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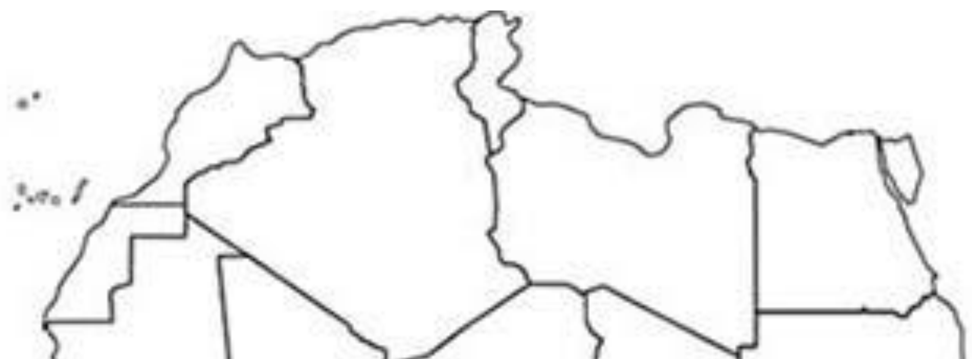

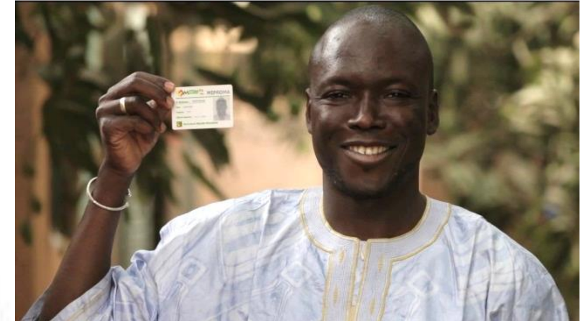

HEALTH INSURANCE AT A GLANCE IN AFRICA

Country	Program	Target Population	Benefits Package	Funding	Future Directions/Next Steps	Source of Information
Benin	Mutuelles de Sante Approximately 200 schemes	About 5% of the population in the Informal sector	Limited services (varies)	Member contributions	Rolling out of RAMU, putting in place the necessary institutional structure to support it- expansion of coverage including consolidation of the small Mutuelles	HFG, 2013. *Health Insurance Matrix*, Updates for Selected Sub-Sahara African Countries, Working document Benin Private Sector Assessment. SHOPS Project 2013 http://abtassociates.com/AbtAssociates/files/50/5009aaae-6662-434a-aad1-7a5934f0eb9b.pdf
	Social Insurance Fund (Caisse Mutuelle de Prévoyance Sociale du Bénin (CMPSB ex MSSB))	Populations of the informal economy	Health insurance and old age pension			
	Social Welfare programs (3 main programs)	Indigent, vulnerable groups such as pregnant women, children, people living with HIV, people with chronic diseases etc.	Medical evacuation and hospital care on national territory, assumption of costs of care, etc.			
	General observation: With low coverage and fragmented risk pools, but moving towards consolidation and expansion of population coverage; legal framework/policy/subsidy in place to support expansion and sustainability.					
Botswana	Botswana Public Officers' Medical Aid Scheme (BPOMAS)	Civil servants (including employees of parastatal enterprises) and their dependents.	Consultation, hospitalization, diagnostics, medication	Government covers 50 percent of the premium for each employee	MOH is looking to expand coverage of BPOMAS to all employees in the public sector (as only about half of public servants have joined as a principal member). Possible expansion mechanisms include: increase the premium subsidy, removing VAT on medical services.	Tom Achoki, Elaine Baruwa, Sean Callahan, Qinani Dube, Sophie Faye, Lauren Rosapep, Josef Tayag, Thierry van Bastelaer, Lauren Weir, and Julie Williams. 2015. *Advancing Universal Health Coverage in Botswana by Expanding Membership in BPOMAS.* Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.
	Private Medical Aid Schemes (legally different from "insurance" in Botswana). Currently 8 main schemes.	Any private citizens seeking to enroll, mainly those with formal private sector employment and their dependents	Currently no standardized minimum benefits package.	Member premiums and copays	Botswana's regulatory agency, the Non-bank Financial Institutions Regulatory Authority (NBFIRA) is in the late stages of developing the country's first regulations of the medical aid schemes.	Callahan, Sean, Tanvi Pandit-Rajani, Ilana Ron Levey, and Thierry van Bastelaer. 2014. *Botswana Private Health Sector Assessment*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.
	General observation: With about 17 percent of the total population covered by a private medical aid scheme, most citizens, even those with medical aid coverage, receive at least some of their health care from essentially free public health facilities. The government has been working on a health financing strategy since 2013 which could lead to changes in risk-pooling mechanisms.					

