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FINANCING OF UNIVERSAL HEALTH COVERAGE AND FAMILY PLANNING

Financing of Universal Health Coverage and Family Planning

A Multi-Regional Landscape Study and Analysis of Select West African Countries

January 2017

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The Health Finance and Governance Project
USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The five-year, $209 million global project is intended to increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

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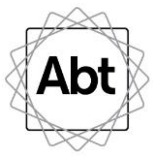

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A MULTI-REGIONAL LANDSCAPE STUDY AND ANALYSIS OF SELECT WEST AFRICAN COUNTRIES

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ACRONYMS

ANAM	*Agence Nationale d'Assistance Médicale* / National Agency for Medical Assistance (Mali)
ANAM	*L'Agence Nationale de l'Assurance Maladie* / National Health Insurance Agency (Benin)
APSAB	*Association Professionnelle des Societés d'Assurances du Burkina Faso* / Professional Association of Insurance Companies of Burkina Faso (Burkina Faso)
CAMNAFAW	Cameroon National Association for Family Welfare (Cameroon)
CAMS	*Cellule d'Appui aux Mutuelles de Santé* / CBHI Technical Support Cell (Cameroon)
CANAM	*Caisse Nationale d'Assurance Maladie* / National Health Insurance Fund (Mali)
CBHI	community-based health insurance
CNPS	*Caisse National de Prévoyance Sociale* / Social Security (Cameroon)
CNSS	*Caisse Nationale de Sécurité Sociale* / National Social Security Fund (Burkina Faso, Guinea)
CONSAMAS	*Concertation Nationale des Structures d'Appui aux Mutuelles et Assurances de Santé* / National Coordination of CBHI Schemes and Health Insurances (Benin)
CPS	*Cellule de Planification et de Statistique* / Planning and Statistics Unit (Mali)
DHS	Demographic and Health Survey
FCFA	West African CFA franc (Burkina Faso)
FP	family planning
GIZ	*Deutsche Gesellschaft für Internationale Zusammenarbeit* / German Corporation for International Cooperation (Cameroon)
HFG	Health Finance and Governance Project
HIV/AIDS	human immunodeficiency virus / acquired immunodeficiency syndrome
HSDP	Health and Social Development Plan (Mali)
INAM	*L'Institut National d'Assurance Maladie* / National Agency for Medical Assistance (Togo)
INSD	*Institut National de la Statistique et de la Démographie* / National Institute of Statistics and Demography (Burkina Faso)
IPM	*Institution de Prévoyance Maladie* / Sickness Insurance Institution (Senegal)
IPRES	*Institut de Prévoyance Retraite et Sociale* / Institute of Social Welfare and Retirement (Senegal)
IUD	intrauterine device

MPHH	Ministry of Public Health and Hygiene (Mali)
MPSWSS	Ministry of Public Service Work and Social Security (Burkina Faso)
MS	*Ministère de la Santé* / Ministry of Health (Togo)
MSHA	Ministry of Solidarity and Humanitarian Action (Mali)
MWCFP	Ministry of Women, Child and Family Promotion (Mali)
NGO	non-governmental organization
NHA	National Health Accounts
NHFS for UHC	National Health Financing Strategy toward Universal Health Coverage / *Stratégie nationale de financement de la santé vers la CSU* (Guinea)
PDS	*Plan de Développement Sanitaire* / Health Development Plan (Niger)
PMAS	*Le pool micro-assurance santé* / The micro health insurance pool (Senegal)
PNDS	*Plan National de Développement Sanitaire* / National Health Development Plan (Benin, Guinea, Togo)
PRODESS	Programme for Social and Health Development (Mali)
PROMUSCAM	*Plateforme des Promoteurs des Mutuelles de Santé au Cameroun* / Platform for the Promotion of CBHI (Cameroon)
RAMED	*Régime d'Assistance Médicale* / Medical Assistance Mechanism (Mali)
RAMU	*Régime d'Assurance Maladie Universelle* / Universal Health Insurance Plan (Benin)
RH	reproductive health
ST-AMU	*Secrétariat technique de l'assurance maladie universelle* / universal health insurance technical secretariat (Burkina Faso)
STI	sexually transmitted infection
TB	tuberculosis
UEMOA	*L'Union Economique et Monétaire Ouest Africaine* / West African Economic and Monetary Union (Niger)
UHC	universal health coverage
UN	United Nations
USAID	United States Agency for International Development
UTM	*Union Technique de la Mutualité Malienne* / CBHI Technical Unit (Mali)
WARHO	West Africa Regional Health Office
WHO	World Health Organization

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EXECUTIVE SUMMARY

Recognizing that a healthy population promotes economic development, resilience, and strength, many governments have started pursuing a universal health coverage (UHC) agenda. The international community, national governments, and private organizations and individuals are converging on the principle that universal access to family planning is a goal worthy of increased financial investment. Improved access to family planning is also important for a country's economic development, and it helps countries improve key population health outcomes for mothers, newborns, and children.

The reality of limited resources for health care has brought increased scrutiny of how health care is financed. To reach UHC, governments are looking to pursue more and better spending mechanisms for health care and to promote financial protection for households. While there is no single or perfect model for financing health care, the health policy community can draw on international experience to identify best practices.

The purpose of this report is to present findings of a landscape study of observed trends and lessons learned from fifteen countries across multiple regions. We conducted detailed analyses of eight countries in West Africa: Benin, Burkina Faso, Cameroon, Guinea, Mali, Niger, Senegal, and Togo ("core countries"). We reviewed the health financing landscapes of seven additional countries at various stages of achieving UHC to draw lessons learned and inform potential strategies: Ethiopia, Ghana, Indonesia, Kenya, Malaysia, Nigeria, and South Africa ("reference countries").

Parties interested in the report may include Ministries of Health or national UHC agencies, regional governments, UHC stakeholders in the West Africa region, the United States Agency for International Development / West Africa Regional Health Office and country Missions, and the private sector.

Chapter 1 of the report discusses the landscape study findings from an analysis across the fifteen countries. Chapters 2–9 of the report present in-depth findings from the eight core countries, including descriptions of each country's health financing landscape and its government's strategies for UHC and family planning, a discussion of the country's health financing challenges and strengths, and potential opportunities for high-impact interventions that could improve the country's health financing landscape for UHC and family planning.

Government Strategies to Pursue Universal Health Coverage and Universal Access to Family Planning

All fifteen governments mentioned UHC or a similar concept in major government health sector strategies, although most countries do not intend to reach universal coverage during their strategy's timeframe. Instead, governments generally plan to implement measures to increase population coverage under existing or new initiatives with a gradual scale-up. In general, countries' UHC strategy documents embrace the concept of progressive universalism, as described by Gwatkin and Ergo (2011) and adopted by the 2013 Lancet Commission on Investing in Health (Jamison et al. 2013). That is, they include multiple strategies to improve coverage for the poor, the informal sector, and the formal sector (and imply this will happen simultaneously). Most countries had specific strategies for engaging the private sector under their umbrella UHC strategy. Family planning, however, was often absent from the main policy documents and was often addressed in separate family planning or reproductive health strategy documents. Governments with separate strategy documents for family planning appear to have more concrete and specific action plans for family planning, whereas governments that mention family planning in a broader health system strategic plan demonstrate less detailed plans.

Although the fifteen countries vary in terms of coverage and use of family planning, many of the strategies for improving access to family planning are common to all of them, such as increasing awareness and demand through social marketing, task shifting to allow for community-based distribution, and increasing the number of distribution points for family planning services.

Health Financing Mechanisms in Core and Reference Countries, and Private Sector Engagement

Even in the least fragmented health care systems, health services are financed through a plurality of mechanisms. Most or all of the health financing mechanisms described below are included in the health financing landscape of all fifteen countries. Levels of service coverage, population coverage, and financial protection varied.

These coverage levels are a key way to measure a country's progress toward UHC and universal access to family planning. To assess the latter, one can evaluate the degree to which health financing mechanisms cover family planning services (i.e., seek to ensure their delivery), the percentage of the population who can and do access those services under each mechanism, and what degree of financial protection is provided for family planning.

Chapters 2–9 of this report elaborate on each of these mechanisms in the eight core countries; lessons from the seven reference countries are woven into the multi-regional analysis of Chapter 1.

Government-financed provision of health services exists in all study countries. Government funding to facilities allows them to operate without charging patients the full cost of providing services. The government often does the purchasing; in some countries, community committees are established to have a say in how facilities spend available funds. In many low- and middle-income countries, the purchasing mechanism employed by government purchasers is *input-based financing* (e.g., paying for health worker salaries, commodities, and infrastructure). Governments often pair such direct financing for health services with *demand-side financing* (e.g., paying for services on behalf of patients to reduce financial barriers to accessing care) to improve equity of access to health services.

User fee waivers or vouchers are two examples of pro-poor financing mechanisms, reducing cost sharing by poor and vulnerable households. Malaysia's experience as an upper middle income country with near-universal health coverage through the public health delivery system provides valuable lessons for West African countries as economies grow, health systems mature, and governments face new challenges arising from an epidemiological transition and an aging population. Governments can implement legal frameworks now to enable health system reforms to address changing needs.

In general, at least some family planning commodities are provided free in facilities and by community health workers who receive public financing, but these distribution systems can be improved. A voucher scheme in Kenya provides targeted subsidies for safe motherhood, long-term family planning methods, and gender-based violence recovery services. These subsidies benefit households as well as public and private providers. They may be applicable in the West African context, where governments are seeking to reduce financial barriers to priority services such as family planning, and to encourage demand and quality improvements among public and private providers.

Social health insurance is often part of a government strategy to purchase health services for members by mobilizing and pooling funds from public and private sources and based on members' ability to pay. Many governments plan to implement or scale up social health insurance schemes and have passed laws to this effect. However, mobilizing the required resources to adequately subsidize even basic benefits for citizens with limited or no ability to contribute can be a challenging and much longer process.

The rollout of Indonesia's ambitious single-payer system starting in 2014 is partly a result of a legal action brought by citizens to hold the government accountable for the 2004 law on the National Social Security System. Nigeria's Basic Health Care Provision Fund needs to receive annual budget appropriations to ensure it gets implemented. In 2012, legislation addressing Ghana's National Health Insurance Scheme reform required inclusion of family planning to be determined by the Minister of Health, but three years later, the government had yet to provide the policy directive and implementation guidelines necessary to make family planning methods part of the scheme. South Africa's government is in advanced preparations to scale up National Health Insurance in a multi-phased approach that is expected to span more than a decade.

Governments need to allocate significant funding to scale up social health insurance, so many countries focus social health insurance programs on employees in the formal sector, where administration is most feasible. However, unequal financial protection between the formal sector (often the wealthier households) and the rest of the population can create a cycle of inequity and higher levels of fragmentation in the health system.

Community-based health insurance (CBHI) is often included the UHC strategies of low- and middle-income countries because of its perceived comparative advantage in targeting and enrolling underserved, uninsured, and largely informal-sector populations into risk-pooling schemes. While increasing the number of CBHI schemes may seem feasible for governments in the short term, the model often leads to government-sponsored health financing mechanisms. For example, in Ghana, community members initially volunteered to manage the schemes; however, eventually they migrated into a more professional management arrangement, and the scheme managers became salaried government staff.

Enrollment in CBHI schemes is often voluntary or not enforced, so schemes are often vulnerable to *adverse selection*, where disproportionate enrollment by high-risk individuals accompanies non-participation by low-risk individuals. CBHI initiatives such as Ethiopia's may eventually evolve into larger risk pools once that transition is operationally feasible for the government. That transition could be beneficial for ensuring CBHI scheme members get financial protection for health services provided by regional or national hospitals.

Private health insurance is a health financing mechanism present in the fifteen study countries, although its role varies from country to country. Private health insurance tends to target wealthier households and workers in the formal sector. There are, however, a few rare examples of private health insurers and private CBHI schemes targeting lower-income households or workers in the informal sector. Some private companies voluntarily offer employees premium subsidies or other health benefits for private health insurance in order to attract and retain skilled people, in Kenya and Nigeria, for example. In general, this model does not contribute significantly to population coverage in countries with small formal sectors.

Household out-of-pocket spending means households pay providers directly for health goods and services at the time of service. This is the dominant financing mechanism in most of the fifteen study countries. Households in all countries invariably pay out of pocket for some health services or commodities, as seen even in Malaysia, where most services are provided free or at very low cost through a strong network of public health facilities. In countries with low levels of other health care financing and risk-pooling mechanisms, out-of-pocket spending on health care accounts for the majority of household spending, and household spending as a proportion of total health expenditure is generally quite high.

There is growing interest in mobilizing private financing. Because household spending is already a large proportion of total health spending and core countries have relatively small formal sectors, this study did not identify many examples of how to engage the private sector in health financing. However,

governments can improve equity and increase efficiency by implementing health financing mechanisms that spread risk among a large pool and protect households from catastrophic costs. Governments must continually reform the health system to pursue better and more-equitable coverage for the population, and the path to UHC needs to evolve over time as population needs and demands change.

Government-subsidized programs that lack the resources to cover all citizens will by necessity or design cover a subset of the population. This can undermine social solidarity and equity, however, and potentially derail the goal of *progressive universalism*. Smaller-scale or more-targeted health financing mechanisms can promote more-equitable access to essential services. Additionally, ensuring universal access to family planning through UHC initiatives is critical.

Many governments of the core countries in this study envision simultaneous interventions to improve financial protection for health care and pursue UHC: finance health facilities with public funds, scale up social health insurance, and encourage the establishment of CBHI schemes to contribute to population coverage of hard-to-reach populations. With relatively small formal sectors, core countries will need to dramatically grow the number of CBHI schemes in order to reach near-universal enrollment among their populations. Population coverage of CBHI and other forms of insurance is low in most of them.

This study's review of health financing landscapes in all core countries reveals several opportunities for each to expand on, or introduce, new health care financing mechanisms that can increase coverage for health care and family planning.

1. INTRODUCTION

1.1 A Groundswell of Support for Universal Health Coverage and Universal Access to Family Planning

Support for universal health coverage (UHC) is growing globally. As the international community increasingly subscribes to the principle that all people have a right to health and well-being, many governments are making strides on the path toward UHC. Similarly, the international community, national governments, and private organizations and individuals are converging on the principle that universal access to family planning is a goal worthy of increased financial investment.

