it took power in 1994, as already mentioned above. Providing affordable healthcare can be understood as part of this strategy. This is especially true as the CBHI is primarily a tool of development for the informal and mainly rural sector, where the RPF legitimacy is arguably at its slimmest. While the rural population is mostly Hutu, the RPF is historically composed of urban 'old caseload' Tutsi returnees who fled the country following the 1959 violence and consequently have few links with the rural world and their 'hill of origin' (Ansoms, 2009: 295). The CBHI can be interpreted as the broad-base tool to bring development and foster regime legitimacy in the rural areas. Such tool is especially needed, given the nature of the settlement. The horizontal concentration of power in the political settlement means that potential threats to the ruling elite are not in the form of well identified opposition groups. They are potential, diffuse and posed by the rural majority. It then becomes rational to implement a functioning, broad-based programme of redistribution through subsidised health insurance. The universalism of the Rwandan CBHI can be interpreted as an attempt to create a *de facto* triple solidarity in Rwanda, able to build regime legitimacy and contribute to a post-ethnic society. It creates, first, a solidarity between people of the same community around the health centre; second, a solidarity, likely to increase as the economy expands, between the informal and formal as well as urban and rural sectors; and, thirdly, and as a result, a national solidarity. In this respect, the Rwandan case echoes the attempt of many post-independence African regimes to decrease ethnic division and foster a national identity through ambitious social policies (Kpessa et al., 2011).

⁵⁷ Interview with Vincent Biruta, Kigali, 19 February 2015.

However, such interpretation does not so far explain why the government has condoned practices of harsh implementation that created resentment and delegitimised the scheme by decreasing ownership. If the goal was the mere satisfaction of the rural mass for the RPF to maintain its power, why not implement the scheme with fewer rigours, lower the premium price, or even lift user fees partially or totally? One part of the answer lies again in the nature of the political settlement. The centralisation of power in the hands of the RPF gives it a long-term horizon. It allows it to consider 'social protection policies that may take time to design and implement, and that deliver benefits in the medium to long term' as indeed hypothesised by Lavers and Hickey (2015: 10), instead of policies that 'deliver quick wins to maximise immediate political returns and secure electoral support for the coalition'. CBHI, then, is not just about immediate redistribution or contenting people. It is part of a broader project of regime legitimation, requiring deep transformation and sustained performance, not short-term unsustainable redistribution exposed to potential reversal. The RPF, comforted by its hegemony, is consequently ready to adopt policies requiring unpopular choices in the short term, that will, in its mind, allow the health insurance system to function in a sustainable manner in the long term.

The other, and main, reason why the government has embraced unpopular policy choices is ideological. Other, potentially more popular, policy options to improve access to healthcare, such as health financing through general taxation, or CBHI compulsory enrolment coupled with lifting user fee, could have been compatible with the nature of the Rwandan political settlement. Yet they would not have been compatible with the ideas underpinning the ruling coalition.

Taking ideas seriously

While power dynamics may provide insights into the government's commitment to rollout the CBHI, a focus on interests alone would under-explain the scheme's design and expansion. As hypothesised by the second pillar of the theoretical framework, ideas played a pivotal role in the adoption and design of CBHI. Drawing on the distinction presented at the beginning, this role is visible at the level of paradigms, problem definitions and policy ideas.

Empirical materials reveal that CBHI in Rwanda was in part the product of specific paradigms, i.e. 'mental roadmap', of the RPF-led coalition. Three main overarching paradigmatic ideas can be identified. First of all, national self-reliance was pivotal in the RPF ideology. It can be traced from the years of guerrilla and exile, but also from general distrust towards the outside world, anchored in the passive role of the international community during the genocide. Such a paradigm transpires in the unflinching refusal of lifting user fees even partially, as this was equated, in the minds of officials, to long-run dependency on the outside world. It features also in the determination to make the *whole* population participate financially in the CBHI, either through compulsory enrolment or through the subsidising of the scheme by the

formal sector. The suspicion towards the outside world is also perceptible in the impressive independent attitude of the government towards donors' views, despite their technical expertise and financial power. The government did not hesitate to oppose them or stop their activities if they were deemed contrary to its vision. As summarised by an informant involved in the health sector, for donors in Rwanda it is 'obedience or disappearance'.⁵⁸