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Burkina Faso	Community-Based Health Insurance in some regions. CBHI is uses pay-for-performance in 3 regions	Informal sector	• First level (primary health care and drugs); • Second level (hospitalization care and treatment and drugs)	• Member contribution • Under pay for performance mechanism members contribute 20% (3 000 FCFA ≈ $6/year)	In the process of implementing AMU (Assurance Maladie Universelle), a UHC reform. AMU has 3 components: AMV (voluntary enrollment), AMO (mandatory enrollment) and AMI (for poor with no contribution). The AMU law was adopted September 2015 by CNT (Conseil National de la Transition). The country is now waiting for the implementation decree to start the process.	http://lepays.bf/assurance-maladie-universelle-le-cnt-adopte-le-projet-de-loi/ Presentation document on Universal Health Insurance in Burkina Faso Zida et al : Policy note, Sustainability strategies for Universal Health Insurance in Burkina Faso; Jun 2012 (http://www.who.int/evidence/sure/BurkinaFasoPBAssuranceMaladie2012.pdf)
	General observation: With low coverage and fragmented risk pools,, but moving towards consolidation and expansion of population coverage. In the process of drafting a legal framework for the AMU reforms.					
Burundi	Carte d'Assurance Maladie (CAM)	Informal sector	Basic package of services at health centers and district hospitals	• Members pay premium and approximately 20% co-pay at time of service • Government subsidy • Development partners	• Improve public perception to increase uptake • Ensuring financial sustainability	Ministry of Health. 2015. CAM Procedures Manual. https://www.minisante.bi/images/Documents/Manuel%20Procdures%20CAM.pdf
	Mutuelle de la Fonction Publique	Government workers	Basic package of services at public providers	• Member contributions • Government subsidy		
	Community based-health insurance e.g. Mutuelle de Santé des Caféiculteurs du Burundi	Various	Basic package of services at public providers	• Member contributions • Government subsidy	• Financing sustainability : members numbers are falling as government resources are targeted towards CAM	
	General observation: With past problems with management, financial planning, and transparency, there is a need to address poor public perception. The CAM is under-resourced which results in late reimbursements to providers, which is threatening its sustainability.					