On September 25, 2015, the United Nations General Assembly adopted the resolution "Transforming Our World: The 2030 Agenda for Sustainable Development," defining the post-2015 development agenda. Its Sustainable Development Goal #3 states: *Ensure healthy lives and promote well-being for all at all* ages (2015, p. 14). UHC and universal access to family planning are critical strategies for achieving this goal.[A]

In 2013, the Lancet Commission on Investing in Health reviewed the case for investment in health and reported that reductions in mortality account for about 11% of recent economic growth in low- and middle-income countries as measured in their national income accounts (Jamison et al. 2013). Recognizing that a healthy population promotes economic development, resilience, and strength, many governments in West Africa and other regions have started pursuing a UHC agenda. The political and moral imperative of UHC is gaining ground in Africa as more people recognize that progress toward UHC promotes equity, basic rights, and human security in health (World Bank 2016).

Improving access to family planning is a critical global health imperative. The right to health includes the right to control one's health and body, including sexual and reproductive freedom (United Nations 2000). Improved access to family planning is also important for a country's economic development, and it helps countries improve key population health outcomes for mothers, newborns, and children. Many governments have recognized the importance of including family planning services in the essential package of health services made accessible to and promoted among their populations. Limited availability or high cost of family planning, due to inadequate funding or inequitable financing mechanisms, can be a prohibitive barrier. Health financing mechanisms that do not prioritize family planning services can also create barriers among providers for delivering these services within an integrated package of services. Improving financing for family planning can reduce unmet need among the population and help West African governments achieve key population health milestones.

1.2 Why Health Financing Matters

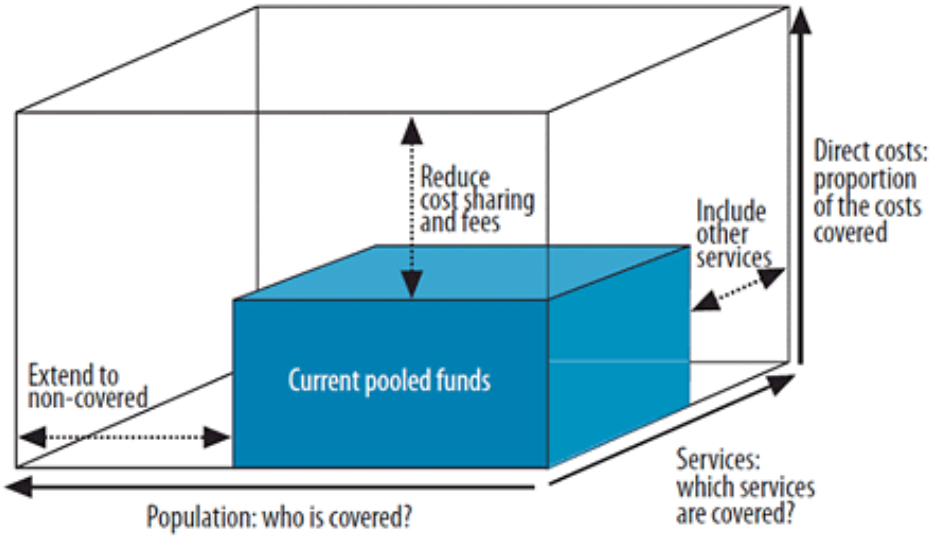
Health financing is one of the six health systems building blocks and underlies all three dimensions of the UHC cube: population coverage, service coverage, and financial protection (Figure 1). Expanding population and service coverage and financial protection involves increasing fiscal space. The reality of limited resources for health has brought increased scrutiny on how health is financed. To reach UHC,

A. Target 3.7: "By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes." Target 3.8: "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."

governments are looking to pursue more and better spending for health and promote financial protection for households. While there is no single or perfect model for financing health care, the healthpolicy community can draw on international experience to identify best practices.

Health financing is one of the six health systems building blocks, and underlies all three dimensions of the UHC cube: **population coverage, service coverage**, and **financial protection** (Figure 1). Expanding population and service coverage and financial protection involves increasing fiscal space. The reality of limited resources for health has brought increased scrutiny on how health is financed. To reach UHC, governments are looking to pursue more and better spending for health and promote financial protection for households. While there is no single or perfect model for financing health care, the health policy community can draw on international experience to identify best practices.

Figure 1: Universal Health Coverage (UHC) Cube



Source: World Health Organization.

Health is financed everywhere, even in contexts where risk-pooling schemes and other financial protection mechanisms are lacking. In these contexts, household out-of-pocket spending is the default health financing mechanism. However, a health system that relies heavily on households to finance their own health care deters development. These households may either forgo care or incur impoverishing health care costs. Forgoing care can lead to morbidity, disability, mortality, or a reduction in quality of life and productivity, creating lasting consequences for the household and for future generations. Catastrophic health care costs may impoverish the household or cause it to divert funds from other needs that are critical to the household and society at large, such as education and food.

How health care is purchased is also important. Every health financing system incorporates built-in incentives and disincentives. These forces affect the behaviors and actions taken by all participants in the system, including households, other private sector actors, government, donors, and providers, and they can affect the systemic efficiency as well as the health outputs and outcomes that are produced. For example, when households must purchase health services on an as-needed basis, they forgo care, especially preventive and promotive care, when they do not perceive a tangible or immediate benefit. Private employers might be incentivized to offer health benefits to employees to attract talent and to enhance health and productivity. Governments might be dis-incentivized from allocating a higher percentage of government spending to health if the donor community is willing to finance health programs.

The ways health services are purchased also introduce a range of behavioral incentives for providers that affect how they provide care and what services they provide. For example, fee-for-service payments to providers from purchasers—such as households paying user fees, an insurance scheme, or the government—tend to incentivize providers to provide more and more-costly services, without necessarily producing a concomitant increase in the quality of care or improved health outcomes. Alternatively, when health services are purchased through financing the salaries of health workers, the opposite phenomenon can occur, incentivizing the providers to provide fewer and possibly lower-quality services. Large health purchasers such as insurers are more capable than are individuals of holding providers accountable for quality and quantity of services through mechanisms such as strategic purchasing, including results-based financing, and accreditation.

Kutzin (2013) argues that for health financing policy to align with the pursuit of UHC, effective reforms must aim explicitly at improving coverage and the intermediate objectives linked to it, such as improving efficiency, enhancing equity in health resource distribution, and increasing transparency and account-ability. Health system financing functions of revenue collection, pooling, and purchasing should be performed in a coordinated policy and implementation approach to ensure these objectives are met.

In this report, we focus on health financing mechanisms and how they contribute to a government's pursuit of UHC.

1.3 Activity Description

The United States Agency for International Development / West Africa Regional Health Office (USAID/WARHO) supports strengthening country commitment and capacity to achieve UHC. The Health Finance and Governance Project (HFG), a global project funded by USAID, was requested by USAID/WARHO to:

- Enhance general understanding of programs that countries have used to advance UHC goals, including lessons learned and potential roles for the private sector
- Increase capacity for identifying gaps and opportunities in regional and country-specific approaches to achieve UHC
- Identify lessons learned from interventions that advance UHC goals and that advance potential family planning outcomes within UHC programs

This report presents findings of a landscape study on health financing, which include observed trends and lessons learned from fifteen countries across multiple regions and detailed analyses of eight of those countries in West Africa. Parties interested in the report may include Ministries of Health or national UHC agencies, regional governments, UHC stakeholders in the West Africa region, USAID/WARHO and country Missions, and the private sector.

In this chapter, the study team discusses the landscape study methods and findings from a multi-country analysis. In Chapters 2–9, we present in-depth findings from eight West African countries. For each of these countries, we describe the health financing landscape, the government's strategies for UHC and family planning, the health financing challenges and strengths, and potential opportunities for high-impact interventions that could improve the health financing landscape for UHC and family planning.

1.4 Methods

HFG undertook a landscape study to identify regionally relevant strategies and policies for health financing for UHC and family planning. Health financing specialists from HFG reviewed the health financing landscape for UHC and family planning across eight countries in West Africa: Benin, Burkina Faso, Cameroon, Guinea, Mali, Niger, Senegal, and Togo ("core countries"). HFG also reviewed the

health financing landscape of seven additional countries ("reference countries") at various stages of achieving UHC to draw lessons learned and inform potential strategies. Table 1 summarizes key characteristics across the fifteen countries.

HFG selected the fifteen study countries using a scoring system to rank potential study sites. The selection matrix is presented in Annex A. Potential core countries comprised the twenty-one countries in West Africa that are included in the USAID West Africa Regional Development Cooperation Strategy. We assigned scores to four selection criteria and selected the eight countries based on their total scores. HFG identified potential reference countries through consultation with USAID/WARHO and the West Africa Health Organization. From thirteen candidates, we selected seven reference countries based on further consideration of factors such as the country's overall progress toward UHC and the health financing mechanisms in use.

Table 1: Basic Characteristics of Fifteen Countries included in the Landscape Study

		Income level[1]	Population (2015)[2]	Unmet need for family planning[3](%)	Household health expenditure as percentage of total health expenditure[4](%)
Core countries	Benin	Low	10,879,800	32.6	42
	Burkina Faso	Low	18,105,600	24.5	35
	Cameroon	Lower-middle	23,344,200	23.5	52
	Guinea	Low	12,608,600	23.7	62
	Mali	Low	17,599,700	26.0	54
	Niger	Low	19,899,100	16.0	56
	Senegal	Low	15,129,300	25.6	41
	Togo	Low	7,304,600	33.6	60
Reference countries	Ethiopia	Low	99,390,800	26.3	34
	Ghana	Lower-middle	27,409,900	29.9	45
	Indonesia	Lower-middle	257,564,000	11.4	45
	Kenya	Lower-middle	46,050,300	17.5	32
	Malaysia	Upper-middle	30,331,000	15.4	48
	Nigeria	Lower-middle	182,202,000	16.1	72
	South Africa	Upper-middle	54,490,400	16.5	52

[1]World Bank. 2016. World Development Indicators Databank. Accessed August 2016 at http://databank.worldbank.org/data/home.aspx.
[2]World Health Organization. Global Health Observatory. Accessed June 2016 at http://www.who.int/gho/en/.
[3]See Table 3 for sources.
[4]See Table 5 for sources.

Three HFG researchers collected qualitative, descriptive data on the health financing arrangements in the fifteen countries using the data collection template presented in Annex B. They conducted a desk-based review of the following key government strategies and study reports: the government's health sector strategic plan, UHC strategy, or equivalent; the government's health financing policy or equivalent; the government's reproductive health or family planning policy or equivalent; Demographic and Health Survey reports for the country; and National Health Accounts reports for the country. The review also involved collecting data from additional public domain sources identified through web-based searches, including other government strategy documents, studies and reports, peer-reviewed journal articles, news articles, and gray literature.

Three senior health financing specialists based in West Africa traveled to each of the eight core countries to collect additional data in person that had not been identified in the desk-based review. They held meetings with key informants to understand each government's commitment to UHC,

implementing structures in place for rollout of initiatives, current challenges to implementation, and other topics. These key informants included government policy officials and program managers, managers of parastatal agencies or private companies, heads of national associations, development partners, and others. Meetings were conducted in French. In these meetings, the consultants also collected documents that were not available in the public domain. Annex C lists key contacts identified by the consultants.

Next, the HFG research team analyzed the data from all fifteen countries to identify the following:

- Themes across all countries
- Innovative health financing models that may be applicable to the West African context
- Potential opportunities for strengthening the health financing landscape in pursuit of UHC and better access to family planning

Landscape study findings and analyses are presented in the following sections.

1.5 Financing for Universal Health Coverage and Access to Family Planning, and How Countries Are Engaging the Private Sector

In this section, we summarize government strategies to pursue UHC and universal access to family planning, and draw cross-country comparisons of these strategies.

Many governments publicly state their strategy for progressing toward UHC in a government strategy document. Many describe how the government aims to involve the private sector. Table 2 summarizes government strategies for progressing toward UHC and governments' vision for engaging private financing agents and providers.

All fifteen governments mentioned UHC or a similar concept in their strategies, proving the pervasiveness of this concept in the post-2015 era. However, most countries do not intend to reach universal coverage during the strategy timeframe. Instead, governments generally plan to implement measures to increase population coverage under existing programs. Even so, government strategies for expanding population coverage generally involve long-term initiatives with a gradual scale-up. Most countries had specific strategies for engaging the private sector under their umbrella UHC strategy.

There is a trade-off between making rapid gains in population coverage versus pursuing concurrent progress along the three main dimensions of UHC: population coverage, service coverage, and financial protection (Figure 1). The 2013 Lancet Commission argued for public financing of progressive pathways toward UHC that are pro-poor from the outset (Jamison et al. 2013). Gwatkin and Ergo (2011) coined the term "progressive universalism" to mean a "determination to include people who are poor from the beginning." In general, countries' UHC strategy documents embrace the concept of progressive universalism by including multiple strategies to improve coverage for the poor, the informal sector, and the formal sector (and imply this will happen simultaneously).

The principle of progressive universalism also applies to implementation. If the government prioritizes efforts to achieve UHC on implementing social health insurance for civil servants and/or other formal sector workers because they are easier to identify and enroll, the principle is not met.

Strategies to increase or attain universal access to **family planning** were often absent from the higher-level UHC documents from Table 2. Family planning services are often included in governments' essential packages of health services; policies and strategies to increase access were often stated in

family planning or reproductive health strategy documents or costed implementation plans and promoted through the Family Planning 2020 Movement.

Unmet need for family planning is higher in most West African countries than in most of the reference countries in the study (Table 3). Benin and Togo have the highest rates of unmet need among study countries at 32.6 and 33.6 percent respectively. Indonesia, Kenya, Malaysia, and South Africa—all countries with middle-income status—have the highest rates of contraceptive use among married women. Although the fifteen countries vary in terms of coverage and use of family planning, many of the strategies for improving access to family planning are common ones, such as increasing awareness and demand through social marketing, task shifting to allow for community-based distribution, and increasing the number of distribution points for family planning services, including through the private sector.