Second, the CBHI design is rooted in the paternalistic RPF vision of what a 'good Rwandan' should be. People should not 'get anything for free' in post-1994 Rwanda. Self-reliance applies consequently not only to the nation, but also to the individual. 'Free things' are especially dangerous at the individual level because they foster a culture of assistance and subservience. As explained by Protais Musoni, RPF historical figure and former minister of local government: 'free [health]care has never been an option because it makes people subservient'.⁵⁹ The importance of this idea was especially conspicuous when some donors attempted to pay for the CBHI subscription for a large part of the population regardless of their wealth status and were asked to stop. For the RPF, if they want to get out of poverty, Rwandans have to play an active role. They especially have to change their 'mindset' and 'mentality', an important rhetorical element in officials' discourse (e.g. Ansoms, 2009: 298; Gaynor, 2014: S56). The government-aligned *New Times* recently identified, for example, as an obstacle to CBHI enrolment, 'poor mentality among former indigents who graduated from poverty [*i.e. moved up in ubudehe categories*] and now have to pay subscription by themselves'.⁶⁰ The quote is revealing on how paying CBHI subscription and individual dependence are opposed, and how getting out of poverty is a 'graduation' in life, *i.e.* the result of an active process. In this perspective, what matters is not only getting out of poverty, it is also the effort put into the process itself. Part of the effort is to find the money to pay for the CBHI premium. Poverty, including poor access to healthcare, is not only envisioned as a trap in which people are caught. It is also a disease of dependency that compulsory CBHI enrolment can help to fight.

Third, the adoption of CBHI was, at the beginning, the product of the RPF's belief that grassroots democratic participation promotes reconciliation and fights 'the sub culture of passive obedience which left people open to political and sectarian manipulation' (MINALOC, 2004: 11). As clearly stated by the report on the implementation of the CBHI pilot,

The way prepayment schemes are organised – holding regular discussions and elections in general assemblies with their members, and following a contractual relationship with their partners – contributes to democratisation in Rwanda, to empowerment of ordinary people, and to

⁵⁸ Interview with former donor by phone, 20 March 2015.

⁵⁹ Interview with Protais Musoni, Kigali, 20 February 2015.

⁶⁰ 'Mutuelle subscription rate at 79%', *The New Times*, 12 January 2016.

the reconstruction and reconciliation of civic society five years after the genocide (Schneider et al., 2000a: 19).

For this reason, as stated by a MoH high official, 'after 1994, the idea of participation was present everywhere'.⁶¹ Regarding the CBHI, this was visible in the MoH's determination to depart from the Zambian model of insurance management by health facility staff and introduce co-management between the population and civil servants. This early concern in popular participation contributed to the adoption of a CBHI model rather than, for instance, a more general social health insurance based on general and compulsory tax.

Yet, the empirical evidence presented showed that tension has arisen between initial concerns for popular ownership and the concern to fast-track CBHI development. As noticed in the 2007 mid-term evaluation of the Global Fund grant, reflecting on the 2007 CBHI Law,

'the *mutuelles* look less of a community managed health insurance and more like a 'parastatal', particularly when it comes to management and administration. Community participation is limited to raising awareness and enrolling members into the *mutuelles*. (Kalavakonda et al., 2007: 5; see also Kalk et al., 2010: 95).

The paradigmatic idea of fostering grassroots ownership has clashed with the overarching need to make the system 'work'. Especially, the concern to boost CBHI enrolment and limit mismanagement led to making the scheme compulsory, while staffing the CBHI management body with MoH, and later RSSB staff, instead of population representatives. In other words, the pursuit of a sustainable health insurance model able to contribute to the ruling elite's legitimation project and serve its paradigmatic ideas of national and individual self-reliance has trumped the concerns of fostering popular ownership.