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Cote d'Ivoire	Insurance for public sector employees through a general "mutuelle"	Public sector employees		Government pays 70% and employee contributes 30% of base salary	Côte d'Ivoire is beginning to implement 2 new mechanisms for financial protection: 1. RAM will be a non-contributory, government-subsidized scheme based on the principle of national solidarity. Benefits will include outpatient care, inpatient care, maternity care, and generic drugs. Indigents will have access to covered curative and maternity care provided in in-network public and community facilities and hospital care with a referral from the lower-level facilities. Funding for RAM from subsidies from the central government and regional resources, investment income, donations and bequests, and earmarked taxes. Central government funding is projected to be 30 billion CFA (US$63 million) per year, equivalent to the amount spent on the free care policy since 2011. 2. RGB will be a contributory scheme based on the principle of third-party payment and co-payment. It will be available to all residents, whether nationals or non-nationals, who are not eligible for the RAM. Revenue for the RGB will be provided through contributions (voluntary or mandatory), late penalties, investment income, government subsidies, donations and bequests, and other funding mechanisms (e.g. taxes on coffee and cocoa products).	Juillet A., Konan C., Hatt L., Faye S., Nakhimovsky S., May 2014. *Measuring And Monitoring Progress Toward Universal Health Coverage: A Case Study in Côte d'Ivoire.* Bethesda, MD: Health Finance & Governance Project, Abt Associates, 38p. Private Voluntary Health Insurance in Development: Friend Or Foe? 2007. edited by Alexander S. Preker, Richard M. Scheffler, Mark C. Bassett http://www.esciencecentral.org/journals/free-health-care-in-public-health-establishments-of-cote-divoire-born-dead-omha-2329-6879.1000114.pdf
	Private health insurance.	Small wealthier segment of the population	Depends on the insurance plan	Households pay premiums		
	Free public healthcare system.	Free for mothers and children under six years	Mothers do not have to pay for deliveries and children will get free treatment for illnesses.	Government financing of free care		
	Fee-for-service in public and private sectors for everyone else.			Household out of pocket spending to pay user fees		
	General observation: With low coverage and fragmented risk pools, but moving towards consolidation and expansion of population coverage.					

Country	Program	Target Population	Benefits Package	Funding	Future Directions/Next Steps	Source of Information
Ethiopia	Community Based Health Insurance being scaled up at provincial level (started as pilot)	Below poverty line and informal sector	Consultation, hospitalization, diagnostics, medication	• Member contributions • General government revenue	Scale-up and eventual consolidation to form National Health Insurance	HFG, 2013. Health Insurance Matrix, Updates for Selected Sub-Sahara African Countries, Working document.
	Social Health Insurance	Formal sector	Consultation, hospitalization, diagnostics, medication	• Member contributions • Employer contributions • General government revenue	Scale-up and eventual consolidation to form National Health Insurance	
	General observation: With low coverage and fragmented risk pools, but with growing federal subsidy of CBHI schemes, expanding population coverage, legal framework/policy/subsidy in place to support it.					
Ghana	National Health Insurance Scheme	All population	Consultation, hospitalization, diagnostics, medication	• Value-added tax of 2.5% on goods and services called Health Insurance Levy (NHIL) – 70% • Earmarked portion of social security taxes from formal sector workers – 23% • Individual premiums - 5% • Miscellaneous other funds from investment returns, Parliament, or donors – 2%.	• Continued scale-up • Addressing sustainability through new provider payment methods, benefit package, and review of revenue sources	NHIA website: http://www.nhis.gov.gh/benefits.aspx Joint Learning Network website: http://programs.jointlearningnetwork.org/programs
	General observation: With high coverage and consolidated risk pools, continued scale-up is expected to cover all population; legal framework/policy/subsidy in place to support it.					

Country	Program	Target Population	Benefits Package	Funding	Future Directions/Next Steps	Source of Information
Kenya	National Hospital Insurance Fund Established in 1966	All population For those in the formal sector, it is compulsory to be a member. For those in the informal sector and retirees, membership is voluntary	Inpatient Services with the share of expenses covered determined largely by the type of hospital. The NHIF's hospital network has 3 tiers. At "Contract A" hospitals, primarily government hospitals, NHIF beneficiaries receive comprehensive cover with no overall limit on the amount of benefits received.	• Payroll Tax: salaried employees pay contributions based on a graduated scale on income and automatically deducted through payroll. • Employer contributions • Voluntary member pay monthly premium	• Implement the National Social Health Insurance Fund consolidating the hospital fund and a number of small micro/community based health insurance schemes • Using mobile money to expand access to workers in the informal sector through creating a more convenient way to pay monthly premiums.	Joint Learning Network website: http://programs.jointlearningnetwork.org/programs HFG, 2013. *Health Insurance Matrix*, Updates for Selected Sub-Sahara African Countries, Working document.
	General observation: With limited coverage, but legal framework in place for consolidation and expansion of coverage.					
Malawi	Private Insurance Schemes (non-mandatory)	Formal and non-formal sector	Consultation, hospitalization, diagnostics, medication	• Member contributions • Employer contributions	• Government has engaged GIZ to assist in conducting feasibility assessment of National Health Insurance[1] with an aim of increasing domestic financing of health services by taping revenue from non-poor in the informal sector	Ministry of Health, Department of Planning and Policy Development, Lilongwe, Malawi: Malawi Health Financing Situation Analysis. 2012 Malawi Health Financing Strategy – Draft 3, May 2014. A comprehensive review of literature on international and local experiences of Health Fund and Proposed Malawi Health Fund. 2015 Concept Paper on Health Insurance Scheme for Financing Malawi Health Sector. 2014 Policy Reform Paper on Health Insurance for financing Malawi Health Sector. 2014 Health financing reforms in Malawi: A review of potential options with reference to current General Tax funded systems and Health insurance proposal. 2015.
	Free health care	All population	Consultation, hospitalization, diagnostics, medication	• General government taxation	• Government has also engaged World Bank to review the proposed National Health Fund2 which aims at generating and allocating efficiently additional resources for the Health Sector	
	General observation: With all people covered by the Free Health Care System and private health insurance schemes only covering 0.2% of the population, the free health care system is facing serious funding challenges.					