Table 2: Government Strategies for Pursuing UHC in the Fifteen Study Countries

Country	UHC strategy document(s)	Summary of main strategies to pursue UHC	How does the government plan to engage the private sector?
Core Countries			
Benin	National Health Development Plan 2009-2018 National Health Financing Strategy for Universal Coverage 2016-2022	• Scale up social health insurance (*Regime d'Assurance Maladie Universelle*) • Scale up CBHI • Strengthen medical assistance to the poor and vulnerable (0-5 years) including: • Strengthen the capacity of facilities to include these populations in service provision • Decentralize the indigent health funds to all municipalities • Expand the indigent health fund to cover all health areas	• Enhance collaboration of public and private sectors for improved health policy implementation • Regulate and contract private sector to improve the coverage and delivery of quality services
Burkina Faso	UHC plan 2015-2017 Law on universal health insurance adopted 2015	• Provide a standard package of services that is 80-100% subsidized by the government • Insure the formal sector through National Social Security Fund (including self-employed) • Insure active and retired government workers through the Retirement Fund for Public Servants • Scale up CBHI for the rural and informal sectors	• Continue to purchase services from private facilities • Increase the role of the private sector in advocating for uptake of *mutuelles* by the population
Cameroon	National Health Development Plan 2011-2015	• Establish mechanisms for risk pooling • Support the establishment and monitoring of CBHI • Set up financial mechanisms to support the indigent population • Identify new public-private partnerships • Develop procedures manual for contracting with private providers	• Implement a partnership strategy with private sector, and identify public-private partnerships • Contract with providers

Country	UHC strategy document(s)	Summary of main strategies to pursue UHC	How does the government plan to engage the private sector?
		• Strengthen government capacity for contracting	
Guinea	National Health Development Plan 2015-2024	• Provide free care for the elderly in public health facilities • Conduct a study on the status of UHC implementation • Establish structures for technical monitoring, piloting, and implementing UHC	• Scale up coordination with the private sector

Mali	Health and Social Development Plan 2014-2023
	(Draft) Health Financing Strategy for UHC, 2014-2023
		• Increase the population covered by risk-pooling schemes, including:
		  ◦ CBHI for informal sector workers
		  ◦ Compulsory Health Insurance scheme for government civil servants
		  ◦ Medical Assistance Mechanism for the indigent
			• Develop an official public-private partnership strategy

Niger	National Health Financing Strategy for UHC in Niger 2012	• Increase mobilization of domestic and external resources • Promote CBHI • Promote health insurance in both public and private sectors • Implement a social security fund for health, including determination of structure, governance, and funding sources	• Engage with private providers in urban centers • Develop a structure for placing private sector health professionals in underserved areas

Senegal	National Health Development Plan 2009-2018
	
	Plan Emergent Senegal
	
	Strategic Plan for the Development of Universal Health Coverage in Senegal (2013-2017)
		• Implement exemptions and assistance programs for vulnerable groups, such as the Sesame Plan for people age 60 and over, subsidies for indigents and for people with specific diseases, free deliveries and caesarean sections (except in the Dakar region), and alternative forms of protection for persons not covered by formal coverage options
		• Reform the institutional and legal framework of social security for workers and retirees
		• Facilitate vulnerable groups' access to resources
		• Strengthen the social reintegration program
		• Improve access to equipment for the disabled and wards of the state
		• Consolidate and expand social transfer mechanisms
		• Implement the UHC initiative that promotes
			• Develop public-private partnerships by:
			  ◦ Identifying players
			  ◦ Defining terms of reference, objectives, expected results, methodology, and monitoring and evaluation of partnerships
			  ◦ Developing contracting guidelines

Country	UHC strategy document(s)	Summary of main strategies to pursue UHC	How does the government plan to engage the private sector?
		CBHI	

Togo	National Health Development Plan 2012-2015	• Support universal access to essential health services through:
		  • Devolution and decentralization
		  • Improving health information and monitoring
		  • Strengthening human resources for health (scaling up community-based services; strengthening public-public and public-private partnerships including traditional medicine, civil society, and community structures; and updating the national policy for contracting originally adopted in 2003)
		  • Improving access and quality of care
		  • Improving access to medicines, vaccines, blood banks, and essential medical technologies
		  • Strengthening health financing through performance-based financing, resource mobilization, optimal resource allocation, and increasing financial protection for vulnerable groups
		  • Strengthening community participation through social networks and community health workers
			• Develop public-private partnerships
			• Contract health services from private sector
			• Increase private financing for health

Ethiopia	Health Sector Transformation Plan 2016-2020	• Improve equity, coverage, and use of essential health services through:
		  • Promoting community engagement through various strategies (certificate of competency evaluation of households; self-reliance movements; health and health systems literacy; rollout of the Health Development Army; rollout of the second-generation health extension program)
		  • Improving efficiency and effectiveness (financial management; transparency and accountability development program; regular financial and performance audits; efficiency gain; efficient use of facility revenues; implementation of social health insurance and community-based health insurance)
			• Implement the 2013 Public-Private Partnership in Health Framework

Country	UHC strategy document(s)	Summary of main strategies to pursue UHC	How does the government plan to engage the private sector?
Ghana	National Health Policy 2007	• Reduce maternal and child mortality; prevent, fight against disease; and improve the quality of care • Develop human resources • Reinforce partnerships in the sector and promote ethics generally and in medicine specifically • Improve resource mobilization from all domestic and international sources of funds • Improve health financing equity, including risk pooling, assistance to the poor and vulnerable, and lowering catastrophic cost of care • Conduct annual review of resource allocation and purchasing mechanisms and realign them in view of national priorities and funding sources • Strengthen harmonization and effectiveness of aid, incentives, transparency, accountability, and efficiency in the public sector • Reinforce sector management	• Promote private sector investment in health service and health-enhancing facilities
Indonesia	Ministry of Health Strategic Plan 2015-2019	• Improve public health • Improve disease control • Increase access to and quality of health facilities • Increase the number, types, and quality of providers • Improve access to pharmaceuticals and medical devices • Increase synergy between national and sub-national levels • Improve partnerships, planning, and monitoring and evaluation • Increase health research • Strengthen transparent and good governance • Improve capacity of the Ministry of Health • Integrate and improve the health information system	• Incorporate large and small private businesses and private households into national health insurance scheme

Country	UHC strategy document(s)	Summary of main strategies to pursue UHC	How does the government plan to engage the private sector?
Kenya	Kenya Health Sector Strategic and Investment Plan 2014-2018	• Manage the Kenya Essential Health Service Package • Manage the service delivery system • Oversee community services • Provide supervision and mentorship services (integrated supportive supervision using updated Kenya Quality Model for Health) • Provide oversight of an integrated, pluralistic health system (e.g., conduct private sector assessments to deepen understanding of the role of the private sector in the health industry) • Develop mechanisms for engaging with stakeholders • Conduct joint development of operational and strategic plans and review processes • Regulate standards for health services, including quality of services, and their assessment • Develop a comprehensive legal and regulatory framework in the health sector	• Promote private sector participation in financing of health through public-private partnerships and other mechanisms
Malaysia	2016-2020 Country Plan	• Enhance targeted support for underserved communities (i.e., expand mobile health care, improve primary health care teams, and establish domiciliary health care programs) • Improve system delivery for better health outcomes (i.e., introducing lean management practices in public hospitals and enforcing health regulations) • Expand health system capacity (i.e., develop new facilities, upgrade existing facilities, enhance health care personnel capacity and capabilities) • Intensify collaboration with private sector and NGOs to increase health awareness	• Intensify collaboration with private sector and NGOs to increase health awareness
Nigeria	National Strategic Health Development Plan 2010-2015 National Health Act of 2014	• Develop a basic minimum package of services • Determine how certain populations can be exempt from payment • Establish a Basic Health Care Provision Fund • Establish new governing bodies for the health sector at the federal level	• Contract with private providers through the National Health Insurance Fund

Country	UHC strategy document(s)	Summary of main strategies to pursue UHC	How does the government plan to engage the private sector?
South Africa	National Health Insurance for South Africa: Toward UHC 2015	• Improve risk pooling through establishment of National Health Insurance • Implement National Health Insurance in three phases (includes strengthening the service delivery platform and improving quality in the public health sector)	• Through National Health Insurance, accredit private providers and purchase services from them on behalf of enrollees • Help private medical schemes adjust their role after health sector reforms

Key: NGO=non-governmental organization.

Table 3: Family Planning Indicators in the Fifteen Study Countries

		Data Source[1]	Unmet need for family planning (%)	Married women currently using any modern method of contraception (%)	Married women currently using long-acting reversible contraceptives (IUD, injections or implants) (%)	Sexually active unmarried women currently using any modern method of contraception (%)
Core countries	Benin	2011-12 DHS	32.6	7.9	3.5	24.4
	Burkina Faso	2010 DHS	24.5	15.0	9.9	58.7
	Cameroon	2011 DHS	23.5	14.4	3.9	48.0
	Guinea	2012 DHS	23.7	4.6	1.6	41.1
	Mali	2012-13 DHS	26.0	9.9	6.9	33.5
	Niger	2012 DHS	16.0	12.2	2.5	39.9
	Senegal	2014 DHS	25.6	20.3	14.0	51.9
	Togo	2013-14 DHS	33.6	17.3	12.6	38.4
Reference countries	Ethiopia	2011 DHS	26.3	27.3	24.5	52.3
	Ghana	2014 DHS	29.9	22.2	14.0	31.7
	Indonesia	2012 DHS	11.4	57.9	39.1	18.8
	Kenya	2014 DHS	17.5	53.2	39.7	60.9
	Malaysia	UN, 2015[2]	15.4	41.7	Not available	Not available
	Nigeria	2013 DHS	16.1	9.8	4.7	54.9
	South Africa	1998 DHS[3]	16.5	55.1	25.0	67.8

Key: DHS=Demographic and Health Survey; IUD=intrauterine device; UN=United Nations.
[1]Unless stated otherwise, indicators source is ICF International. The DHS Program STATcompiler. http://www.statcompiler.com/. Accessed June 2016.
[2]United Nations 2015.
[3]A 2015 DHS was under way in South Africa at the time of analysis for the report.

Strategies to finance and increase coverage of family planning are sometimes integrated into general strategy documents covering the health sector. Sometimes these strategies are found in stand-alone reproductive health and family planning strategy documents or costed implementation plans. Governments with separate strategy documents or costed implementation plans for family planning appear to have more-concrete and more-specific action plans for family planning, whereas governments that roll family planning strategies under a broader health system strategic plan demonstrate less detailed plans. Table 4 summarizes strategies for progressing toward increased access to family planning and the governments' vision for the role of private financing agents and providers.[B]

Table 4: Government Strategies for Increasing Access to Family Planning in the Fifteen Study Countries

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
Core Countries			
Benin	National Multisectoral Strategy for Sexual and Reproductive Health of Adolescents and Youths 2010-2020 National Budgeted Action Plan for Repositioning Family Planning in Benin 2014-2018	• Improve the institutional, socio-cultural, and political development environment around sexual reproduction of adolescents and youth and HIV/AIDS • Improve the level of knowledge and skill of adolescents and youth around sexually transmitted infections and HIV/AIDS, including the provision of reproductive health training • Improve the availability and accessibility of quality services for increased use by adolescents and youth, including free modern contraceptive methods in public health facilities • Increase budget allocation for contraceptive purchasing through 2018 to 250 million FCFA • Strengthen improvements in reproductive health through revisions to policies, norms, and protocols	• Increase collaboration within family planning framework • Leverage community networks to ensure nationwide availability and accessibility of contraceptives

[B] The table includes the most recent family planning strategy or costed implementation plan according to the Family Planning 2020 website where available (http://progress.familyplanning2020.org/). For countries that had not joined the Family Planning 2020 Movement at the time of the study, we identified the document in the public domain.

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
Burkina Faso	National Family Planning Stimulus Plan 2013-2015 Strategic Plan for Reproductive Health Product Security 2009-2015	• Create demand among rural populations through outreach, and among urban populations through mass media campaigns, and educate adolescents and young people about FP • Supply (product availability): reduce supply shortages in public health facilities through better monitoring and management of FP commodities • Improve access to FP services by improving quality of FP services, improving coverage of sub-urban and rural populations through mobile units and advanced strategies (better staffed and equipped facilities to visit less well-off ones one day each month to provide services), and improving coverage of rural population by strengthening community-based services. • Create an individual budget line for RH products and tax and custom duty exemption for RH products (reagents, delivery kits, FP methods)	• National Family Planning Stimulus Plan mentions greater emphasis on private sector, but no further details provided • Improve service availability in private sector • Improve inter-sectoral coordination and include private sector representatives in coordination committees
Cameroon	National Family Planning Action Plan 2015-2020 National Health Development Plan 2011-2015 Strategic Plan for the National Multi-Sectoral Program for Combating Maternal, Newborn & Child Mortality in Cameroon 2014-2020	• Increase national and local government contributions to FP • Improve administration of contraceptives and treatment of side effects through community mobilization, training health workers in IUDs, improving supply of contraceptives • Improve post-partum, post-abortion family planning and family planning for adolescents	• Define a framework for cooperation with private sector so more private facilities can offer FP services and in a way that the Ministry of Health can monitor. Increase social franchising by 100 for each year of the plan
Guinea	National Health Development Plan 2015-2024 National Action Plan for Repositioning Family Planning in Guinea 2014-2018	• Increase family planning contraceptive prevalence through: • Integrating family planning into public and private health facilities	• Integrate family planning into private health facilities

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
		• Implementing family planning services into community-based health care package of services • Offering all modern contraception methods to women of childbearing age • Providing public and private structures with contraception and management tools • Organizing family planning awareness campaigns • Improve the enabling environment for use of family planning services • Improve the monitoring and coordination of family planning services	
Mali	National Action Plan for Family Planning 2014-2018*	• Integrate FP messages in *mutuelles* • Develop a policy for introducing a third-party payer for FP services on behalf of adolescents and poor women • Develop performance-based financing strategy that will include FP • Mali government has committed to financing 10% of costs of contraceptives.	• Development of a strategy for involving the private sector into FP services and to expand social franchising with private sector in all regions
Niger	Health Development Plan 2011-2015 Family Planning in Niger: Action Plan 2012-2020	• Increase the availability of contraceptives, materials, and other family planning inputs • Promote the large-scale and community-based distribution of contraceptives through public and private health facilities including social marketing • Integrate family planning into the basic health care package • Promote an enabling environment for family planning	• Support NGOs conducting social marketing campaigns