Overall, taking ideas seriously explains why the solution to financial access to healthcare could not take the form of lifting user fees or financing health through general taxation. While the political settlement might have been compatible with such alternative policy choices, *ideas were not*. CBHI was the policy solution that was best suited for the regime legitimation project *and* fitted the regime core paradigmatic ideas of popular self-reliance. As well summarised by a WHO evaluation of health system financing in Rwanda:

[besides affordable healthcare], the *mutuelles* respond to two other national priorities. First, they are instruments of social cohesion, which has been a major priority of the government in promoting national reconciliation and reconstruction of the country. Second, as opposed to tax-based or other public financing approaches, *mutuelles* promote the

⁶¹ Interview with former MoH high official, 29 January 2015.

self-sufficiency of communities, calling on them to take a hands-on approach in their socioeconomic development [...]. Therefore, positive externalities of *mutuelles* are a strong part of the rationale that motivated the Government of Rwanda to engage in a national roll-out of these schemes in 2006. (WHO, 2009: 59)

Table 1: Community-based health insurance and ideas

Level of idea	Type of idea	Ideas relevant to CBHI
Paradigmatic ideas	<i>Normative</i>	<ul style="list-style-type: none"> • Rapid socioeconomic development is essential to regime legitimation • Rwanda should be in the long run self-reliant and not depend on external actors • Mentality of dependency and assistance holds Rwanda back on the path to development and unity
	<i>Cognitive</i>	<ul style="list-style-type: none"> • The state mobilises all available resources and disciplines individuals in the pursuit of rapid socio-economic progress • The state must limit its dependency on donors' money in the long run • The population should not be passive in this process, but provide contributions to it
Problem definition	<i>Normative</i>	<ul style="list-style-type: none"> • Access to healthcare should not be unaffordable and limit the socio-economic development of the country • A mentality of passivity exists in the population • The country must reduce its dependency on donors in the financing of its health system
	<i>Cognitive</i>	<ul style="list-style-type: none"> • Financial resources from the state and the population must be harnessed to lower financial access to healthcare, while boosting national and individual self-reliance.
Policy ideas	<i>Normative</i>	<ul style="list-style-type: none"> • Healthcare should be accessible for all • Any able individual should contribute money
	<i>Cognitive</i>	<ul style="list-style-type: none"> • Out-of-pocket expenditure is limited by pre-payment and risk pooling. • CBHI cost is shared between the state, the beneficiaries and subsidised by the formal sector • CBHI is compulsory • CBHI is managed by professionals

Source: Based on the typology in Lavers and Hickey (2015), drawing on Schmidt (2008).

A compulsory, broad-based CBHI was adopted in Rwanda because it was compatible with a certain repartition of power in the polity, *as well as* the RPF mental roadmap, its framing of the issues surrounding access to healthcare, and policy ideas (Table 1).

Conclusion

This article's objective was to understand the political drivers behind the adoption and implementation of the Rwanda CBHI, the key initiative that made Rwanda the country with the highest health insurance coverage in Sub-Saharan Africa. To do so, it used a theoretical framework focusing on political settlements and the role of ideas.

The nature of the political settlement clearly gave the government a large space to engage the country on the path of universal health coverage to ultimately serve its legitimization project of rapid socio-economic development. The virtual absence of political opposition in Rwanda allowed the quick adoption and roll-out of the demanding policy that CBHI is. Unlike in situations of competitive political settlements, where power is more equally distributed between political groups, the nature of the Rwandan settlement made quick, ad hoc and unsustainable solutions focused on immediate political gain unnecessary for regime maintenance. The government could roll out a broad-based programme, and adapt it quickly to emerging problems, even if this meant undermining popular ownership of the programme.

However, the nature of the political settlement is in itself not enough to understand why the government chose CBHI instead of other approaches to expand access to healthcare. Other solutions, such as CBHI coupled with lifting of user fees, a national insurance model, or healthcare financed through general taxation, were compatible with the political settlement. The government had the space to implement such solutions that may even have created less popular resentment. Yet the article argued that these alternative policies did not fit with the RPF paradigmatic ideas as well as the CBHI solution did. The ideational paradigms of national self-reliance and the visceral belief that 'one should not get anything for free' in post-genocide Rwanda impacted ideas both at the level of problem definition and policy, to ultimately result in the CBHI's current form. The same political settlement, but with different ideas, would have probably resulted in another form of social protection in the health sector.

