

LETTER TO EDITOR

Political economy as strategy: Lessons from
Rwanda's community-based health insurance
reforms**Regis Hitimana¹, Ina Kalisa¹, Uwaliraye Parfait², Shivani Shukla^{3,4*}, Soleine Scotney³, Amit Chandra⁵, and Daniel Palazuelos^{6,7}**¹Rwanda Social Security Board, Kigali, Rwanda²Ministry of Health, Republic of Rwanda, Kigali, Rwanda³Financing Alliance for Health, Nairobi, Kenya⁴Department of Global Health and Development, Faculty of Public Health and Policy, London School of Hygiene & Tropical Medicine, London, United Kingdom⁵Department of Global Health, School of Health, Georgetown University, Washington, DC, United States of America⁶Partners In Health, Boston, Massachusetts, United States of America⁷Division of Global Health Equity, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts, United States of America**Abstract**

Rwanda's community-based health insurance (CBHI) evolved into a compulsory, nationally pooled, and largely government-financed scheme that achieved high population coverage but developed persistent fiscal deficits, prompting major reforms in 2020–2021. We examine how those reforms became politically feasible and argue that Rwanda's reform strategy reflected political economy in practice through mutually reinforcing approaches: anchoring the financing response in central fiscal institutions, linking revenue mobilisation to visible expansion of the benefits package, framing sustainability as a national fiscal priority, and institutionalising more transparent, rule-based benefits-package decisions. Rwanda's experience illustrates how political economy considerations can shape health financing reforms by influencing where authority is located, how costs and benefits are distributed, and how politically sensitive decisions are managed.

Keywords: Community-based health insurance; Political economy; Health financing reform; Rwanda; Universal health coverage; Priority setting

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1. Introduction

Community-based health insurance (CBHI) has been widely used to extend health coverage to people excluded from formal insurance, particularly rural populations and workers in the informal sector (Ekman, 2004; Fadlallah *et al.*, 2018). Extending insurance coverage matters because health insurance can enable people to obtain needed care without financial hardship and, in turn, contribute to better health outcomes. However, voluntary enrolment and small risk pools have limited the financial sustainability of many schemes (Ekman, 2004; Fadlallah *et al.*, 2018; Mladovsky, 2014). As schemes expand towards universal coverage, successful models have often moved beyond

traditional community-based arrangements through compulsory enrolment, public subsidies and national risk pooling. Rwanda is one such example.

Introduced as a pilot in three districts in 1999, Rwanda's scheme expanded nationwide by 2004. Initially based on a flat premium, it subsequently linked contributions to Ubudehe, Rwanda's national socio-economic classification system, with government subsidies for poorer households (Chirwa *et al.*, 2021; Ministry of Health, 2021a). Although labelled community-based, the scheme relied on district authorities rather than community organisations for management and risk pooling (Chemouni, 2018). In 2015, more than 500 district insurance pools were consolidated into a single national fund managed by the Rwanda Social Security Board (RSSB) (Ministry of Health, 2021a; Nyandekwe *et al.*, 2020). By then, CBHI had become a compulsory, nationally pooled and largely government-financed health insurance system. Evidence from Rwanda also suggests that the scheme provided financial protection: enrolment was associated with a reduction in annual per capita out-of-pocket health spending of approximately RWF 3,600 (about US\$12) and in catastrophic health expenditure (Woldemichael *et al.*, 2019).

Despite these reforms, CBHI recorded persistent deficits, reaching RWF 17.6 billion in 2017–18 as the cost of the benefits package outpaced growth in contributions and public subsidies (Nyandekwe *et al.*, 2020). The 2020–2021 reforms therefore sought to improve financial sustainability while expanding access to high-cost hospital

services. These reforms are relevant to political economy because health financing reforms alter who pays, who benefits and how resources are allocated (Fox & Reich, 2015; Sparkes *et al.*, 2019).