[1] USAID funded project, SSDI-Systems, implemented by Abt Associates provided technical assistance on Health Insurance

[2] USAID funded project, SSDI-Systems, implemented by Abt Associates assisted the MoH to develop the Health fund proposal

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Mali	Mutuelles (community-based health insurance)	Informal sector	Consultation, hospitalization, diagnostics, medication	• General government revenues • Member contributions	• 2010-2011 national strategy for CBHI adopted to strengthen mutuelles from isolated, individual community initiatives to a standardized national network with central government funding to expand membership	Joint Learning Network website: http://programs.jointlearningnetwork.org/programs https://www.hfgproject.org/scaling-community-based-health-insurance-mali/ HFG, 2013. *Health Insurance Matrix*, Updates for Selected Sub-Sahara African Countries, Working document.
	Mandatory Health Insurance	Civil servants, contractors, employees, MPs, retirees	Consultation, hospitalization, diagnostics, medication	• Member contributions • Employer contributions	• RAMED for indigents funded by general government revenue to cover consultations, hospitalization, diagnostics, and medication	
	General observation: With low coverage and fragmented risk pools, but moving towards consolidation and expansion of population coverage; legal framework/policy/subsidy in place to support roll out of RAMED.					
Mozambique	Highly subsidized health care provided by National Health Service Growing private health sector in urban areas charging fee-for-service	All population	Consultation, hospitalization, diagnostics, medication	• General government taxation • Donor funding • User fees: By law, the price for consultation in a public facility is less than US$1, and all medicines are provided at the subsidized price of MZM5 per prescription. Exemptions cover indigent populations and services such as malaria, HIV/AIDS, tuberculosis, maternal and child care and chronic illness.	National Health Insurance scheme under discussion	Mozambique National Health Sector Plan 2007-2012 http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Country_Pages/Mozambique/PlanoEstrategicoSectorSaude_2007-2012.pdf http://www.developmentprogress.org/blog/2014/06/02/universal-health-coverage-thoughts-mozambique
	General observation: With almost no health insurance.					