Yet, not all paradigmatic ideas have conserved their power over time. The idea of popular participation has slowly faded away. From a collection of a 'pure' CBHI scheme (based on voluntary enrolment), the government has effectively built what now looks like a compulsory national health insurance. Enrolment is compulsory, and money is centrally pooled and flows through the state accounting system. The scheme is government-led and managed by professionals. Yet, the trace of the paradigmatic idea of popular ownership and management is still visible in the reluctance of government officials to acknowledge this evolution to researchers and in the very maintenance of the name 'CBHI'. If the idea of popular ownership has declined, it is first because it could not resist the pressure created by the RPF legitimization strategy to quickly expand and streamline the scheme. It is also because tension arose with the ideological project, through compulsory enrolment, of focusing on national and individual self-reliance.

References

- Ansoms, A. (2009). 'Re-engineering rural society: The visions and ambitions of the Rwandan elite'. *African Affairs*, 108 (431): 289-309.
- Appiah, B. (2012). 'Universal health coverage still rare in Africa'. *Canadian Medical Association Journal*, 184(2): E125-E126.
- Atim, C. (1998). *The Contribution of Mutual Health Organizations to Financing, Delivery, and Access to Health Care: Synthesis of Research in Nine West and Central African Countries*. Technical Report No. 18. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates,.
- Béland, D. (2005). 'Ideas and social policy: An institutionalist perspective'. *Social Policy & Administration*, 39(1): 1-18.
- Beswick, D. (2010). 'Managing dissent in a post-genocide environment: The challenge of political space in Rwanda'. *Development and Change*, 41(2): 225-251.
- CCM Rwanda (2005). *Assuring Access to Quality Care: the Missing Link to Combat AIDS, Tuberculosis and Malaria*. Kigali: Country Coordinating Mechanism (CCM) Rwanda.
- Chemouni, B. (2014). 'Explaining the design of the Rwandan decentralization: Elite vulnerability and the territorial repartition of power'. *Journal of Eastern African Studies*, 8(2): 246-262.
- De Allegri, M., Sauerborn, R., Kouyaté, B. and Flessa, S. (2009). 'Community health insurance in sub-Saharan Africa: What operational difficulties hamper its successful development?' *Tropical Medicine & International Health*, 14 (5): 586-596.
- Di John, J. and Putzel, J. (2009). 'Political settlements: Issues paper', Governance and Social Development Resource Centre, Birmingham, UK.
- Dror, D. M. and Jacquier, C. (1999). 'Micro-insurance: Extending health insurance to the excluded'. *International Social Security Review* 52(1): 71-97.
- Gaynor, N. (2014). "'A nation in a hurry": The costs of local governance reforms in Rwanda'. *Review of African Political Economy*, 41(sup1): S49-S63.
- George, A. and Bennett, A. (2004). *Case Studies and Theory Development in the Social Sciences*. Cambridge, MA; London: MIT.
- George, A. and McKeown, T. (1985). 'Case studies and theories of organizational decision making', in R. Coulam and R. Smith (eds.), *Advances in Information Processing in Organizations* (pp. 43-68), Greenwich, CT: JAI Press.