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
		• Employ mobile and other advanced strategies for the provision of family planning and reproductive health services	
Senegal	National Action Plan for Family Planning, 2012-2015**	• Broaden the range of social marketing products • Conduct effective implementation of product delivery through the *Pharmacie Nationale d'Approvisionnement* • Set up mobile units • Improve the regulatory framework and engage in better regulation of the market • Ensure insurance support for FP services through CBHI schemes and social security • Establish social franchises • Increase the number of points of service in the private sector	• Establish a multi-sectoral structure dedicated to public-private partnerships • Provide direct training for private actors, especially for administration of long-lasting methods • Systematically integrate private data
Togo	Action Plan for Repositioning Family Planning, 2013-2017	• Scale up community-based distribution of family planning services • Develop mobile and outreach strategies for rural populations • Develop plans to secure and strengthen logistics and product management	• Sign memoranda of understanding with civil society organizations to advocate for increased government funding • Contract with private media outlets • Integrate FP services in private clinics • Develop a civil society and private sector engagement strategy; contract with private sector providers
Ethiopia	National Reproductive Health Strategy, 2005-2015	• Rationalize the current method mix through strategic assessment of contraceptive needs • Identify sources of new donor funding for commodity procurement	• Increase distribution at private facilities and NGOs

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
		• Allocate, as part of the Federal Ministry of Health and regional budgets, funds for procuring no less than half of contraceptive stocks for public sector use • Document the costs/benefits of eliminating import tariffs on FP commodities procured for non-commercial purposes	
Ghana	Ghana Family Planning Costed Implementation Plan 2016-2020	• Promote and nurture change in social and individual behavior • Increase age-appropriate and rights-based information, access, and use of contraception among young people ages 10-24 • Improve availability and access to a full method mix; quality of client-provider interactions with a particular focus on improving counseling on delaying, spacing, and limiting for all client age and population groups • Improve distribution and ensure full financing for commodity security in public and private sectors • Strengthen advocacy to build political will for rights-based family planning amongst community leaders, religious and cultural institutions, and policymakers at all levels • Strengthen provision of family planning services and information through Community-Based Health Planning and Services	• Encourage the private commercial sector to become more involved in family planning commodity procurement, distribution, sales, and promotion • Engage the Society for Private Medical and Dental Practitioners • Strengthen training and supportive supervision to promote client rights, conduct client follow-up, provide long-acting reversible contraception and permanent methods, and complete proper record keeping and reporting • Scale up public-private partnership ventures as alternative supply and distribution mechanisms
Indonesia	Strategic Plan for Population and National Family Planning Development 2010-2014	• Reduce total fertility rate of 2.1 births per woman and net reproduction rate of 1.0 by 2015 • Reduce the number of teenage pregnancies through prevention of pre-marital sex, early marriage and abuse of drugs	• Maintain a registry of health facilities that provide routine FP services and Family Information System

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
Kenya	Reproductive Maternal Neonatal Child and Adolescent Health Investment Framework	• Address supply-side barriers for contraceptives method mix, including: long-acting reversible methods, efficient distribution systems, and competency-based training and updates using World Health Organization medical eligibility for contraceptive use for nurses, clinical officers, and doctors in long-acting reversible methods, FP/contraception counseling, and follow-up • Ensure contraceptive commodity security and adequate financing for contraceptives • Train pharmacy staff to provide FP methods • Increase/expand community-based distribution of FP commodities and services through initiatives, which will include task sharing • Expand the output-based aid voucher program to include a wider range of FP services focusing on underserved groups and youth • Increase the coverage of postpartum FP planning services in facilities • Encourage long-acting and reversible methods among underserved groups such as adolescents/youth • Increase the availability of facilities providing voluntary FP services integrated into other services, including services for HIV/AIDS. Also increase availability of voluntary FP services in the non-health sector, and promote dual method use for HIV prevention.	• Scale up youth-friendly health services and use NGOs, community-based organizations and social media to more effectively reach youth • Involve a wide range of stakeholders such as private sector, schools, universities, and uniformed forces to increase availability and quality of voluntary FP/contraceptive services
Malaysia	None identified	• None identified	• Not specified

	Family planning strategy document or costed implementation plan	Summary of main strategies to pursue increased access to family planning	How does the government plan to engage the private sector?
Nigeria	Nigeria Family Planning Blueprint (Scale-Up Plan)	• Provide free commodities at public facilities • Permit injectables provision by community health extension workers, to greatly expand the potential number of service providers	• Increase private sector delivery channels, including faith-based organizations, private hospitals/clinics, and pharmacies
South Africa	South Africa's National Strategic Plan on HIV, STIs, and TB 2012-2016	• Integrate family planning into maternal and child health services as part of preventing new HIV, STI, and TB infections	• Not specified

1.6 Health Financing Mechanisms in Core and Reference Countries, and Private Sector Engagement

In this section, we discuss mechanisms found in the health financing landscape and draw cross-country comparisons of the study countries.

Even in the least fragmented health systems, health services are financed through a plurality of mechanisms. Table 5 shows the breakdown of financing sources in each of the fifteen countries, as well as the percentage of total health expenditure managed by private pre-paid plans (private insurance). The landscape of health financing sources varies from country to country. The table demonstrates how households must shoulder a larger proportion of the health financing "pie" in countries where government and donors finance a smaller proportion of health care costs. Across all countries, households shoulder the largest proportion of health spending. In general, households in West Africa (the eight core countries plus Ghana and Nigeria) shoulder a larger proportion of total health expenditure than do households in most countries outside the region.

To better understand the private sector's financing role in a health system, it helps to understand the extent to which publicly financed health services meet the health care needs of households in that country. If public financing for health services does not fully cover the costs to facilities to deliver services, facilities will usually mobilize private financing by charging user fees to supplement their operating budgets. Furthermore, if the publicly financed service delivery system is under-resourced and cannot deliver quality services, many households that can afford to will opt out of the system and seek care in the private sector. However, without proper regulation and supervision, private providers and private insurers often cannot meet the needs of poor and vulnerable households, or those of the non-poor informal sector.

Table 5: Financing Sources of Total Health Expenditure in the Fifteen Study Countries

		Data source	House-holds (%)	Others (NGOs, employers) (%)	Govern-ment (%)	Rest of the world (donors) (%)	Total (%)	Private pre-paid plans as percentage of total expenditure on health
Core Countries	Benin	2012 NHA	42	5	24	29	100	<1
	Burkina Faso	2013 NHA	35	7	30	26	100	2
	Cameroon	2011 NHA	52	1	33	14	100	1
	Guinea	WHO Guinea fact sheet 2014	62	2	9	27	100	Not available
	Mali	2013 NHA	54	6	12	28	100	<1
	Niger	2013 NHA	56	1	30	12	100	<1
	Senegal	2008 NHA	41	5	37	17	100	21.1
	Togo	2008 NHA	60	0	23	17	100	2
Reference Countries	Ethiopia	2010/11 NHA	34	1	16	50	100	Not available
	Ghana	2012 NHA	45	6	40	5	100	2
	Indonesia	2014 NHA	47	14	39	0	100	2
	Kenya	2012/13 NHA	32	11	31	26	100	9
	Malaysia	1997-2014 NHA	48		52	0	100	7
	Nigeria	Global Health Expenditure Database, estimate for year 2014	72	21		7	100	2
	South Africa	Global Health Expenditure Database, estimate for year 2014	52		4	0	100	Not available

Key: NGO=non-governmental organization; NHA=National Health Account report; WHO=World Health Organization.

Note: Percentages in the table signify the percentage of total health expenditure contributed by that financing source in that country.

Most or all of the health financing mechanisms described below are included in the health financing landscape of all fifteen countries. Levels of service coverage, population coverage, and financial protection vary. These coverage levels are a key way to measure a country's progress toward UHC and

universal access to family planning.[c] To assess the latter, one can evaluate the degree to which health financing mechanisms "cover" family planning services (i.e., seek to ensure the delivery of such services), the percentage of the population who can and do access those services under each mechanism, and what degree of financial protection is provided for family planning.

Chapters 2–9 of this report elaborate on each of these mechanisms in each of the eight core countries and provide a more comprehensive picture of health coverage there. Text boxes throughout this section highlight health financing reforms implemented in reference countries, providing lessons that could be relevant to the West African context.

1.6.1 Publicly financed health services

Government-financed provision of health services exists in all study countries. While the specifics and degree of public subsidies vary across countries, governments recognize that health services are a public good. Publicly provided health services are financed using general tax revenue, other public funds, or donor funds. While the government might be considered a financing source for general tax revenue, that money ultimately comes from private households and employers who pay taxes. Governments may subsidize preventive, basic, secondary, and sometimes tertiary services, provided at public facilities or by community health workers. Box 1 describes how Malaysia's government has focused on financing public facilities to reach nearly universal coverage of basic health services throughout the country. Box 2 describes how the government of Ethiopia publicly finances essential health services, including family planning services.

Government funding to facilities allows them to operate without charging patients the full cost of providing services, unlike in a system fully financed by household out-of-pocket spending. Public financing tends to be directed to publicly owned and managed health facilities; increasingly, however, governments additionally contract with private for-profit and not-for-profit facilities to increase access. Government funding for community health workers allows citizens, particularly those in rural and underserved areas, to receive essential public health services without incurring the full direct and indirect costs of traveling to a facility.

Resources for financing of facilities are usually mobilized through several means: general tax revenue; local government budgets; taxes on alcohol, tobacco, or sugar (so-called sin taxes); or cost-recovery mechanisms such as user fees, paid by patients. Risk pooling occurs when the healthy subsidize the sick: the cost of any given patient's care is paid from funds available to the broader population. The government often does the purchasing; in some countries, however, community committees are established to have a say in how facilities spend available funds. In many low- and middle-income countries, the purchasing mechanism employed by government purchasers is *input-based financing*. This means that the government pays for inputs such as health worker salaries, commodities, and infrastructure instead of paying for outputs such as the number of services provided or number of patients treated (*output-based financing*). Togo's government, for example, employs input-based purchasing exclusively. Senegal's government purchases services at public facilities using a combination of input-based and results-based financing (which pays on the basis of outputs plus a quality assessment).

Governments often pair direct financing for health services with demand-side financing to improve equity of access to health services. User fee waivers or vouchers are two examples of pro-poor financing mechanisms that work by reducing cost sharing by poor and vulnerable households to access services. Box 3 describes a voucher mechanism in Kenya that provides targeted subsidies to poor

[c] The World Health Organization and the World Bank published a framework for monitoring progress toward UHC with input from the global community (WHO and World Bank 2014). Indicators include tracer measures of coverage of essential health services and measures of financial protection. Both categories of measures include measures of equitable distribution among the population. HFG has applied the methodology in 2 of the 15 study countries: Ethiopia and Senegal (Alebachew et al. 2014, Tine et al. 2014).

women to access family planning and other services. With a pro-poor policy objective comes the requirement for a government to ensure that subsidies benefit the needy. Though effective targeting theoretically allocates scarce resources to those in need, implementing it can be administratively challenging and therefore costly. Some governments instead provide universal subsidies for certain priority health services such as institutional deliveries and family planning commodities.

Box 1: Malaysia: Adapting health financing strategies in the face of changing demand

West African countries have demonstrated political will to adopt new—or adapt existing—health financing strategies to expand service and population coverage and increase financial protection. Governments in these countries have recently published health sector strategic plans or universal health coverage strategies that show a commitment to reviewing current evidence, identifying gaps and weakness in the health financing landscape, and addressing those gaps and weaknesses through a multi-year strategic plan.

Malaysia's experience as an upper-middle-income country with near-universal health coverage through the public health delivery system provides valuable lessons for West African countries as economies grow, health systems mature, and governments face new challenges arising from an epidemiological transition and an aging population.

Malaysia does not have a publicly managed and financed health insurance scheme. Some 95% of the cost of treatment in public facilities is financed by the government; patients pay the remainder through low user fees. The government uses general tax revenue to purchase services on behalf of the population through input-based financing. Malaysian public health facilities receive line-item budgets based on historical spending, and health care workers in these facilities are salaried civil servants. Government sources state that 90% of the Malaysian population has access to some form of care through this system (Ministry of Health Malaysia, n.d.). Use of services is reportedly high and equal across income groups, and poor and vulnerable groups do not incur high out-of-pocket spending for health services.

However, Malaysia's experience shows that UHC is never fully attained and governments must continue to implement health systems reform to meet changing needs. Malaysia is experiencing an epidemiological transition, an aging population, and increasing demand for costly and more advanced health care technology and procedures, such as renal dialysis. The government also expresses concern that the high level of subsidy encourages overuse of health services (Ministry of Health Malaysia). To maintain near-universal health coverage, the health system must become more efficient. There are reports of health services rationing in the form of long waiting times and limited availability of essential medicines at public facilities; these challenges will only worsen if resources become more constrained. Real or perceived higher quality delivered in private facilities has created a situation where wealthier people opt out of the public system. Though this trend can relieve pressure on public facilities if they treat fewer people, it also can have adverse consequences, including fragmenting service delivery and reducing equity.

West African countries can anticipate some of these same challenges as they advance toward UHC and their health systems evolve and disease burden shifts. Governments can implement legal frameworks now to enable health system reforms to address changing needs.

Box 2: Public financing for essential health services in Ethiopia

West African governments finance essential health services in part by providing input-based financing for public health facilities to pay for their provision of services, with oversight and supervision from local governments and the community. Indeed, this strategy is shared by many governments around the world.

The government of Ethiopia provides input-based financing for public health facilities across the country. Health facilities provide essential services to the local population with oversight and supervision from local governments and the community. The Essential Health Services Package for Ethiopia, published by the central government in 2005, provides guidance to local governments and health facilities on the services that must be available and provided at a minimum standard of care at public health facilities. Several family planning services are included in the package, among them promotion and advice on family planning; information, education, and counseling on family planning; provision of condoms, pills, combined pills and injectable contraceptives; provision of long-term contraceptives at health centers; and provision of permanent methods at district hospitals. The package is designed to foster an integrated service delivery approach essential for advancing the health of the population.

Input-based public financing is transferred to facilities for the provision of the Essential Health Services Package. Though patients pay user fees for some services, many of the services in the Essential Health Services Package, including services for family planning, are exempted from cost-sharing requirements.

Box 3: Kenya: Vouchers for safe motherhood, family planning, and violence recovery services

A voucher scheme in Kenya provides targeted subsidies for safe motherhood, long-term family planning methods, and gender-based violence recovery services. These subsidies benefit households as well as public and private providers. They also may be applicable in the West African context, where governments are seeking to reduce financial barriers to priority services such as family planning and to as encourage demand and quality improvements among public and private providers.