Sparkes *et al.* (2019) identify six dimensions of political economy relevant to health financing reform: interest-group, bureaucratic, budget, leadership, beneficiary and external-actor politics. Their framework links these dimensions to strategies for advancing reform. We apply it to Rwanda's 2020–2021 CBHI reforms, focusing on bureaucratic, budget, interest-group and leadership politics. The analysis shows how these political economy considerations were reflected in four features of reform: locating authority within central fiscal institutions; sequencing new revenue measures alongside visible benefits expansion; managing the interests of new contributors and providers; and securing high-level political support. These four political economy dimensions and the corresponding strategies used in Rwanda are summarised in Table 1.

2. Institutional positioning: Anchoring reform in fiscal authority

A defining feature of Rwanda's CBHI reform was the institutional location of responsibility for the reform. Although CBHI remained a health financing programme, its financing pressures were addressed through a cross-government process led by the Ministry of Finance and Economic Planning (MINECOFIN), working alongside the Ministry of Health (MoH) and the Ministry of

Table 1. Political economy dimensions of Rwanda's 2020–2021 CBHI reform

Dimension	Political economy challenge	Strategy used in Rwanda
Bureaucratic politics: Which parts of government are involved, and how they coordinate or compete	CBHI's deficit was a cross-sectoral problem	Reform authority located in the Ministry of Finance and Economic Planning, working with the Ministry of Health and Ministry of Local Government
Budget politics: How money is raised and allocated, and who controls that decision	Contribution increases are hard to sustain when perceived as new costs with no visible return	Revenue mobilisation and benefits expansion introduced together; CBHI's deficit reframed as a national fiscal risk rather than a sectoral funding request
Interest group politics: How organised groups - industries, providers, unions - respond to new costs or benefits	New contributors, including telecommunications, banking, insurance and petroleum sectors, had no prior stake in CBHI financing	Benefits expansion concentrated on services used by the same urban, formally employed populations whose employers were the new contributors; tertiary hospitals and specialists gained newly reimbursable high-cost services
Leadership politics: Whether senior political leaders back the reform and make it a visible priority	Cross-sector coordination and investments also required political buy-in beyond the health ministry	The 2019 National Leadership Retreat identified CBHI financial sustainability as a national priority, providing high-level political backing for subsequent reforms.

Note: Framework adapted from Sparkes *et al.* (2019).

Abbreviation: CBHI: Community-based health insurance.

Local Government (MINALOC). The CBHI Financial Sustainability Plan emerged from this process, and contribution reforms were advanced through central fiscal institutions rather than solely through the health sector (Ministry of Health, 2021b).

This positioning reflected the nature of the financing challenge. CBHI's deficit was not only a question of health spending; it involved decisions about domestic revenue mobilisation, public subsidies and the allocation of resources across sectors. Locating reform authority within fiscal institutions brought these decisions into a broader government discussion about financial sustainability while retaining technical leadership from the health sector. This approach is consistent with evidence that health financing reforms are more likely to progress when they are connected to institutions with authority over wider fiscal and policy decisions (Sparkes *et al.*, 2019).

The feasibility of these reforms also reflected institutional choices made before 2020–2021. The consolidation of more than 500 district-level CBHI pools into a single national fund managed by the RSSB in 2015 created the institutional platform through which new financing arrangements could be channelled and managed (Chemouni, 2018; Nyandekwe *et al.*, 2020). By the time financial sustainability became a pressing concern, Rwanda had already moved away from a fragmented community insurance model towards a nationally coordinated financing structure.

3. Strategic sequencing and windows of opportunity

The 2020–2021 reforms addressed two pressures simultaneously: CBHI required additional and more predictable financing, while beneficiaries expected access to a broader benefits package. Rwanda linked contribution reforms with expansion of the benefits package.

The 2020 Prime Minister's Order expanded the financing base of CBHI through new contributions from selected sectors, including telecommunications operators, banks, insurers and petroleum importers (Ministry of Health, 2021a). The 2021 Ministerial Instructions expanded the benefits package to include higher-cost services—specifically dialysis for kidney disease, cancer treatment, orthopaedic and cardiac interventions—that had previously been unaffordable for most households (Ministry of Health, 2021b). This sequencing likely enhanced political feasibility by linking new contributions to tangible gains in coverage, giving contributing sectors a clearer stake in the reform and reframing the discussion from paying more to gaining more.