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Namibia	Private Medical Aid Funds	Any private citizens seeking to enroll, mainly those with formal private sector employment and their dependents	Each medical aid fund has multiple benefit packages on offer, each targeting different markets and health risk profiles.	• Member contributions • Employer contributions • In addition to the contributions received, the medical aid schemes also generated income from investments	Most medical aid funds have also introduced low cost options in an attempt to increase their market size and potential for risk pooling and generally all funds provide for cross-subsidization across the different benefit package options	Ohadi, Elizabeth; Jones, Claire; Avila, Carlos. December 2015. A Review of Health Financing in Namibia. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.
	Public Service Employees Medical Aid Schemes	Public Service Employees	Consultation, hospitalization, diagnostics, medication	• 15% member contributions • 85% government contributions • Member contributions are based on a flat rate regardless of salary level, which makes the contributions highly regressive.		
	General observation: With total coverage through medical aid schemes quite limited, but plans in place to increase coverage by, establishing a mandatory health insurance fund providing medical benefits to employees.					
Nigeria	National Health Insurance Scheme	All population	Comprehensive	• Employer contributions • General government revenues • Member contributions	• Expansion of coverage including consolidation of a number of small mirco/community based health insurance schemes • Includes the Formal Sector Social Health Insurance Program, Voluntary Contributors Social Health Insurance Program, Tertiary Institutions Social Health Insurance Program, Community Based Social Health Insurance Program, Public Primary Pupils Social Health Insurance Program, and Vulnerable Group Social Health Insurance Programs • Basic Health Care Provision Fund financing for PHC facilities as part of National	Joint Learning Network website: http://programs.jointlearningnetwork.org/programs HFG, 2013. *Health Insurance Matrix*, Updates for Selected Sub-Sahara African Countries, Working document. http://www.nhis.gov.ng/home/#.Vo_srPkrKM8

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					Health Bill	
	General observation: With low coverage and fragmented risk pools, but moving towards consolidation and expansion of population coverage; legal framework/policy/subsidy in place to support it.					
Rwanda	Mutuelles de Sante	Below poverty line, rural and informal sector About 85%	Comprehensive	• Members pay annual premiums of USD $6 per family member with a 10% service fee paid for each visit to a health centre or hospital. • General government revenues • Donor funding	• Addressing sustainability; poorer districts are at much higher risk of bankruptcy.	Joint Learning Network website: http://programs.jointlearningnetwork.org/programs http://www.gov.rw/services/health-system/ http://www.moh.gov.rw/fileadmin/templates/Docs/insurance_policy1.pdf http://www.moh.gov.rw/fileadmin/templates/Docs/insurance_policy1.pdf
	Rwandaise d'Assurance Maladie (RAMA) established in 2001.	Mandatory for public servants and their dependents Voluntary for private sector employers (less than 4%)	out-patient, inpatient, maternity care (pre-post.), essential drugs, medical imagery, and laboratory tests	• 15% of the basic salary of which 7.5% is paid by the employer and 7.5% by the employee • Contributions from private sector employees	• National risk pool that links all 3 types of insurance	
	Military Medical Insurance (MMI) managed within the Ministry of Defense.	The military and their dependents (less than 4%)		• 22.5% of gross salary, of which 17.5% is paid by the government and 5% by each military staff		
	General observation: With high coverage and strong regional and national level networking; legal framework/policy/subsidy in place to support it.					

Country	Program	Target Population	Benefits Package	Funding	Future Directions/Next Steps	Source of Information
Senegal	Government Social Insurance Scheme	Government employees and retirees	Consultation, hospitalization, diagnostics, medication	• Member contributions • Employer contributions	Expand coverage to the parents (mother and father) of the principal holder	Tine, Justin, Sophie Faye, Sharon Nakhimovsky, and Laurel Hatt. April 2014. *Universal Health Coverage Measurement in a Lower-Middle-Income Context: A Senegalese Case Study.* Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.
	Private Social Insurance Scheme	Private sector employees	Consultation, hospitalization, diagnostics, medication (but degree of coverage varies)	• Member contributions • Employer contributions	Implement the reinsurance and solidarity fund for the Social Health Insurance Institutions (IPMs)	
	Mutuelles	Informal sector	Limited services (varies)	• Member Contributions	• Consolidation and providing government funding to broaden packages • reinsurance • scale up to cover more population	
	General observation: With low coverage and fragmented risk pools,but moving towards consolidation and expansion of population coverage; legal framework/policy/subsidy in place to support it.					
South Africa	Currently 83 private medical schemes.	Medical schemes cover only those in the formal sector, equal to about 16.2% of the total population. The remaining 84% of the population relies on public health services financed by general tax revenues.	Medical schemes are mandated to cover the costs of Prescribed Minimum Benefits (PMBs) based on a positive list of medical conditions: (1) any emergency medical condition; (2) 270 medical conditions; and (3) 25 chronic conditions.	• In 2014, medical schemes spent R102.2 billion for all benefits including PMBs which accounted for 52.5% of the total. • However, members of medical schemes are subjected to high OOPs to cover private hospital fees, specialists' and medicine costs. Members spent R20.7 billion out-of-pocket in 2014. • Providers are paid FFS which fuels cost escalation. Per capita cost is higher than OECD average! Consequently, the premiums charged to scheme members have risen twice as fast as the CPI (9.2% compared to 4.6%).	• Introduce National Health Insurance to pool funds to provide universal access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status. • NHI will be implemented through the creation of a single fund that is publicly financed and publicly administered. • The health services covered by NHI will be provided free at the point of care. • Funding will be linked to an individual's ability-to-pay and benefits from health services will be in line with an individual's need for health care.	National Health Insurance for South Africa: Towards universal health coverage. Department of Health of South Africa. December 2015. (aka "White Paper"). http://www.gov.za/documents/national-health-insurance-south-africa-policy-paper