The "output-based aid voucher scheme," funded by the German Development Bank and the government of Kenya, launched in 2006. The scheme has operated in Kisumu, Kitui, Kiambu, and Kilifi counties and in Korogocho and Viwandani informal settlements in Nairobi. Safe motherhood and family planning vouchers are sold through distributors to poor women in rural districts and low-income areas of Nairobi for a highly subsidized price. The gender-based violence recovery services vouchers are provided free in accredited facilities, regardless of the patient's socio-economic status.

The output-based aid voucher scheme allows the government to mobilize private sector resources for delivery of priority health services. It also strengthens the health service delivery system by encouraging demand-side use of priority public health services with a targeted subsidy, as it provides additional revenue for providers. This revenue can be used to cover the facility's operating costs and improve quality of care. Managers at private for-profit and faith-based facilities report the additional revenue as the biggest benefit from the program. A majority reported the extra revenue improved availability of supplies, drugs, and equipment; it enhanced client comfort through the provision of meals, accommodation, and improved cleanliness. Public facility managers reported the revenue from the program as a benefit, but a majority expressed disappointment with being unable to use the funds to improve public services due to restrictive guidelines from the Ministry of Health (Njuki et al. 2015).

A secondary benefit of the output-based aid voucher scheme is that it helps the government build health sector experience in targeting, accreditation, claims, reimbursement, and quality assessment—all useful capabilities for the government's National Health Insurance Fund.

The landscape study revealed that in general, at least some family planning commodities are provided free in facilities and by community health workers receiving public financing. Ghana, for example, provides free family planning commodities and services through public and some private providers. International donors often finance such commodities, which are then distributed through the health care

delivery system. These distribution systems can do better, however, as evidenced by persistent levels of unmet need for family planning. Additionally, many government strategies acknowledge an urgent need to improve uptake of family planning and to improve health worker skills to administer certain long-acting and permanent family planning methods such as intrauterine devices and vasectomies (see Table 4).

1.6.2 Social health insurance

Social health insurance is an umbrella term for a health financing mechanism used by governments to purchase health services for members by mobilizing and pooling funds from public and private sources. Social health insurance differs from other kinds of insurance in that people contribute regular prepayments ("premiums") according to their ability to pay. As a result, wealthier people pay more into the scheme and cross-subsidize the less wealthy, in a progressive rather than regressive financing model. In addition, a social health insurance scheme, as with other health insurance schemes, pools health risks of all members. This means that healthy members subsidize the costs to care for those who are sick; all members receive the same level of financial protection against unpredictable health events, regardless of their contributions or health status. When participation in a social health insurance scheme is mandatory and membership is sufficiently large, adverse selection is minimized. [D]

Many governments plan to implement or scale up social health insurance schemes and have passed laws to this effect. Nevertheless, mobilizing the required resources to subsidize adequately even basic benefits for citizens with limited or no ability to contribute can be a challenging and much longer process (see Box 4). This is particularly true for countries with a limited tax base and a small formal sector.

For this reason, many countries focus social health insurance programs on those employed in the formal sector. Formal sector employees and their employers have greater capacity to contribute and advocate more effectively for government resources. Additionally, it is easier for a scheme to identify, enroll, and collect premiums from the formally employed. Schemes often mobilize resources through employer contributions via a payroll tax and employee contributions via mandatory payroll deductions. Contributions from employers and employees are usually a flat percentage of the employee's salary, so that people with higher salaries contribute more money in absolute terms than do people with lower salaries. However, governments that implement social health insurance first for formal sector employees may not be adhering to the *progressive universalism* concept. Unequal financial protection between the formal sector (often the wealthier households) and the rest of the population can create a cycle of inequity and higher levels of fragmentation in the health system.

Most countries in the study offer a social health insurance scheme or are planning one, although features of the schemes and their population coverage vary widely. For example, Togo's scheme covers civil servants and government retirees, Kenya's scheme covers civil servants and retirees as well as private sector workers, and Indonesia's scheme aims for a "single-payer" health system that will cover the entire population. Box 5 describes South Africa's plan to establish social health insurance. In another variation, the government may require certain populations to enroll in privately operated risk-pooling schemes. For example, a law in Senegal requires large employers to enroll their employees in *Institutions de Prévoyance Maladie* (Sickness Insurance Institutions). Chapter 8 covers this Senegal model in more detail.

[D] Adverse selection can be defined as strategic behavior by the more informed partner in a contract against the interest of the less informed partner(s) (Belli 2001). In this example, it refers to the tendency for the sick to enroll and the healthy to opt out of the social health insurance scheme.

Box 4: Ghana, Indonesia, and Nigeria: Turning commitment to UHC into reality

Enabling legislation is a first step in realizing universal health coverage. To turn political commitment into reality, countries must determine how to finance the expansion of coverage through the annual budgeting and appropriations process.

Across West Africa, governments are implementing health financing reforms in pursuit of UHC. The implementation phase involves many steps, such as setting up a stream of financing for an institute like Togo's National Institute of Health Insurance to oversee and operationalize a social health insurance scheme, or establishing a coordinating body like Niger's Federation of CBHI Schemes. Below are three examples of how governments from the study's reference countries have taken further actions beyond publishing a health sector strategy or law to implement a reform.

Family planning advocates in Ghana successfully lobbied national legislators to address access challenges by covering family planning education and services under the National Health Insurance Scheme, which includes free maternal health care. In 2012, reform legislation required inclusion of family planning services that would be determined by the Minister of Health (Naik, Morgan, and Wright 2014). However, a legal mandate for coverage expansion does not ensure effective coverage expansion. Three years later, the government had yet to provide the policy directive and implementation guidelines necessary to make family planning methods part of the National Health Insurance Scheme package in practice (IPPF 2015).

The rollout of Indonesia's ambitious single-payer system starting in 2014 is partly a result of a legal action brought by citizens to hold the government accountable for the 2004 law on the National Social Security System. That law stipulated that the government must establish non-profit bodies to implement five mandatory social insurance programs covering health care, workplace accidents, death, old-age risks, and pensions, to be funded by beneficiary contributions. By 2011, the government was criticized for delaying to transform the four state-owned insurance companies into non-profit entities. Delays motivated citizen groups to file a lawsuit and organize street protests (Hatt et al. 2015).

Nigeria's former administration successfully lobbied the Senate to pass the National Health Act of 2014, which legally established a Basic Health Care Provision Fund and other structures for expanding coverage to the informal sector and the poor under the National Health Insurance Scheme. However, the Basic Health Care Provision Fund ultimately needs to receive annual budget appropriations, which makes the Fund susceptible to changes in government and government fiscal priorities. Civil society, indeed, voiced concerns that one year after the National Health Act had been passed and a new government had come to power, the new government would not fund the Act in the 2016 government budget (Ikhuoria 2016).

1.6.3 Community-based health insurance

Community-based health insurance (CBHI) schemes were present in all of the study countries, although their presence is very small in Togo, Indonesia and Malaysia. CBHI is often included in UHC strategies in low- and middle-income countries because of its perceived comparative advantage in targeting underserved, uninsured, and largely informal-sector populations and enrolling them into risk-pooling schemes.

The CBHI model tends to be popular in countries where health system coordination mechanisms (e.g., health management information systems with high-quality patient-level data) are less developed and where social solidarity is a prominent social value. Community members volunteer to manage the schemes and undertake most of the health financing functions, including resource mobilization (from members), risk pooling, purchasing, and claim settlement. Regional, national, or parastatal agencies that are not physically located in CBHI service areas are not often well positioned to assume these functions.

Box 5: Implementing social health insurance in phases: South Africa's experience

Most governments across West Africa are engaged in or about to start implementation of social health insurance. Implementing a social health insurance scheme requires an enormous effort, including complementary health system strengthening to enhance success of the scheme. The introduction of social health insurance can also disrupt other parts of the health sector. In response to this disruption, governments must plan and manage accordingly. The government of South Africa prepared a detailed implementation plan of its health insurance scheme which illustrates the complexity of such an effort and provides helpful lessons for West African countries.

South Africa's government is in advanced preparations for reforming the health system to implement National Health Insurance, in line with its UHC strategy. The health system is currently fragmented: eighty-three Medical Schemes represent relatively small risk pools that provide financial protection against catastrophic costs. These schemes are mainly employment based. The informal sector and the poor have few options for accessing and financing health care. The government produced a green paper in 2011, which received many comments from stakeholders; subsequently, it produced a revised white paper in 2015. The detailed white paper outlines a roadmap to reform all aspects of the complex health system to align with National Health Insurance by 2025 (Department of Health 2015). The roadmap illustrates all the many moving pieces to be considered during a health system reform effort.

In phase 1, the government will establish a Transitional Fund to finance National Health Insurance start-up activities before it can start mobilizing revenue through prepayments. It will undertake various health systems strengthening initiatives such as scaling up quality improvement efforts in public clinics and hospitals, implementing a Centralized Chronic Medication Dispensing and Distribution program, and amending applicable laws. It will also develop systems and processes for a provider payment system, a patient registration system, a provider accreditation and registration system, and a fraud and risk mitigation system.

In phase 2, the government will use the Transitional Fund to purchase primary health services on behalf of enrollees. Later, the government will start purchasing hospital and emergency services on behalf of enrollees. National Health Insurance will start mobilizing resources to replenish its funds by realigning public funding that will no longer be necessary once National Health Insurance is functional, such as Compensation Funds and state subsidies to medical schemes. The government will deploy the patient registration system in public health facilities and start enrolling the population, focusing first on vulnerable groups.

In phase 3, the government will start collecting mandatory prepayments, accrediting private hospitals and specialists, and purchasing those services.

The reforms may require private medical schemes to transition their role in the health system or risk going out of business. The white paper lays out such options as creating a single virtual pooling arrangement for the schemes, having schemes transition from providing comprehensive to supplemental coverage, and hiring experts from the shrinking medical scheme industry to administer National Health Insurance.

In some countries, such as Ethiopia, Ghana, and Nigeria, the central agency running a large social health insurance scheme has oversight and management responsibility over CBHI schemes, and the CBHI schemes must operate and provide coverage according to the central agency's standards. In Mali, the Technical Union of Community Based Health Insurance launched a mobile money application with Mali's CBHI schemes, and paying premiums with mobile money is growing in popularity among enrollees (see Chapter 6). In other countries, although governments are moving to integrate CBHI schemes with government health financing initiatives, they remain only loosely or not at all coordinated with government. In Benin, the government intends to incorporate existing CBHI schemes under the *Régime d'Assurance Maladie Universelle* (Universal Health Insurance Plan).

Increasing the number of CBHI schemes may seem feasible for governments in the short term, but the model often leads to government-sponsored health financing mechanisms. For example, community members in Ghana initially volunteered to manage the schemes, but eventually they migrated into a

more professional management arrangement and the scheme managers became salaried government staff. Box 6 discusses how Ethiopia's CBHI initiative is evolving.

Box 6: How Ethiopia's CBHI initiative is evolving to incorporate regional and national risk pools

Governments across West Africa have publicly adopted CBHI as a strategy for expanding health care coverage to the indigent and informal sector workers, but many CBHI schemes in these countries are still operating with small risk pools. One trend observed in this study is governments seeking to consolidate these small risk pools to improve financial stability and gain other benefits. Ethiopia's government is engaging in such an effort now. Its experience may provide helpful lessons for other governments as they move in a similar direction.

Ethiopia's government is showing how health financing mechanisms can evolve over time to improve health coverage in pursuit of UHC. As Ethiopia's CBHI initiative matures, the government is looking for ways to improve the financial stability of the model and continue to improve access to services. As of June 2016, CBHI schemes are providing services to beneficiaries in a total of 181 districts, covering over 10 million people throughout Ethiopia (HFG 2016). Building upon the gains in coverage already achieved through rollout of district-level schemes, Ethiopia's government expects reforms to create larger regional- and national-level risk pools and expanded service coverage. While district-level CBHI schemes helped the government mobilize critical resources and target uninsured, informal sector low-income communities, these smaller schemes are exposed to financial instability due to the small size of their risk pools. Consolidating risk pools will enhance overall scheme viability by increasing cross-subsidization of risk, and enable CBHI schemes to expand access to and continuity of care at secondary and tertiary facilities.

To execute this reform initiative, the Federal Ministry of Health issued a Directive for local governments to link district-based risk pools with a regional and a national risk pool. Each region is expected to establish a regional risk pool. The Federal pool will be formed later to incorporate experience gained from the operation of regional risk pools. The regional CBHI risk pools will contract with secondary- and tertiary-level hospitals in their region. CBHI members will obtain a referral from their district facilities to receive full benefits for regional or tertiary hospital services, paid through the regional CBHI risk pool. Failure to get a proper referral would result in reduced benefits, offset by a cost-sharing requirement for the patient. The Regional CBHI pool is proposed to be funded by a fixed federal government subsidy and by a portion of the prepayments made by or on behalf of paying and indigent members mobilized by district-level CBHI schemes.

Experience also shows that resource mobilization, pooling and purchasing can be administratively challenging. Many communities struggle to fulfill these functions in a way that keeps schemes financially viable. Schemes collect prepayments from members, pool the funds, and then use the pooled funds to pay providers for services rendered. A CBHI scheme must therefore determine which services it can afford to cover based on how much it collects in prepayments from the community. Often, CBHI schemes face challenges collecting enough revenue from members to fully cover the cost of services that members will use. Instead, some governments heavily subsidize CBHI schemes and establish a minimum list of covered services, which the scheme must cover. Under this alternative arrangement, CBHI schemes can still perform the administrative functions of mobilizing prepayments from the community and paying providers, especially in remote and underserved areas which regional and national agencies would find difficult to fulfill. CBHI enrollment tends to be voluntary (or when mandatory, enrollment is not enforced by the CBHI administrators). CBHI schemes are therefore particularly vulnerable to adverse selection where disproportionate enrollment by high-risk individuals accompanies non-participation by low-risk individuals. CBHI initiatives like the one in Ethiopia may eventually evolve into larger risk pools once that transition is operationally feasible for the government. This transition could be beneficial for ensuring CBHI scheme members get financial protection for health services provided by regional or national hospitals.

1.6.4 Private health insurance

Private health insurance is a health financing mechanism present in all fifteen study countries, although its role varies from country to country. Private health insurance tends to target wealthier households and workers in the formal sector, although there are a few examples of private health insurers and private CBHI schemes targeting lower-income households or workers in the informal sector.

