Case report

Conceptualizing and researching health equity in Africa through a political economy of health lens – Rwanda in perspective

Dennis Raphael⁎, Morris Komakech

School of Health Policy and Management at York University, 4700 Keele Street, Toronto, Ontario M3J 1P3, Canada

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ABSTRACT

Research on promoting health equity by reducing health inequalities in Africa presents an emerging research frontier. Concepts from the political economy of health literature such as decommodification, stratification, class mobilization, and the relative responsibility ascribed to the state, marketplace, and family in defining the quality and distribution of economic and social resources, i.e., the social determinants of health, have relevance for the African health scene. We use Rwanda as an example to show how these considerations can inform research and policy action to promote health equity in Africa. Based on evidence of Rwanda’s generally better health and narrower health inequalities than other sub-Saharan African nations, we explore some of the political, economic, and social forces promoting health equity in Rwanda. We conclude that Rwandan actions are consistent with movement towards a welfare state that acts in the service of promoting health equity.

1. Introduction

Research on promoting health equity by reducing health inequalities in Africa presents an emerging research frontier. A 2018 review of health inequalities research output found few research publications emanating from low- and middle-income as compared to high-income nations (Cash-Gibson, Rojas-Gualdrón, Pericàs, & Benach, 2018). There were only 15 outputs from Rwanda over the 49-year period of 1966–2015.

This case report illuminates how Rwanda, a nation with a complex and troubled history, is making strides towards promoting health equity and reducing health inequalities. The source of health inequalities is contested such that they can be explained as emanating in genetics, behaviours, community factors, health care systems, or societal structures and processes that distribute the economic and social resources necessary for health (Bartley, 2016). A consensus is emerging that a broad political economy analysis that considers how political and economic structures and processes shape, through public policy, the nature of the health care system and the distribution of economic and social resources best explains the overall health of a nation and the extent of health differences among social groups, i.e., health inequalities (Raphael & Bryant, 2019). These structures and processes are shaped by political and economic traditions (Bambra, 2013). While many of these concepts were developed in the context of Western capitalist societies, they provide a foundation for further theorization of how welfare state-related policies can promote health equity in the developing world. For Africa, applying the welfare concept is of particular importance due to the rapid ongoing transformation of national economies to the neoliberal market-oriented models that mirror the capitalist economies of Western societies (Labonté & Ruckert, 2019; Usman & Bashir, 2018). These economic transformations are altering the structure of African societies and relations between the state and citizens in a manner that generates wide-ranging inequalities (De Maio, 2014; Forster, Kentikelenis, Stubbs, & King, 2019).

In this paper we examine the health equity implications of welfare state concepts such as decommodification, stratification, class mobilization, and the relative role of the state, market, and family in distributing economic and social resources necessary for health. We then examine the Rwandan health equity scene and identify the political, economic, and social forces at play in that nation.

2. Background

We acknowledge that the development of Rwanda’s nascent welfare state has been influenced by Africa’s history of colonialism and the impact of international donor and civil society organizations upon social policies. Especially important has been their influence upon state activity and the

⁎ Corresponding author.
E-mail addresses: draphael@yorku.ca (D. Raphael), komakech@yorku.ca (M. Komakech).

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2.5. Social determinants of health and the social determinants of health inequalities

Social determinants of health and the social determinants of health inequalities

Social determinants of health are the economic and social conditions that influence the health of individuals, groups, and nations (Raphael, 2016). These include education, employment and working conditions, food security, health services, housing and income distribution, and the social safety net. Social determinants of health inequalities are the societal structures and processes that form the quality and distribution of these determinants (Mantoura & Morrison, 2016). The economic system distributes financial resources, the political system makes laws and regulations that also do so, and ideological beliefs justify these distributions. These structures and processes are shaped by the balance of power of sectors in society and the mediating role of the state (Bryant & Raphael, 2020).

2.6. Welfare states

A welfare state is a nation in which organized power modifies the play of market forces in at least three directions: “first, by guaranteeing individuals and families a minimum income irrespective of the market value of their work or property; second, by narrowing the extent of insecurity by enabling individuals and families to meet certain social contingencies (for example, sickness, old age, and unemployment) that lead otherwise to individual and family crises; and third, by ensuring that all citizens without distinction of status or class are offered the best standards available in relation to a certain agreed range of social services” (Briggs, 1961, p. 14).

The welfare state literature explains how the power and influence of classes and groups act through political and economic systems to distribute these resources (Bryant & Raphael, 2018). Various typologies of welfare states have been devised with relevance to both developed and developing nations. These are summarized in Box 1.