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	General observation: With extremely limited coverage, and fragmented and inequitable risk pools; Political commitment to NHI but the proposal represents significant changes in financing and institutional roles.					
Tanzania	National Health Insurance Fund	Public servants Enrollment is mandatory for formal sector employees and voluntary for all informal sector workers	Inpatient & outpatient care from public and accredited faith-based & private facilities & pharmacies.	• 6 percent of the employee's salary. The employer contributes 3% and the employee pays the remaining 3%. • Informal sector workers pay a flat fee	• Consolidation to broaden the risk pool • Scale up to cover more population	HFG, 2013. *Health Insurance Matrix*, Updates for Selected Sub-Sahara African Countries, Working document. http://nhif.or.tz/index.php/about-nhif/rreports (Fact Sheet Inside NHIF 2012-13) Musau, Stephen, Grace Chee, Rebecca Patsika, Emmanuel Malangalila, Dereck Chitama, Eric Van Praag and Greta Schettler. July 2011. *Tanzania Health System Assessment 2010.* Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc. *http://ihi.eprints.org/1796/1/Health_insurance_cover_in_Tanzania_Issue_11.pdf*
	National Social Security Fund (NSSF): Social Health Insurance Benefit	Mandatory for private and parastatal formal sector employees, and up to 5 dependents	Outpatient and inpatient care up to TZS 80,000 at selected facilities. Members have to sign up in order to receive benefits.	No earmarked contribution, reimbursement funds taken from NSSF contributions from employees and employers		
	Community Health Fund	Informal and rural sectors– voluntary, household enrolment for a couple and their children under 18 years.	Primary level public facilities. Limited referral care in some districts	Member contributions of Between TZS 5,000-20,000 per year/household Government revenue (matching)		
	General observation: With low coverage and fragmented risk pools, but moving towards consolidation and expansion of population coverage; legal framework/policy/subsidy in place to support it.					
Uganda	Community Health Insurance (Save for Health Uganda)	Informal sector	Comprehensive (with ceiling per episode of illness)	• Member contributions	In the process of rolling out a National Health Insurance Fund with the aim of increasing coverage in a phased approach starting with the formal sector and eventually to the informal sector	HFG, 2013. *Health Insurance Matrix*, Updates for Selected Sub-Sahara African Countries, Working document http://www.shu.org.ug/index.php/programme-areas/community-health-financing-chf
	General observation: With very limited coverage, but legal framework in place for consolidation and expansion of coverage however with limited traction.					

Country	Program	Target Population	Benefits Package	Funding	Future Directions/Next Steps	Source of Information
Zambia					In the process of rolling out a Social Health Insurance Scheme with the aim of increasing coverage in a phased approach starting with the formal sector and eventually to the informal sector	HFG, 2013. *Health Insurance Matrix*, Updates for Selected Sub-Sahara African Countries, Working document
	General observation: With a process in place for drafting a legal framework.					