Private insurers offering comprehensive health care benefits are likely to target younger, wealthier, and healthier individuals and avoid people at high risk for using costly health services (a practice often referred to as "cherry picking" or "cream skimming"). In countries with low market penetration, the risk pools are also small and somewhat unstable, which further motivates private insurers to avoid potentially costly enrollees. In the absence of regulation and enforcement, the private insurance market excludes a large majority of a population.

Market penetration of private health insurance is limited across most study countries, especially the core West African countries (see Table 5). Senegal appears as an outlier in Table 5 for private health insurance penetration because *Institutions de Prévoyance Maladie* (Sickness Insurance Institutions) technically are private insurance companies. However, the government regulates them and mandates enrollment, so they more resemble social health insurance than voluntary private health insurance. A few voluntary private insurance products offered in Senegal have market penetration closer to what is observed across other study countries.

Some private companies voluntarily offer employees premium subsidies or other health benefits for private health insurance in order to attract and retain skilled people, in Kenya and Nigeria, for example. In general, however, the private health insurance model does not contribute significantly to population coverage in countries with small formal sectors. Private health insurance might also offer supplemental coverage if the formal sector is already required to contribute to a social health insurance scheme, such as the plan under South Africa's UHC roadmap. Private insurers might offer alternative coverage to a social health insurance scheme, as in Kenya, where wealthier households who prefer to access care at private facilities not covered by the mandatory social health insurance scheme purchase private health insurance.

Private insurance products tailored to meet the needs and incomes of lower-income households are uncommon in the health financing landscape in most study countries, but can still play a role. Some private CBHI schemes exist in Burkina Faso and elsewhere, but information about them is very limited in the literature. Ghana had many private CBHI schemes prior to the initiative to bring them under the government-run National Health Insurance Scheme. In Kenya, some private insurers offer health insurance products with limited benefits, lower-cost provider networks (e.g., faith-based hospitals or public facilities), and correspondingly lower premiums that target non-poor informal sector workers.

Simple, affordable health insurance products can play a role in reducing burdensome costs associated with health care (e.g., for transportation or to offset lost wages). However, unsubsidized private health insurance plans with comprehensive benefits are usually unaffordable to all except the wealthiest households.

1.6.5 Household out-of-pocket spending

Household out-of-pocket spending is the dominant financing mechanism in most of the study countries, meaning households pay providers directly for health goods and services at the time of service. The household acts as the resource mobilizer and the purchaser. Risk pooling is essentially absent, exposing the household to catastrophic health care costs. As mentioned previously, a health system that heavily relies on most households having to pay directly for their health care is economically inefficient, promotes inequity, and deters development.

Households in all countries invariably pay out of pocket for some health services or commodities, as seen even in Malaysia, where most health services are provided free or a very low cost through a strong network of public health facilities. Consumer choice is important, and consumers may choose to pay more out of pocket for services at private or non-covered providers, or for non-covered services or supplies, such as brand-name pharmaceuticals.

Table 5 shows the percentage of total health spending borne by households in each study country. Total spending for health comprises both out-of-pocket spending and prepayments for risk-pooling schemes. In countries with low levels of other health financing and risk-pooling mechanisms, out-of-pocket spending accounts for the majority of household spending, and household spending as a proportion of total health expenditure is generally quite high. The goal of UHC is not to eliminate out-of-pocket spending for health entirely, but to ensure households have adequate financial protection against catastrophic costs when someone in the household experiences a health shock.

1.7 Discussion

Pursuing UHC and universal access to family planning often requires major health financing reforms to strengthen the health care system, mobilize new sources of funding, and improve efficiency. Governments can improve equity and increase efficiency by implementing health financing mechanisms that spread risk among a large pool and protect households from catastrophic costs. Such mechanisms can also encourage households to seek care that lowers morbidity and can improve micro- and macro-economic outcomes. No country can claim to have a perfectly equitable and efficient health financing landscape. Studying how other countries have successfully made gains in equity, service coverage, and financial protection can be illuminating. Reviewing lessons learned across countries can help a government design reforms that anticipate future challenges and needs.

Nevertheless, governments face challenges mobilizing resources to expand equitable service coverage and financial protection. The study identified evidence of this in the core West African countries as well as the reference countries outside the region (Box 6 discusses the cases of Ghana, Indonesia, and Nigeria). The World Health Organization (2011) reported that none of the countries in the study that had been part of the 2001 Abuja Declaration, and therefore had committed to allocate at least 15% of government budgets to health, had reached the target 10 years later. Because governments are not funding health care at recommended levels, and because health reforms can be costly, interest is growing in mobilizing private financing. However, Table 5 shows that private sources (households, employers, domestic non-governmental agencies) are already the main financiers of health care (not to mention that government financing is mainly sourced from general tax revenue, which comes from households and industry).

Governments have opportunities to improve the efficiency and equitability of private financing by removing barriers to and implementing more-efficient health financing mechanisms. The reference countries in this study did not provide many examples of how to engage the private sector in health financing.

The path to UHC is long and evolving. Governments must continually reform the health care system to pursue better and more equitable coverage for their populations. Population needs and demands change, as illustrated in Malaysia, where the government is now seeking health system reform to introduce new (or bolster less prominent) financing mechanisms to build on the system of publicly funded health services. In South Africa, the health financing landscape that evolved under Apartheid covers some of the population well, but leaves many out. Instead of building parallel and separate systems for different populations, that government is now aiming to reform the health system to introduce national health insurance that will cover everyone. In Ethiopia, the government plans to reform the existing CBHI landscape by rolling community-level schemes into regional and national-level

risk pools, similar to how Ghana allowed CBHIs to formally become part of its National Health Insurance Scheme.

Government-subsidized programs that lack the resources to cover all citizens will by necessity or design cover a subset of them. This can undermine social solidarity and equity and potentially derail the goal of *progressive universalism*. Unequal financial protection between the formal sector (often the wealthier households) and the rest of the population can create a cycle of inequity and higher levels of fragmentation in the health system. If wealthy households are excluded or are allowed to opt out, they cannot efficiently cross-subsidize the provision of care for the poor and vulnerable. If wealthier people obtain health services at private facilities instead of the public service delivery system, the parallel service delivery systems may deliver unequal quality of care. Similarly, if a financing mechanism such as social health insurance excludes the informal sector because of operational challenges with enrollment and resource mobilization, a large proportion of the population will be left without financial protection. Furthermore, an efficient financing approach directs limited resources for subsidies to those who need them, but accomplishing this is operationally challenging.

Many countries have promoted CBHI as a strategy to cover the informal sector and poor and vulnerable populations. CBHI is popular because it is more feasible to implement health financing functions (resource mobilization, risk pooling, and purchasing) by mobilizing human resources within communities. However, CBHI schemes often have limited benefit packages and present many administration and financial stability challenges. As health systems mature, private CBHI schemes often consolidate and may provide a foundation for an expanding government-sponsored insurance program, as seen in Ghana. In another approach, Ethiopia is scaling up health insurance for rural and informal sector low-income households with district-level schemes that operate with community-based governance. CBHI may be a stepping-stone to higher levels of coverage—beginning by enrolling hard-to-reach populations, and leveraging principles of community solidarity for health, and eventually transitioning into more sustainable schemes with government oversight and subsidy. In a similar scenario, Indonesia is now consolidating district-run social insurance schemes under a national single-payer system.

Smaller-scale or more-targeted health financing mechanisms can promote equitable access to essential services. A voucher scheme in Kenya is benefitting both providers and patients. It provides additional revenue for providers, and it helps patients access family planning and gender-based violence recovery services by removing some financial barriers and encouraging them to seek care. The voucher scheme fills a gap in Kenya's health financing landscape and in Kenya's ability to ensure access to family planning services, and it complements other health financing programs such as the National Health Insurance Fund.

Ensuring universal access to family planning through UHC initiatives is critical. Most of the study countries did not mention family planning under the high-level UHC strategy document, although many have separate family planning or reproductive health strategy documents. Since UHC is an enabler of health and well-being and of economic and development gains, integration of family planning services under UHC schemes and throughout the country's health financing landscape is not only a moral imperative but also a strategic one. As donor resources for family planning decline, governments will need to replace and expand alternative financing mechanisms to reduce both unmet need and maternal, newborn, and child deaths.

Most core West African countries in this study share commonalities. Many governments envision simultaneous interventions to improve financial protection for health and pursue UHC: finance health facilities with public funds, scale up social health insurance, and encourage the establishment of CBHI schemes to contribute to population coverage of hard-to-reach populations. With relatively small formal sectors, core countries will need to dramatically grow the number of CBHI schemes in order to reach near-universal enrollment among their populations. Population coverage of CBHI and other forms of insurance is low in most core countries. Out-of-pocket spending for health services is a very large

proportion of total household spending for health, and often a large proportion of total health expenditure in the country, while household spending for health insurance is relatively small. Government allocations to health are still below the Abuja Declaration target. Financing for family planning predominantly comes from donors, although the governments manage some family planning distribution through public health facilities or other mechanisms. This study's review of health financing landscapes in all core countries reveals several opportunities for each country to expand on or introduce new health financing mechanisms that will increase coverage for health care and family planning.

The next parts of this report review in detail the health financing mechanisms and coverage of family planning in each of the eight core West African countries. For each country, the authors identify opportunities to expand coverage across the three coverage dimensions.

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2. BENIN

2.1 Country Snapshot

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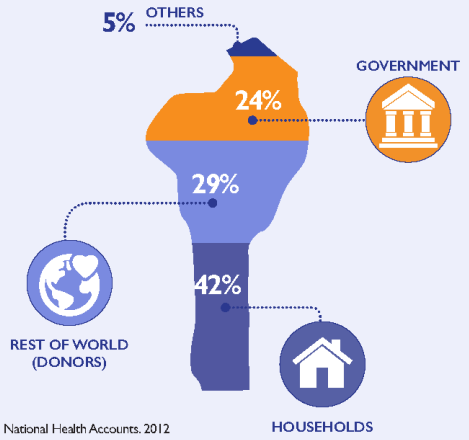
Benin

FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

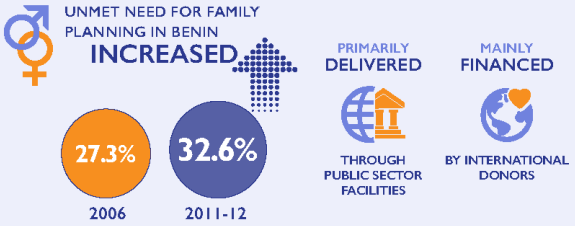
Benin's Strategies for Improving Coverage of Health Services

TOTAL HEALTH SPENDING BY SOURCE[a]



[a] Benin National Health Accounts. 2012

FAMILY PLANNING



KEY INDICATORS

Indicator	Value (Year)
Population	10,879,800 (2015)*
General government expenditure on health as a percentage of total government expenditure	8% (2012)**
Total health spending per capita	US$34 (2012)**
Private prepaid plans as a percentage of total expenditure on health	0.05%**
Unmet need for family planning	32.6% (2011-12)***
Married women currently using any modern method of contraception	7.9% (2011-12)***
Married women currently using long acting reversible contraceptives (IUD, injections or implants)	3.5% (2011-12)***
Sexually active unmarried women currently using any modern method of contraception	24.4% (2011-12)***

* World Health Organization. Global Health Observatory. http://www.who.int/gho/en. Accessed July 2016.
** Benin National Health Accounts. 2012.
*** ICF International. 2012. The DHS Program STATcompiler. http://www.statcompiler.com. Accessed June 2016.

Benin's universal health coverage (UHC) strategy is elaborated in its *Plan National de Développement Sanitaire 2009-2018 (PNDS)*.[1] The PNDS promotes social health insurance – Regime d'Assurance Maladie Universelle (RAMU) – as a vehicle for increasing access to and financial protection for health services through a network of community-based health insurance schemes;[2] RAMU implementation began in July 2016. Beyond RAMU, government strategies focus on resource mobilization, including diaspora remittances, services to vulnerable populations, and private sector engagement. In 2013, Benin established a public-private partnerships platform to improve regulation of and contracting with the private sector. Currently, 49% of total health spending is private, mostly from out-of-pocket household spending. Five companies provide private health insurance.[3]

Benin recognizes the need to improve the availability, accessibility, and use of family planning services.[4] Nationwide, unmet need for family planning services rose from 27.3% in 2006 to 32.6% in 2011-12.[5] The government is committed to identifying family planning needs and increasing the contraceptive prevalence rate to 20% by 2018.[6] At present, family planning commodities are financed primarily by international donors and delivered through public facilities.[7]

Challenges and Opportunities

Benin's challenges lie in low public health spending, financial barriers to health care access, and low penetration of health insurance. That said, a successfully scaled up RAMU could lower out-of-pocket spending and increase access to care, especially in rural areas. Functioning private and government-run mutuelles could provide knowledge transfer on effective management and coordination to RAMU mutuelles. Last, implementation of private-public partnerships and private sector participation in publicly managed health financing schemes, as described in the *Politique Nationale de Santé*, can further Benin's goal of achieving an integrated national health system that guarantees health for all.

1 Benin Ministry of Health. September 2009. Plan National de Développement Sanitaire 2009-2018.
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7 United Nations Population Fund (UNFPA). April 2015. Benin: UNFPA Supports the Improvement of Family Planning Services.

Figure 2: Benin Country Snapshot

Public and Private Sector Roles in Health Financing

The public and private sectors contribute to three main health financing functions:

RESOURCE MOBILIZATION

RISK POOLING

PURCHASING

THE PUBLIC SECTOR'S ROLE IN HEALTH FINANCING

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
• General tax revenue (24% of THE) • Grants or loans from development partners (29% of THE)	• Social health insurance (RAMU) will pool risk of formal and informal sector workers at the health zone level in 34 zones	• The government purchases services at public health facilities through: » Fee-for-service payments to facilities, based on the service provided, the health system level (primary, secondary, tertiary), and the individual's socioeconomic circumstance » Subsidies for health care for pregnant women and children under 5 years » Performance-based financial incentives for health workers

THE PRIVATE SECTOR'S ROLE IN HEALTH FINANCING

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
• Household out-of-pocket payments (42% of THE) • Household voluntary prepaid contributions (0.05% of THE)	• Private insurers pool risk at the scheme level, although only 5.4% of the population is covered	• Households are the main private sector purchasers of health services in Benin • Households pay out-of-pocket for family planning services • To minimize fraud, Benin's Agence Nationale d'Assurance Maladies (National Agency of Health Insurance or ANAM) oversees participating health providers and establishes allowable fees for services covered by private health insurance schemes

Health Financing Mechanisms by Population Segment

Health financing mechanisms available to population segments will vary:

PUBLIC SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Publicly-financed health services	☑	☑	☑
Mandatory social health insurance	☑		
Voluntary community-based health insurance		☑	☑

PRIVATE SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Voluntary private health insurance	☑	☑	
Out-of-pocket spending	☑	☑	☑

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Abt

2.2 Background

Health financing is a core building block of a health system and a key enabler of progress toward universal health coverage and universal access to family planning. Governments often use a plurality of health financing mechanisms to advance toward universal health coverage. In Chapter 1, we presented trends across the health financing landscape across fifteen countries in multiple regions and drew lessons that may be applicable in Benin and other West African countries. This chapter describes the health financing landscape in Benin and identifies opportunities where the government and other stakeholders can develop, strengthen, and expand the country's health financing mechanisms to progress toward universal health coverage and access to family planning.