Box 1 Welfare state typologies

<table>
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<th>Typology</th>
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<td>Esping-Andersen (1990)</td>
<td>Social Democratic: Characterized by universalism, comparatively generous social transfers, commitment to full employment and income protection; and a strongly interventionist state. Conservative: Status differentiating welfare programmes in which benefits are often earnings related, administered through the employer; and geared towards maintaining existing social patterns. Liberal: State provision of welfare is minimal, social transfers are modest and often attract strict entitlement criteria; and recipients are usually means-tested and stigmatized. Wood and Gough (2006) Actual or Potential Welfare State Regimes: Human Development Index (HDI) scores are high as is public spending; international flows low. Less Effective Informal Security Regimes: Low HDI and low public spending with medium international flows. Externally Dependent Insecurity Regimes: Very low HDI and low public spending with high international flows.</td>
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All imply that the extent of stratification and decommodification of necessary resources and state management shape the distributions of economic and social determinants of health. Welfare states can be shaped and sustained through class and group mobilization. Stratification refers to institutionalized differences amongst society members and is usually defined in terms of wealth, income, education and power and influence (Scott, 2014). Stratification is both a cause and result of the ability of specific classes and other groups to shape public policy to meet their needs.

Stratification can lead to social inequalities whereby some groups enjoy opportunities and rewards which in turn, create health inequalities. Provision of universal benefits and services that decommodify the necessities for health mitigates the health effects of stratification (Bambra, 2005).

Decommodification is the ability to have a decent quality of life independent of paid employment (Esping-Andersen, 1990, 1999). In addition to replacement income associated with retirement, sickness and disability, and unemployment, important features of daily life that can be decommodified – i.e., provided without payment – are elementary, secondary and postsecondary education, health care and social services, and pensions, among others (Menahem, 2010).

Roles of the state, family and market differ among welfare states.
Effective welfare states have a strong state role in distributing resources while others cede control to market forces and/or dominant social groups. Class/power mobilization refers to the ability of classes or groups of citizens to attain the power to move a state towards approaches that benefit them (Esping-Andersen, 1990).

3. Health-related variables in the welfare state literature

It appears that for both developed and developing nations, health outcomes are better when stratification is lower, decommodification is higher, public transfers in the form of supports and services are greater, taxation is more progressive, and support for progressive political parties is stronger (Bambra, Reibling, & McNamara, 2019; Bryant & Raphael, 2018). Wood and Gough (2006) reinforce the importance to the developing world of labour and financial markets, state legitimacy and competency, extent of societal integration, culture and values, and a nation’s position in the global system.

4. Application to Rwanda

Rwanda has been identified as instituting public policies that enhance health (World Health Organization, 2015). It met its Millennium Goals for Health through its elaborate health sector and public policies that improve the quality and equitable distribution of numerous social determinants of health (Abbott, Sapsford, & Binagwaho, 2017).

4.1. Health outcomes and health inequalities

Health outcomes and extent of health inequalities are indicators of welfare state development and movement towards health equity. Health outcomes. Rwanda compares very well to other sub-Saharan nations on two important health indicators, ranking 2nd in life expectancy at birth and 1st in infant mortality (World Bank, 2020a, 2020b). Rwanda’s life expectancy in 2000 was only 47 years, making its 2017 level of 69 years a remarkable achievement. Similarly, its infant mortality rate in 2000 was 108/1000 as compared to the 2018 rate of 27/1000 (Figs. 1 and 2).

Health inequalities. Health inequalities are sensitive measures of a nation meeting citizen needs. The Health Equity Assessment Toolkit of the World Health Organization documents the extent of several health inequalities among Rwandans (Global Health Observatory, 2018).

Figs. 3–6 provide indicators of access to healthcare as a function of income.

Rwanda does very well in extent of coverage and extent of income-related inequalities for antenatal care, births attended by skilled personnel and full immunization amongst one-year olds. Composite coverage is an index of reproductive, maternal, newborn and child health interventions. Rwanda’s profile is encouraging.
Figs. 7 and 8 show inequalities in infant and under five years mortality rates. Rates in Rwanda are lower than most other sub-Saharan nations, yet inequalities persist. Fig. 9 shows significant inequalities for children sleeping under insecticide-treated nets.

4.2. Non-Health indicators of welfare state development

Key indicators of welfare state development that inform health outcomes are GDP, income inequality and poverty rates. These in turn are driven by public policies that manage stratification, decommodify necessary resources, and provide programs that provide economic and social security. Overall, total expenditures by the Rwandan central government have been increasing and this includes wages and salaries and purchases of goods and services (National Institute of Statistics of Rwanda (NISR), 2019). Since fiscal year 2013/14, the national budget has increased by more than 25 per cent in nominal terms. Of this budget, social protection expenditures in 2017/18 accounted for 4.5% of public spending (United Nations Children’s Fund, 2017). General public services take up 33.9% of public spending.