- Gökgür, N. (2012). 'Rwanda's ruling party-owned enterprises: Do they enhance or impede development?' *IOB Discussion Paper*, 2012.03.
- Golooba-Mutebi, F. (2013). 'Politics, political settlements and social change in post-colonial Rwanda'. ESID Working Paper 24. Manchester: The University of Manchester.
- Golooba-Mutebi, F. and Booth, D. (2013). *Bilateral Cooperation and Local Power Dynamics. The Case of Rwanda*. London: Overseas Development Institute.
- Hsiao, W. C. (2001). 'Unmet health needs of two billion: Is community financing a solution?' World Bank, HNP Discussion Paper.
- Jehu-Appiah, C., Aryeetey, G., Spaan, E., De Hoop, T., Agyepong, I. and Baltussen, R. (2011). 'Equity aspects of the National Health Insurance Scheme in Ghana: Who is enrolling, who is not and why' *Social Science & Medicine*, 72(2): 157-165.
- Kalk, A., Groos, N., Karasi, J. C. and Girrbaach, E. (2010). 'Health systems strengthening through insurance subsidies: the GFATM experience in Rwanda'. *Tropical Medicine & International Health*, 15(1): 94-97.
- Kalavakonda, V., Groos, N. and Karasi, J.-C. (2007). *Mid-term Evaluation of the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) 5th Round Project on Health Systems Strengthening: Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda*. Geneva: The Global Fund.
- Khan, M. (2010). *Political Settlements and the Governance of Growth-enhancing Institutions*. Unpublished manuscript.
- Kpessa, M., Béland, D. and Lecours, A. (2011). 'Nationalism, development, and social policy: The politics of nation-building in sub-Saharan Africa'. *Ethnic and Racial Studies*, 34(12): 2115-2133.
- Kutzin, J. (2012). 'Anything goes on the path to universal health coverage? No'. *Bulletin of the World Health Organization*, 90(11): 867-868.
- Lagomarsino, G., Garabrant, A., Adyas, A., Muga, R. and Otoo, N. (2012). 'Moving towards universal health coverage: Health insurance reforms in nine developing countries in Africa and Asia'. *The Lancet*, 380(9845): 933-943.
- Lavers, T. (2016). 'Understanding elite commitment to social protection: Rwanda's Vision 2020 Umurenge Programme', WIDER Working Paper, No. 2016/93.
- Lavers, T. and Hickey, S. (2015). 'Investigating the political economy of social protection expansion in Africa: At the intersection of transnational ideas and

- domestic politics', ESID Working Paper 47. Manchester: The University of Manchester.
- Longman, T. (2011). 'Limitations to political reform'. In Straus, S and Waldorf, L. (eds.), *Remaking Rwanda: State Building and Human Rights after Mass Violence* (pp. 25-47). Madison, WI: University of Wisconsin Press.
- Lu, C., Chin, B., Lewandowski, J. L., Basinga, P., Hirschhorn, L. R., Hill, K., Murray, M. and Binagwaho, A. (2012). 'Towards universal health coverage: An evaluation of Rwanda Mutuelles in its first eight years'. *PLoS One*, 7(6): e39282.
- Mann, M. (1984). 'The autonomous power of the state: Its origins, mechanisms and results'. *European Journal of Sociology*, 25(02): 185-213.
- MINALOC (2004). *Rwanda Five-year Decentralization Implementation Program*. Kigali: Ministry of Local Government, Republic of Rwanda.
- MoH (2004). *Politique de Développement des Mutuelles de Santé au Rwanda*. Kigali: Ministry of Health.
- Musango L. (2005). *Organisation et mise en place de mutuelles. Défi au développement de l'assurance maladie au Rwanda*. PhD Thesis, Brussels: Université Libre de Belgique.
- Musango L., Doetinchem O. and Carrin G. (2009). 'De la mutualisation du risque maladie à l'assurance universelle: expérience du Rwanda'. Discussion paper 1/2009. Geneva: World Health Organisation.
- Ndiaye P., Soors, W. and Criel, B. (2007). 'Editorial: A view from beneath: Community health insurance in Africa'. *Tropical Medicine & International Health*, 12(2): 157–161.
- NHIA (2014). *National Health Insurance Authority 2013 Annual Report*. Accra : NHIA.
- NISR, MoH and ICF International. (2015). *Rwanda Demographic and Health Survey 2014-15*. Rockville, MD: National Institute of Statistics of Rwanda (NISR), Ministry of Health, and ICF International
- Nzisabira, J. (1992). 'Les organisations populaires du Rwanda: Leur émergence, leur nature et leur évolution'. *Bulletin de l'APAD*, 4.
- OAG (2011). *Value for Money Audit Report of Mutual Health Insurance Scheme (Mutuelles de Santé) for the Period 2009-2010*. Kigali: Office of the Auditor General.