Health financing specialists from USAID's Health Finance and Governance project collected the information presented below. HFG performed desk research and in-country data collection (key stakeholder interviews, policy and planning document collection) to map public and private health financing mechanisms in the country and identify potential opportunities where the government might expand population, service, or financial coverage for health and family planning services.

2.3 Benin's Health Financing Landscape

Benin uses five major health financing mechanisms. Each major mechanism is described in more detail below.

2.3.1 Government financing for health services

Government financing for health services provides financial protection from health costs to the largest proportion of the population. According to Benin's *Plan National de Développement Sanitaire 2009-2018* (PNDS; National Health Development Plan), all Benin citizens are eligible to receive health care at facilities funded directly through the state.

Government financing for health services shields participants from exposure to the full cost of public health services, making it an important health financing mechanism.

Government financing for health services delivered at public health facilities does not cover the full cost of care provision; health facilities assess Ministry of Health-established user fees based on service type and socio-economic status of the user. User fee exemption programs exist for services that treat priority diseases among vulnerable populations. An example of this is no-cost malaria care for pregnant women and children under age 5. Government purchasing occurs though facility-level payments, service subsidies for vulnerable populations, and increasingly, health worker and facility-level performance-based incentives. Throughout the country, several results-based financing programs exist—with the support of development partners—to supplement health worker salaries for favorable results.

2.3.2 Social health insurance

In 2012, the government of Benin issued a decree for *Régime d'Assurance Maladie Universelle* (RAMU; Universal Health Insurance Plan), a mandatory social health insurance scheme that will cover all citizens. The government began RAMU's first of three phases of implementation in July 2016 by covering hospitalization, pharmaceuticals, and additional benefits for the formal sector (Center for Health Market Innovations 2016). Once fully implemented, RAMU will operate as an umbrella of health financial protection mechanisms that will encompass existent CBHI schemes. RAMU will establish risk pools in the form of thirty-four geographically based health zones. In addition, RAMU will serve as a vehicle for government financing of direct medical assistance to the poor, needy, and vulnerable (Ministère de la Santé de Benin 2009). The mechanism for this funding was unclear at the time of this study.

RAMU is financed through tax revenues and individual contributions. Contributions are fixed for formal and non-poor informal sector households, with annual contributions set at FCFA 12,000 per adult and FCFA 1,000 per child (under age 18). Poor and vulnerable households will be exempt from contributions, covered by *le fonds sanitaire des indigents* (the indigent health fund) (Ministry of Health, n.d.). According to the PNDS, this fund will be decentralized at the municipality level to strengthen access to health services for this group. At the time of the HFG study, it was unclear how RAMU contributions would be collected. The government is also considering implementing dedicated taxes for health, such as a value-added tax or a "sin tax" applied to alcohol or tobacco purchases, to finance RAMU. RAMU is also slated to include cost sharing by members at the point of service. When health care is accessed at a departmental or equivalent-level hospital, patients will pay a 10% coinsurance; at a central- or national-level university hospital, patients will pay a 20% coinsurance.

At the time of the HFG study, it was unclear how RAMU would be governed in its entirety, but it is thought that the *L'Agence Nationale de l'Assurance Maladie (*ANAM), in existence since 2012, will have some level of oversight, at a minimum for managing premium collection.

Family planning services are expected to be offered at RAMU-contracted facilities, but at this time, RAMU is not expected to include the cost of these services in its insurance offering. RAMU is expected to mostly cover curative services and to exclude preventive care and family planning.

2.3.3 Community-based health insurance

In Benin, an NGO or foreign partners typically support the financing, operations, and technical aspects of CBHI schemes, but they are governed by the public sector health zone they cover. There are twelve main promotors of CBHI schemes, most of which belong to the *Concertation Nationale des Structures d'Appui aux Mutuelles et Assurances de Santé* (CONSAMAS; National Coordination of CBHI Schemes and Health Insurances), a national entity that exists to harmonize efforts across public and private CBHI schemes.

There are approximately 200 CBHI schemes in Benin. CBHI penetration is relatively low, covering approximately 500,000 (4.7%) of the population. That said, CBHI schemes have the potential to cover an estimated 20-38% of the population based on the geographical distribution of current health zones that CBHI schemes operate within. The government has therefore made CBHI an important component of providing financial risk protection to the non-formal and rural segments of the population. The government intends to engage existing CBHI schemes and incorporate them into RAMU as part of an umbrella structure.

Most CBHI schemes cover curative and antenatal care at the commune level, at community health centers. Additionally, the majority of CBHI schemes cover 70-75% of the costs of generic essential medicines, according to HFG's in-country research.

HFG research indicates that family planning commodities and services are not currently covered under CBHI schemes.

2.3.4 Private health insurance

Private health insurance penetration in Benin is low, at some 5.4%; coverage is concentrated among urban, formal sector households. With the exception of NGOs and development partners, employer-sponsored insurance is largely absent in Benin. At present, five private insurance companies offer voluntary private health insurance products focused on curative services. In addition, among the twelve main promoters of CBHI schemes (see the "Community-Based Health Insurance" section above), some promoters also offer small-scale, private health insurance schemes to the informal sector. Private health insurance schemes are regulated by ANAM.

Family planning is not covered by private health insurance products.

2.3.5 Household out-of-pocket spending

Household out-of-pocket spending comprises nearly half of all health expenditure in Benin, at approximately 42% (Ministry of Health 2013). This high level of out-of-pocket spending suggests that most Beninese citizens lack adequate financial protection for health care costs. As more Beninese citizens gain access to and enroll in financial protection mechanisms such as health insurance, household spending will likely shift from out-of-pocket spending to regular premium payments to risk-pooling schemes offered by the government, employers, the community, or private insurers.

2.4 Progress Toward Universal Health Coverage and Universal Access to Family Planning

The government of Benin is focused on the development and tri-phase implementation of its social health insurance scheme, RAMU. In the PNDS, the government envisions RAMU as an umbrella structure overseeing public and private health insurance schemes as well as initiatives that specifically enhance medical assistance to the poor and vulnerable—for example, pregnant women and high-cost prevalent disease states. Because the RAMU structure necessitates national oversight of regions, health zones, and *communes* to coordinate operations and financing, the government sees RAMU implementation as a mechanism for promoting improvements to integration, governance, partnership, and management of resources across the health system.

The government is also employing strategies to increase efficiency across the existent health financing landscape by mobilizing domestic resources for health, strengthening and collaborating with the private sector, and providing additional supports to CBHI schemes to provide adequate coverage and financial risk protection to rural, non-poor informal, and poor/indigent segments of the population. RAMU describes the imperative to develop CBHI schemes in particular but detailed strategies for doing so were not available at the time of HFG's analysis.

Through key stakeholder interviews, HFG learned that Benin had recently validated and disseminated its national health financing strategy for UHC, *Stratégie Nationale de Financement de la Santé pour la Couverture Universelle du Bénin 2016-2022*. The objectives of the strategy are to use health sector resources more efficiently, implement RAMU and integrate other financial protection mechanisms, and ensure equitable, sustainable, and reliable health financing overall. This reinforces the fourth strategic domain of the PNDS, which highlighted the need to improve health financing mechanisms by mobilizing domestic resources and expanding health insurance to reduce household out-of-pocket spending on health care.

In Benin, donors comprise the second largest source of health sector financing (29%) after household spending. Beyond the provision of direct-to-program and directly managed resources, Benin mobilized additional donor resources for the PNDS by joining The International Health Partnership (IHP+) in 2009. Benin also signed a country compact for donor support of the development and implementation of the PNDS operational plan, the Triennial Health Sector Development Plan. It receives support from the World Bank to assess infrastructural and economic challenges to RAMU implementation as well as European Commission support on governance, infrastructure, communications, and local development (World Health Organization 2013).

Since 2011, the Providing 4 Health Social Health Protection Network (P4H) has supported Benin's advancement toward universal health coverage. First, P4H has provided technical support and recommendations for the implementation of RAMU, including analysis of RAMU's structure, feasibility, and implementation plan. Second, P4H supported the development and validation of Benin's national health financing strategy for UHC (NHFS for UHC) (Providing for Health (P4H) 2016).

In its *Politique Nationale Sanitaire* (national health policy) the government of Benin acknowledged the importance of making family planning services affordable and accessible as well as increasing use. The government has since developed the *Plan d'Action National Budgétisé pour le Repositionnement de la Planification Familial 2014-2018 au Benin* (national action plan budgeted for repositioning family planning), which includes objectives to address demand for and access to family planning services as well as environmental factors and monitoring and coordination. Strategies include strategic communications on family planning; advocacy efforts for including family planning into health services provision at national, subnational, regional, community, and facility levels; outreach and engagement of men and youth; strategies for rural populations; and development of plans to secure and strengthen logistics and product management.

The Ministry of Health has stated the importance of including the private sector in its health financing efforts in both the PNS and PNDS. Interest was specifically expressed around public-private partnership and collaboration, regulation and contracting out of the private sector, and integrating private sector activities into UHC efforts, though specific strategies for doing so were not elaborated. In 2015, Benin established a public-private partnership platform, though information on its specific activities and functioning was not available at the time of HFG's study.

2.5 Opportunities in Health Financing

HFG's analysis of the health financial landscape in Benin revealed several areas where the government might focus efforts to develop, strengthen and expand health financing mechanisms to progress toward UHC and access to family planning.

The government has the opportunity to improve efficiency of its financial risk protection efforts by expanding the availability of health insurance schemes. Existing health financing mechanisms in Benin provide some amount of financial protection for most Beninese citizens, but the out-of-pocket spending rate of 42% demonstrates insufficient financial protection against health shocks. As seen with other countries in this report, reliance on out-of-pocket spending also presents financial access barriers to a large segment of the population given that approximately 35.2% live below the poverty line (Ministry of Health 2013); even the nominal user fees that health facilities are permitted to charge can be cost-prohibitive. As discussed previously, the major health insurance mechanisms in place at present—CBHI and private health insurance—cover only a small proportion of the population. With the July 2016 start of RAMU's implementation, the government has the opportunity to mechanize universal health coverage through national social health insurance.

The government also has opportunities to improve efforts to increase family planning access. Benin's two national family planning policy/strategy documents—*Programme National de Santé de la Reproduction 2011-2015 and the Plan d'Action National Budgétisé pour le Repositionnement de la Planning Familiale 2014-2018*—have been developed but not yet evaluated. Their evaluations could reveal prospects for harmonizing initiatives and improving efficiencies. Also, at present, there does not appear to be a policy requiring ANAM, CBHI schemes, and private insurance schemes to cover family planning services. Family planning is excluded from all existent health insurance options in Benin on the basis of being a preventative, not curative, service type. Given that existing policies and strategies highlight the need to prioritize availability, accessibility, demand, and use of family planning services, developing a policy for coverage of family planning services would facilitate effective initiatives to reduce unmet need for family planning, at 32.6% in 2011-2012. This also presents an opportunity to consider how RAMU will ensure that its planned inclusion of family planning services adequately covers the population considering it will operate through CBHI schemes, which exclude family planning.

In addition, the government may explore opportunities to identify funding needs, enhance resource mobilization, and strategize around revenue collection. For instance, in this early stage of RAMU

implementation, the government may closely assess the sufficiency and sustainability of funds allocated to RAMU. Related to this, the government has the opportunity to monitor the effectiveness of proposed innovative resource mobilization strategies, such as taxation, and continue innovating accordingly. Alongside this monitoring, the government has the opportunity to analyze whether current resource mobilization plans for an indigent health fund—a fund primarily resourced by tax revenues and formal sector premiums—will be sufficient to adequately and sustainably cover health services needed by indigent and vulnerable populations. Lastly, HFG found that CBHI schemes are able to collect only about 55% of their expected revenues from participants, suggesting the need to reinforce and supplement existing revenue collection mechanisms.

The government may seek out best practices and lessons learned in revenue collection from operational CBHI schemes. Finally, Benin has the opportunity to use its existing platform for public-private partnership to better engage the private health sector for more, and better-quality, health services accessible by the population.