Overall GDP. Rwanda has been making steady progress in increasing its GDP. As of 2018, its total GDP was 8.61 billion USD, continuing a rapid increase from 1.667 billion USD in 2002; approximately a 7% a year average increase. On a per capita basis GDP has increased in constant dollars from $709 USD in 2012 to $787 USD in 2018.

Access to necessities. The 2019 Statistical Yearbook provides information on Rwandans’ access to necessities (National Institute of Statistics of Rwanda (NISR), 2019). For virtually all these indicators, the situation is improving. For example, in 2005/6 only 4.3% of households had electricity as the main source of lighting. By 2016/17 this figure had increased to 27.1%. Similarly, in 2005/06, 43.7% of households were shielded with a metal sheet roof; by 2016/17 it had improved to 67.3%. Other indicators include improved drinking water, improved sanitation, households with a radio set, and households owning a mobile phone. Of note, the percentage of households owning a mobile phone was only 6.2% in 2005/6 but increased to 66.9% by 2016/17.

Income inequality. Rwanda’s income inequality is considered to be mid-range in Africa (Oduosula, Cornia, Bhorat, & Conceição, 2017). It is amongst the highest in East Africa but unlike other East African nations, it is declining (Oxfam Uganda, 2017). In the 2005/6 period, the Gini index was 0.522. By 2017 it had declined to 0.429 (National Institute of Statistics of Rwanda (NISR), 2019).

Education and literacy rates. Rates are improving. In 2005/6 the percentage of individuals that had ever attended school was 78.7%. By 2016/17 it had increased to 86.2%. The net attendance rate in primary school similarly increased from 86.6% to 87.6% over this period and net attendance rate in secondary school improved from 10.4% to 23.2%. The literacy rate among people aged 15 to 24 was 76.9% in 2005/6; it is now 86.5% for the 2016/17 period.

Poverty rates. Poverty rates in Rwanda are declining. There are two indicators of poverty provided. The extreme poverty rate was 35.8% in 2005/06. It has declined to 16.0% in 2016/17. The poverty rate was 56.7% in 2005/06 and declined to 38.2% during 2016/17.

Health care coverage. Rwanda is unique in Africa with a very high health insurance rate of 86%. As shown earlier, near-universality is being met in key areas. According to the Ministry of Health, the number of health facilities increased from 1342 in 2017 to 1534 in 2018 (National Institute of Statistics of Rwanda (NISR), 2019).
5. Public policies responsible for these indicators

Drawing from experiences of other African states, the government instituted a series of actions with the goals of achieving near health care universal coverage (Iyer et al., 2018; Sayinzoga & Bijlmakers, 2016). Locally operated health clinics strive to enroll residents and involve them in planning and implementation; low income residents are subsidized; and there are sliding scales for health care premiums based on wealth. Overall planning is under the control of the central government. These actions are driven by the perceived need for health care reform and clear ideas about goals and means to achieve them (Chemouni, 2018). These ideas included numerous programs to develop human resources, decentralization of health service delivery, development of health information systems, various forms of health care financing, and national stewardship of health policy and coordination with international partners (Iyer et al., 2018).

The quality and equitable distribution of health care and additional social determinants of health are enhanced through investments in health care, education, poverty reduction, and water and sanitation. Rwanda implemented five means of improving the health and well-being of people (Binagwaho & Scott, 2015).

(1) Advancing concrete and meaningful equity agendas that drive the post-2015 Millennium Development Goals;
(2) ensuring that goals to meet Universal Health Coverage incorporate a focus on improving quality; and not only quantity of care;
(3) bolstering education and the internal research capacity within countries to improve local evidence-based policymaking;

Fig. 3. Antenatal care.
promoting intersectoral collaboration to achieve goals, and
(5) improving collaborations between multilateral agencies – that are
helping to monitor and evaluate progress towards the goals that are
set – and the countries that are working to achieve improvements in
health within their nation and across the world.

These authors see Rwanda as having implemented a “pro-poor and
pro-vulnerable agenda that extends beyond the traditional ‘health
sector’ to tackle the determinants of health” (p. 203). The Vision 2020
and the Economic Development and Poverty Reduction Strategy ex-
emplify this approach.

More specifically, specific aspects of the elaborate Rwandan public
policy environment have been described as participatory, sustainable
and cost effective (Iyer et al., 2018). Through its Vision 2020, Rwanda
developed the Umurenge Program, a central government-led initiative
with full support across the political spectrum.