The distribution of costs and benefits reinforced this dynamic. Many of the new contributions came from urban, formal-sector industries. The expanded services primarily addressed high-cost non-communicable conditions that were more likely to benefit employees and families of contributing industries. Tertiary hospitals and specialists also gained because services that had previously been beyond most patients' means became covered and reimbursable. The reform therefore created greater alignment between those financing the scheme and those expected to benefit from the expanded package.

The government also introduced a shift from fee-for-service to capitation for primary care between 2020 and 2021 (Umuhoza *et al.*, 2022). Under capitation, providers receive a fixed annual payment per enrolled person. This makes health expenditure more predictable and removes the incentive to over-supply care. Revenue expansion was therefore accompanied by measures to control expenditure growth.

4. Managing resistance and institutionalising decisions

Expanding CBHI financing required contributions from actors who had not previously funded the scheme. Rather than presenting new contributions as a health-sector funding request, government documents framed CBHI financing pressures as a national economic concern—showing, through fiscal analysis, what continued deficits would mean for provider payments, coverage reliability and wider economic stability (Ministry of Health, 2021a).

Negotiation remained necessary. Telecommunications operators, for example, were required to contribute up to 3% of annual turnover, phased in from 2.5% during the initial period (Ministry of Health, 2021b). The phased approach reflects how the government balanced the objective of closing the financing gap with the practical realities of introducing new obligations. Rwanda continued to subsidise contributions for poorer households through the Ubudehe classification, even as new corporate contributors were brought into the financing base (Chirwa *et al.*, 2021).

The most politically sensitive question was which services would be covered. Rwanda addressed this by introducing a structured methodology for benefits-package decisions, based on epidemiological relevance, cost-effectiveness, budget impact and stakeholder input (Ministry of Health, 2021b). Moving priority-setting away from case-by-case negotiation and towards a transparent, rules-based process made difficult trade-offs easier to justify and harder to challenge.

5. Conditions shaping political feasibility

Sparkes *et al.* (2019) note that institutional context shapes political feasibility independently of the six stakeholder dimensions. Three conditions could have shaped political feasibility in Rwanda.

First, Rwanda's state capacity likely enabled the cross-sector coordination (Nyandekwe *et al.*, 2020). This also reflects a specific political settlement: a centralised governance model with strong executive authority and limited space for organised opposition from industries, civil society or political actors (Chemouni, 2018). These conditions may have facilitated the coordination observed in Rwanda but are not necessarily transferable to other settings.

Second, the overlap between who paid and who benefited was not something reformers created from nothing; it reflected an existing feature of Rwanda's economy. The urban, formal-sector industries asked to contribute more were also the employers of populations most likely to use the newly covered services. The broader lesson is not to replicate Rwanda's contributor base, but to consider how the distribution of costs and benefits shapes support for financing reforms in different settings.

Third, timing created a receptive window. The COVID-19 pandemic raised the political salience of health financing globally and in Rwanda (Witter *et al.*, 2025), while the 2019 National Leadership Retreat had already established CBHI sustainability as a shared government priority (Government of Rwanda, 2019).

These conditions help explain why particular approaches were politically feasible in Rwanda, while their relevance elsewhere will depend on the institutional context of each reform.

6. Conclusion

Rwanda's CBHI reforms demonstrate how political considerations shaped the response to financial pressures: authority was anchored in central fiscal institutions, new contributions were linked to visible expansion of benefits, the interests of new contributors were managed alongside continued protection for poorer households, and priority-setting was moved towards a more transparent process. These approaches were supported by Rwanda's institutional context, including a nationally consolidated pool, and an alignment between those asked to contribute and those likely to benefit from expanded coverage. Whether these reforms ultimately improved the scheme's financing position, reduced out-of-pocket spending, improved equity in access to care, and translated into better health outcomes remains an empirical question.

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Conflict of interest

Authors RH and IK are senior officials at the Rwanda Social Security Board, which administers Rwanda's community-based health insurance scheme. Author UP is a former senior official at the Rwanda Ministry of Health and contributed to the reform process analysed in this paper. No competing financial interests are declared.

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