- Odeyemi, I. A. (2014). 'Community-based health insurance programmes and the national health insurance scheme of Nigeria: Challenges to uptake and integration'. *International Journal for Equity in Health*, 13(20).
- Preker A. and Carrin G. (2004). *Health Financing for Poor People: Resource Mobilization and Risk Sharing*. Washington DC: World Bank.
- Preker, A., Carrin, G., Dror, D., Jakab, M., Hsiao, W. and Arhin-Tenkorang, D. (2004). 'Rich-poor differences in health care financing'. In A. Preker and G. Carrin (eds.), *Health Financing for Poor People: Resource Mobilization and Risk Sharing* (pp. 3-52). Washington, DC: World Bank.
- Prunier, G. (1995). *The Rwanda Crisis: History of a Genocide*. London: Hurst Publishers.
- Reyntjens, F. (2004). 'Rwanda, ten years on: From genocide to dictatorship'. *African Affairs*, 103(411): 177-210.
- Reyntjens, F. (2013). *Political Governance in Post-genocide Rwanda*. Cambridge: Cambridge University Press.
- Ridde, V., Robert, E. and Meessen, B. (2010). 'Les pressions exercées par l'abolition du paiement des soins sur les systèmes de santé'. World Health Report: Background paper 43. Geneva: World Health Organization.
- Sabates-Wheeler, R., Yates, S., Wylde, E. and Gatsinzi, J. (2015). 'Challenges of measuring graduation in Rwanda'. *IDS Bulletin*, 46(2): 103-114.
- Saksena, P., Antunes, A. F., Xu, K., Musango, L. and Carrin, G. (2011). 'Mutual health insurance in Rwanda: Evidence on access to care and financial risk protection'. *Health policy*, 99(3): 203-209.
- Schmidt, V. (2002). 'Does discourse matter in the politics of welfare state adjustment?' *Comparative Political Studies*, 35(2): 168-193
- Schmidt, V. (2008). 'Discursive institutionalism: The explanatory power of ideas and discourse'. *Annual Review of Political Science*, 11(1): 303-326.
- Schneider, P., Diop, F. and Bucyana, S. (2000a). *Development and Implementation of Prepayment Schemes in Rwanda*. Technical Report 45. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates.
- Schneider, P., Nandakumar, A. K., Porignon, D., Bhawalkar, M., Butera, D. and Barnett C. (2000b). *Rwanda National Health Accounts 1998*. Technical Report 53. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates.

- Schneider, P. and Diop, F. (2001). *Synopsis of Results on the Impact of Community-based Health Insurance on Financial Accessibility to Health Care in Rwanda*. HNP Discussion Paper. Washington, DC: World Bank.
- Soors, W., Devadasan, N., Durairaj, V. and Criel, B. (2010). 'Community health insurance and universal coverage: multiple paths, many rivers to cross'. World Health Report: Background paper 48. Geneva: World Health Organization.
- Twahirwa A. (2008). 'Sharing the burden of sickness: Mutual health insurance in Rwanda'. *Bulletin of the World Health Organization* 86(11): 823-824.
- Weyland, K. (2009). *Bounded Rationality and Policy Diffusion: Social Sector Reform in Latin America*. Princeton, NJ: Princeton University Press.
- WHO (2009). *Republic of Rwanda Health Financing Systems Review 2008: Options for Universal Coverage*. Geneva: World Health Organization.
- WHO (2010). *The World Health Report 2010: Health Systems Financing. The Path to Universal Coverage*. Geneva: World Health Organization.
- Witter, S. and Garshong, B. (2009). 'Something old or something new? Social health insurance in Ghana'. *BMC International Health and Human Rights*, 9(20).

The Effective States and Inclusive Development Research Centre

The Effective States and Inclusive Development Research Centre (ESID) aims to improve the use of governance research evidence in decision-making. Our key focus is on the role of state effectiveness and elite commitment in achieving inclusive development and social justice.

ESID is a partnership of highly reputed research and policy institutes based in Africa, Asia, Europe and North America. The lead institution is the University of Manchester.

The other institutional partners are:

- BRAC Institute of Governance and Development, BRAC University, Dhaka
- Center for Democratic Development, Accra
- Center for International Development, Harvard University, Boston
- Department of Political and Administrative Studies, University of Malawi, Zomba
- Graduate School of Development, Policy & Practice, Cape Town University
- Institute for Economic Growth, Delhi

In addition to its institutional partners, ESID has established a network of leading research collaborators and policy/uptake experts.

email: esid@manchester.ac.uk

Effective States and Inclusive Development Research Centre (ESID)

Global Development Institute, School of Environment, Education and Development,
The University of Manchester, Oxford Road,
Manchester M13 9PL, UK

www.effective-states.org