This program has three components; 1) public works; 2) Ubudehe
credit scheme (local collective actions); and 3) unconditioned cash
transfers that are part of an active collective participatory poverty re-
duction strategy (Giovannetti & Sanfilippo, 2011). It is noted that the
central government developed and then communicated these policies to
Ministry of Health officials at the central and district levels through a
series of health sector strategic plans. External actors (NGOs and Do-
nors) were then invited for their technical and financial support. In
Rwanda, the role of non-state actors in health service delivery is re-
stricted.

Poverty reduction occurs through collective participatory activities
whereby transfers are government-directed but managed at the village
level such that villagers identify those most in need and work together
for the common good (Joseph, 2005). The Rwandan social policy ap-
proach has reduced poverty among beneficiaries from 40.6% to 9% from its inception (Giovannetti & Sanfilippo, 2011). It is seen as effi-
cient and accountable with little resource waste.
6. Explaining the political and economic forces driving these improvements

As suggested earlier, promoting health equity is more likely when governance ensures universality, reduces stratification and promotes decommodification, and power and influence is not ceded to any one sector. On each of these counts, the Rwandan government scores high grades. Iyer et al. (2018) attribute the success of the Rwandan health care system to factors that can also be applied to other health-related policy areas: strong public sector leadership, investments in information systems, equity-driven policies, and the use of foreign aid to invest in local capacity.

These successes have come about as a result of three key aspects of the Rwandan situation: 1) the dominance of the Rwandan Patriotic Front and its commitment to Rwandan development as stated in its Rwanda Vision 2020 statement (Box 2); 2) control of the public policy environment by the state rather than the private sector; and 3) commitment and implementation of an anti-corruption agenda. These have served to limit stratification and its health effects and decommodified key social determinants of health such as health care, education, and in some cases, housing (Jaganyi et al., 2018).
Box 2
Key elements of Rwanda Vision 2020

- Reconstruction of the nation and its social capital anchored on good governance, underpinned by a capable state;
- Transformation of agriculture into a productive, high value, market-oriented sector, with forward linkages to other sectors;
- Development of an efficient private sector spearheaded by competitiveness and entrepreneurship;
- Comprehensive human resources development, encompassing education, health, and ICT skills aimed at public sector, private sector and civil society. To be integrated with demographic, health and gender issues;
- Infrastructural development, entailing improved transport links, energy and water supplies and ICT networks; and
- Promotion of regional economic integration and cooperation.

At all times, these will be affected by a number of cross-cutting issues including, gender equality and sustainable environmental and natural resource management.


6.1. Rwandan Patriotic Front

The ruling Rwandan Patriotic Front (RPF) was formed as a military group and came to power by ousting the genocidal ruling party in 1994. Paul Kagame became leader of the RPF in 1998 and was elected president in 2003. The RPF is the dominant party and rules through a multi-party coalition. Rwanda provides a high level of government services and the RPF is clearly promoting the improvement of living standards as well as emphasizing gender equality (Chemouni, 2017).

Its commitment and actions towards these goals has given it a reputation of competency and legitimacy (Matfess, 2015). It has been suggested that: “The Public Sector Reforms (PSR) has been successful and so strongly embraced because rulers considered an effective public sector as a crucial tool for their legitimation strategy, which was based on achieving rapid socio-economic progress and projecting an image of impartiality” (Chemouni, 2017, p. 2). Against this backdrop of success, Rwanda has also been criticized for its human rights record such that a clear dichotomy exists in the academic literature with many lauding its developmental achievements (Abbott et al., 2017; Iyer et al., 2018) and
6.2. State control of the public policy environment

In a comparison of health outcomes between Rwanda and Burundi, Iyer et al. (2018) highlight the key role of the Rwandan central government in providing primary health care with relevance for understanding other public policy domains associated with health.

In Rwanda, decisions were made by the national government. Health policy was communicated to Ministry of Health officials at the central and district levels through a series of health sector strategic plans, emphasizing the key areas of focus. Non-governmental organizations (NGOs) and multilateral donors were then consulted for technical and financial support. Rwanda discouraged the independent implementation of health programs by NGOs, mandating that the work be done in collaboration with the government... These arrangements allowed Rwanda’s government to maintain control over how projects were implemented and to steer policy (p. 204).

Another key feature of the Rwandan public policy scene is the use of the RPF-owned private holding company, Tri-Star Investments/CVL, to invest in metals trading, road construction, housing estates, building materials, fruit processing, mobile telephony, and printing, furniture imports and security services (Matfess, 2015). The investment by Tri-Star/CVL to ventures that are expected to have high social benefits is an important component of the political economy of Rwanda (Booth & Golooba-Mutebi, 2012).

6.3. Implementation of an Anti-Corruption Agenda

The central government has implemented, in numerous legislative acts, a rigorous anti-corruption agenda that is monitored through the Office of the Ombudsman (Khan & Pillay, 2019). These include the...
prevention and punishment of money laundering, financing of terrorism, and especially important, assuring that the supply chain and procurement of governments is free of corruption.

These activities have received the praise of international authorities. Indeed, the 2019 Corruption Barometer of Transparency International ranked Rwanda the 4th least corrupt country in sub-Saharan Africa only after Botswana, Seychelles, and Cape Verde (Transparency International, 2019).

State control of public policy, directed by the pro-development ideology of the ruling RPF, and facilitated by anti-corruption initiatives therefore play a large role in Rwanda’s positive health outcomes. Rwanda has provided leadership in health where centralized health and other policy decisions promote a national agenda that limits the role of transnational actors to the periphery (Iyer et al., 2018).

As a result of these public policies, Rwanda is addressing issues of stratification and decommodification through the Ubudehe and other policies. It reduces waste due to corruption, thereby promoting its reputation of competence and legitimacy. These main themes are consistent with the general welfare state literature and offer suggestions for promoting health equity for other African nations.

7. Placing Rwanda into existing welfare state typologies

As noted earlier, Gough and Wood (2006) identify a) Actual or Potential Welfare State Regimes; b) Less Effective Informal Security Regimes; and c) Externally Dependent Insecurity Regimes (Wood & Gough, 2006). It appears to us that Rwanda is a Potential Welfare State clearly moving towards provision of health care and emphasizing important social determinants of health such as education, housing and income. It has achieved notable successes in providing health care on a universal basis which has been assisted by its investments in poverty-reduction and various social determinants of health.

8. Implications for research

Research into health inequalities in Africa has necessarily taken a backseat to more pressing concerns related to the provision of basic
health needs such as water and sanitation, provision of healthcare, and disease prevention. There is much scholarship that has examined the political economy of Rwanda and the economic, economic and social forces shaping public policy (Lavers, 2016; Mann & Berry, 2016). Few of these analyses have however, been explicitly applied to the health equity scene (Abbott et al., 2017; Chemouni, 2018; Iyer et al., 2018).

At the last two conferences organized by the Society for the Advancement of Science in Africa, a very few presentations were concerned with health inequalities and their sources (Kapalanga & Raphael, 2020; Kapalanga, Raphael, & Mutesa, 2019). This paper was written to spur research activities into the sources of health inequalities and means of reducing them through a political economy perspective that makes explicit the structures and processes of society and how they shape health. Special attention should be directed to processes of stratification and decommodification and the state role in shaping the quality and distribution of the social determinants of health. The ability of the state to manage existing groups tensions – for which Rwanda has been a both model of failure during its genocide and is now a reconciliation success – is also worthy of study (Grayson, Hitchcott, Blackie, & Joseph, 2019; Karlsson & Talp, 2017).

9. A final note: democratic governance

Democratic governance is a concern in both developed and developing nations (Raphael, Komakech, Bryant, & Torrence, 2019; Wood & Gough, 2006). There is no denying many of the successes of the Rwandan government in improving the quality and equitable distribution of the social determinants of health. For some however, the impressive gains in social progress in Rwanda have come at the cost of “voice and accountability” (McKay & Verpoorten, 2016). The issue of balancing social progress with human rights must always be viewed in the context of each nation’s history, contemporary context, and its balancing of priorities (Gurusamy & Janagaraj, 2018; Kritz, 2019).
Conflict of interest

The authors Dennis Raphael and Morris DC Komakech confirm that we have no conflicts of interest regarding this manuscript and its content.

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Reference
Dennis Raphael PhD, is a Professor of Health Policy and Management at York University in Toronto. Dr. Raphael has published over 300 scientific publications that focus on health policy, the political economy of health, and social determinants of health. Dr. Raphael is also an author and editor of several books on the health effects of income inequality and poverty, immigrant health, the quality of life of communities and individuals, and the impact of government decisions on Canadians’ health and well-being.

Morris DC Komakech MPH/Global Health, is a PhD student at York University in the School of Health Policy and Management. Mr. Komakech has extensive experience working in Toronto Public Health in chronic disease and injury prevention among adults and older adults. Mr. Komakech has also conducted health research in Africa in maternal child health, HIV/AIDS, the political economy of noncommunicable diseases, and health policy.