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3. BURKINA FASO

3.1 Country Snapshot

USAID FROM THE AMERICAN PEOPLE
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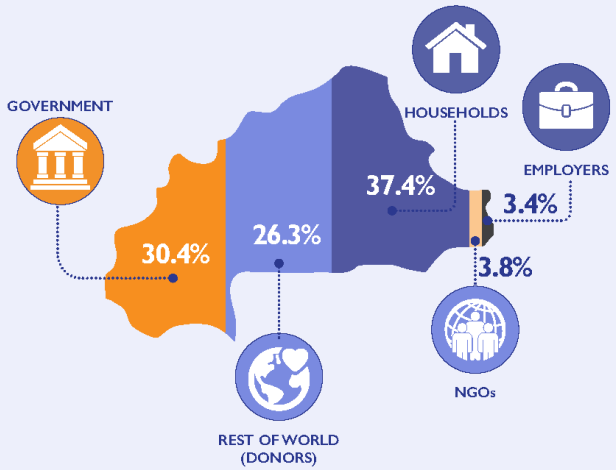
Burkina Faso

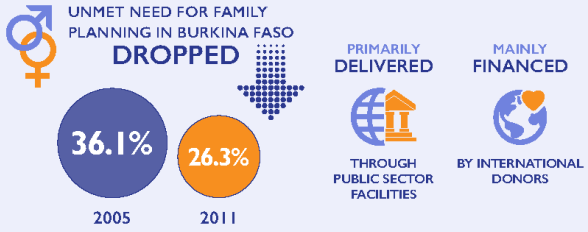
FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

Burkina Faso's Strategies for Improving Coverage of Health Services

TOTAL HEALTH SPENDING BY SOURCE



FAMILY PLANNING



KEY INDICATORS

Indicator	Value (Year)
Population	18,105,600 (2015)*
General government expenditure on health as a percentage of total government expenditure	12% (2013)**
Total health spending per capita	$41 (2013)**
Private prepaid plans as a percentage of total expenditure on health	1.5% (2013)**
Unmet need for family planning	24.5% (2010)***
Married women currently using any modern method of contraception	15% (2010)***
Married women currently using long acting reversible contraceptives (IUD, injections or implants)	9.9% (2010)***
Sexually active unmarried women currently using any modern method of contraception	59% (2010)***

* World Health Organization. Global Health Observatory. http://www.who.int/gho/en/ Accessed June 2016

** http://apps.who.int/nha/database/Select/Indicators/en Accessed July 2016.

*** ICF International. 2012. The DHS Program STATcompiler. http://www.statcompiler.com/. Accessed July 2016.

Since political tensions in 2014, plans to provide health insurance to 20% of the population in Burkina Faso have been delayed. The Ministry of Public Service Work and Social Security (MPSWSS) leads the efforts to achieve UHC and will provide a standard package of services that is 80-100% subsidized by the government. UHC will be achieved through subsidized or free health care for the general population, the National Social Security Fund (CNSS) for the formal sector (including self-employed), the Retirement Fund for Public Servants (CARFO) for active and retired government workers, and voluntary community-based health insurance (CBHI) for the rural population and informal sector. However, population coverage is still very low: CARFO covered less than 1% of the population in 2014[1] and CBHI covered approximately 2% in 2010.[2]

Fifteen percent of married women and 59% of sexually active unmarried women are currently using a modern method of contraception.[3] Three quarters of users obtain their contraceptives via public providers, primarily health centers. The 2013 Health Accounts showed 11% of reproductive health spending is financed by the government despite its goal to finance 70%.[4] Family planning services in public facilities are subsidized but not free of charge.

Challenges and Opportunities

The government has an opportunity to increase levels of financial protection in the country. A 2016 study[5] found that households have a high willingness to pool resources. This provides a significant foundation to develop CBHI schemes in response. The experience of numerous CBHI initiatives across the country provides useful lessons for expanding coverage. The government could provide subsidies to allow poor households to participate (a 46% poverty rate makes the current system unaffordable for many). Similarly, consultations with CBHI schemes, CARFO and CNSS could provide input on how to harmonize benefit packages.

1 CARFO. 2015. Annuaire Statistique. Burkina Faso
2 Ministère de la Fonction Publique du Travail et de la Security Sociale. 2014. Plan d'Opérationnalisation du Régime d'Assurance Maladie Universelle au Burkina Faso. Burkina Faso.
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4 Ministry of Health. 2010. 2009-2015 PLAN STRATEGIQUE DE SECURISATION DES PRODUITS DE LA SANTE DE LA REPRODUCTION
5 Endorsement of universal health coverage financial principles in Burkina Faso, Social Science & Medicine

Figure 3: Burkina Faso Country Snapshot

Public and Private Sector Roles in Health Financing

The public and private sectors contribute to three main health financing functions:

RESOURCE MOBILIZATION

RISK POOLING

PURCHASING

THE PUBLIC SECTOR'S ROLE IN HEALTH FINANCING

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
• General tax revenue (30.4%) • Grants or loans from development partners (26.3%) • Payroll taxes from public employers (for social health insurance)	• Free and subsidized health services available at publicly owned health facilities • CNSS pools risk for formal sector workers • CARFO pools risk for active and retired government workers	• The government purchases services at public facilities through these mechanisms: » User fee exemptions / subsidies for some essential services » User fee waivers for all services for indigent households » Results-based financing (pilots)

THE PRIVATE SECTOR'S ROLE IN HEALTH FINANCING

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
• Household payments for premiums and co-payments for community-based health insurance, and out-of-pocket payments (35% of THE) • Employer contributions to CNSS and private health insurance on behalf of employees	• Community-based health insurance schemes and private health insurers pool risk at the scheme level, although penetration in Burkina Faso is low; these two mechanisms amounted to less than 1.5% of total health spending in 2013	• Households are the main purchasers of health services in Burkina Faso » 6% of family planning spending comes from private sources (households OOP, employers and NGOs) • Community-based health insurance schemes purchase services on behalf of enrollees and reimburse providers on a fee-for-service basis. Capitation payments have been piloted in Nouna district.

Health Financing Mechanisms by Population Segment

Health financing mechanisms available to population segments will vary:

PUBLIC SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Publicly-financed health services	✓	✓	✓
Mandatory social health insurance	✓		

PRIVATE SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Voluntary community-based health insurance		✓	✓
Voluntary private health insurance	✓		
Out-of-pocket spending	✓	✓	✓

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Abt

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Health financing is a core building block of a health system and a key enabler of progress toward universal health coverage and universal access to family planning. Governments often use a plurality of health financing mechanisms to advance toward universal health coverage. In Chapter 1, we presented trends across the health financing landscape across fifteen countries in multiple regions and drew lessons that may be applicable in Burkina Faso and other West African countries. This chapter describes the health financing landscape in Burkina Faso and identifies opportunities where the government and other stakeholders can develop, strengthen, and expand their health financing mechanisms to progress toward universal health coverage and access to family planning.

Health financing specialists from USAID's Health Finance and Governance project collected the information presented below. HFG performed desk research and in-country data collection (key stakeholder interviews, policy and planning document collection) to map public and private health financing mechanisms in the country and identify potential opportunities where the government might expand population, service, or financial coverage for health and family planning services.

Burkina Faso's National Assembly adopted a law in September 2015 that provides a legal framework for implementing universal health insurance. The law introduces an equitable contributory financing system where members pay according to their ability and receive benefits based on their health status. The indigent and poor will be fully subsidized by the state. A third-party payer (potentially the Universal Health Insurance Management Agency) will purchase services from the formal sector and the informal sector on behalf of all citizens. A universal health insurance technical secretariat (*secrétariat technique de l'assurance maladie universelle*, ST-AMU) in the Ministry of Public Service Work and Social Security (MPSWSS) will implement this law.

Burkina Faso aims to achieve UHC by 2025 (*L'Économiste du Faso* 2016). A 2015-2017 roadmap has been developed by MPSWSS that aims to enroll 20% of the population in CBHI by 2017. In Burkina Faso, UHC has been defined to include:

- A package of services that covers primary, secondary, and tertiary care that is 80-100% subsidized by the government (exclusions include eyewear, chronic illnesses, and any care already provided through other government programs)
- Full subsidy for indigent people and partial subsidy for informal and rural populations

In the first phase, Burkina Faso will implement pilots in four zones to cover 10% of the rural and informal sector and 85% of the formal sector populations by 2017.

Burkina Faso currently has three financing mechanisms that eventually will be combined into a single risk pool to improve efficiency and risk transfer: government-financed health services, the National Social Security Fund (*Caisse Nationale de Sécurité Sociale,* CNSS) for the formal sector, and CBHI for the informal sector.

3.3 Burkina Faso's Health Financing Landscape

3.3.1 Government-financed health services

The government finances services in public health facilities via traditional input-based budgeting. The local authorities also contribute funds for health services. Resource mobilization at the local level is expected to increase as decentralization proceeds. Some services are completely free: malaria treatment including insecticide-treated bed nets for children younger than age 5 and pregnant women; pre-natal consultations; treatment for diarrhea, acute respiratory infections, and neonatal infections; vaccination of

children under age 5; vitamin A supplementation; treatment for tuberculosis, leprosy, lymphatic filariasis, and guinea worm; and provision of anti-retroviral drugs. For all other services, including those for family planning, the government subsidizes part of the cost and patients pay user fees to cover the rest.

Burkina Faso is piloting performance-based payments through the support of US $38 million from the World Bank (until 2018). As part of the same program, on the demand side, community-based targeting and health insurance are also being piloted; the poor will be offered a package of free services and free enrollment into a CBHI scheme.

3.3.2 National Social Security Fund

The National Social Security Fund (*Caisse Nationale de Sécurité Sociale*, CNSS) was established by law in 1972. The CNSS finances health care for work-related accidents and family care for public and private sector employees, apprentices, and vocational students. In 2012, more than 58,000 employers covering 283,479 employees were registered with the Fund (*Caisse Nationale de Sécurité Sociale* 2013). Health services for work-related accidents that are covered include emergency care (paid by employer), medical consultations, laboratory tests, drugs and medical goods, orthopedic equipment and prosthetics, rehabilitative treatment, and medical transportation. In addition, the CNSS provides a package of "family care" services for members and dependents. Female members are entitled to three pre-natal consultations, one post-natal consultation (which covers family planning consultation and prescription for contraceptives), tetanus vaccine, and any pregnancy-related treatment. Members' children also receive free vaccinations.

The CNSS spent more than FCFA 117 million (US $201,000) on curative care for work-related accidents in 2012 and approximately FCFA 163 million (US $279,000) for drugs and other medical goods (*Caisse Nationale de Sécurité Sociale* 2013). The CNSS purchases services from its own network of health facilities in all five regions (Ougadogou, Bobo-Dioulasso, Nord, Fada N'Gourma, and Dedougou).

3.3.3 Community-based health insurance

Historically, CBHI in Burkina Faso was established for specific sectors; separate CBHI existed for tax authority staff, the army, the customs authority, the National Telecommunications Office, and the National Society of Electricity of Burkina Faso. Not all of these CBHI schemes have generated the expected enrollment, although that for the army, *Mutuelle des Forces armées nationales*, established in 2006, is considered successful.

Association Songui Manégré / Aide au Développement Endogène is a local non-governmental organization established in 1996 that provides technical support to forty-nine CBHI schemes and three regional unions (Ziniaré, Ouaga et Dédougou). Since 2014, ASMADE has been piloting a CBHI scheme in Kossi and Banwa Provinces via a World Bank–funded FCFA 5 million (US $86,000) project. The pilot has created seventeen CBHI schemes that cover 400,000 members (World Bank et al. 2016). Any member of the community, including formal sector workers, is eligible to join. Premiums and co-payments for the indigent population are fully subsidized by the World Bank in this pilot.

The package of benefits includes curative consultations, ambulatory care, hospitalization (up to 15 days), and surgery. Family planning and treatment of non-communicable and infectious diseases already are subsidized by the government. Laboratory and radiology tests at hospitals and vision care are excluded. Private health facilities do not participate in the pilot. Co-payments are made for the following: 30% of costs at health centers, 10% of costs at regional hospitals, costs for days in the hospital that exceed 15 days, and curative consultations (though the first three are exempt). The pilot incorporates a performance-based provider payment mechanism in one district, Nouna (Kossi Province); elsewhere, the pilot pays health providers on a fee-for-service basis.

Since 2006, a CBHI support network, *Reseau d'Appui aux Mutuelles de Santé*, has supported an additional thirty-five CBHI schemes across the country. Two Belgian organizations—*Mutualité Chrétienne de Liège* (Christian *Mutuelle* of Liège) and *l'Alliance Nationale des Mutualités Chrétiennes de Belgique* (National Alliance of Christian *Mutuelles* Belgium)—provide technical assistance to the network.

A 2012 study on the equity impact of community-based health insurance in Burkina Faso found that "CBHI was ineffective at removing the distance barrier towards health care utilization. Even with CBHI, individuals living far from health facilities were less likely to utilize health care. Distance is crucial because many poorer households are clustered in remote areas that lack adequate health infrastructure" (Parmar et al. 2012). Covering the financial costs of health services may not be sufficient for the rural and poor populations to attain equitable access to health services. Population coverage of CBHI will increase if the benefit package is attractive and responds to the population needs; CBHI will require careful design and regular updates to remain responsive to needs.

3.3.4 Private health insurance

Revenues for the non-life insurance market in Burkina Faso grew by more than 10% in 2013. Although at least 41% of non-life insurance revenue is for accident insurance (APSAB 2013), it is unclear what proportion of this market is health insurance. Non-life insurance was provided through eight insurance companies, fifty-one agents, and seventeen brokers in 2013 (APSAB 2013). Private health insurance companies target the formal sector and wealthier households, but because this market is limited in size, they have begun to target the informal sector with more-affordable products.

Some employers are mandated by law to purchase private health insurance for their workers. Generally, 80% of the premium is covered by the employer and 20% by the employee. Private health insurance is regulated by the Ministry of Finance and the professional association of private insurers (*Association Professionnelle des Societés d'Assurances du Burkina Faso*). More than FCFA 5 million (US $9,000) was paid out by insurance firms for claims expenses through health insurance in 2013.

3.3.5 Household out-of-pocket spending

Out-of-pocket spending by households for health care is the largest source of private financing, representing 35% of total health spending in 2013 (Ministry of Health 2015).

3.4 Progress Toward Universal Health Coverage and Universal Access to Family Planning

Burkina Faso is using free or near-free services in government facilities and CBHI to provide financial risk protection to the majority of the population. How these schemes will be financed and be financially sustainable is unclear, as there currently is no publicly available health financing strategy. The ST-AMU has estimated the cost of achieving UHC (Figure 4), which highlights a growing financing gap. This estimate assumes full premium subsidies for the indigent population; partial subsidies for rural and informal populations; and 50% population coverage through a type of financial protection mechanism by 2020.

The level of risk pooling is still very low in Burkina Faso (1.5% of total health spending in 2013 was through private pre-paid mechanisms). Health financing remains fragmented, with little cross-subsidization among the risk-pooling schemes mentioned above; that is, each CBHI scheme operates independently. The 2011 Demographic and Health Survey showed that only 0.5% of women and 1.5% of men were covered by health insurance in 2010 (INSD and ICF International 2012).

Burkina Faso's 2013-2015 National Family Planning Stimulus Plan (Ministry of Health 2013) will cost US $28 million. In 2013, some 83% of family planning spending was financed by donors, and the

2009-2015 Strategic Plan for Reproductive Health Product Security aims to reduce this to 30% by 2015 (Ministry of Health 2009). The government has maintained its budget line for contraceptives (approximately US $1 million) since 2008, although some products such as the female condom are still fully financed by donors (via social marketing) and households. The government will continue to provide family planning consultations free and subsidize contraceptives. The 2013-2015 plan places more emphasis on partnering with the private sector. It aims for 50% provision through public facilities, 6% through private facilities, 19% through community-based distribution, and 25% through mobile units.

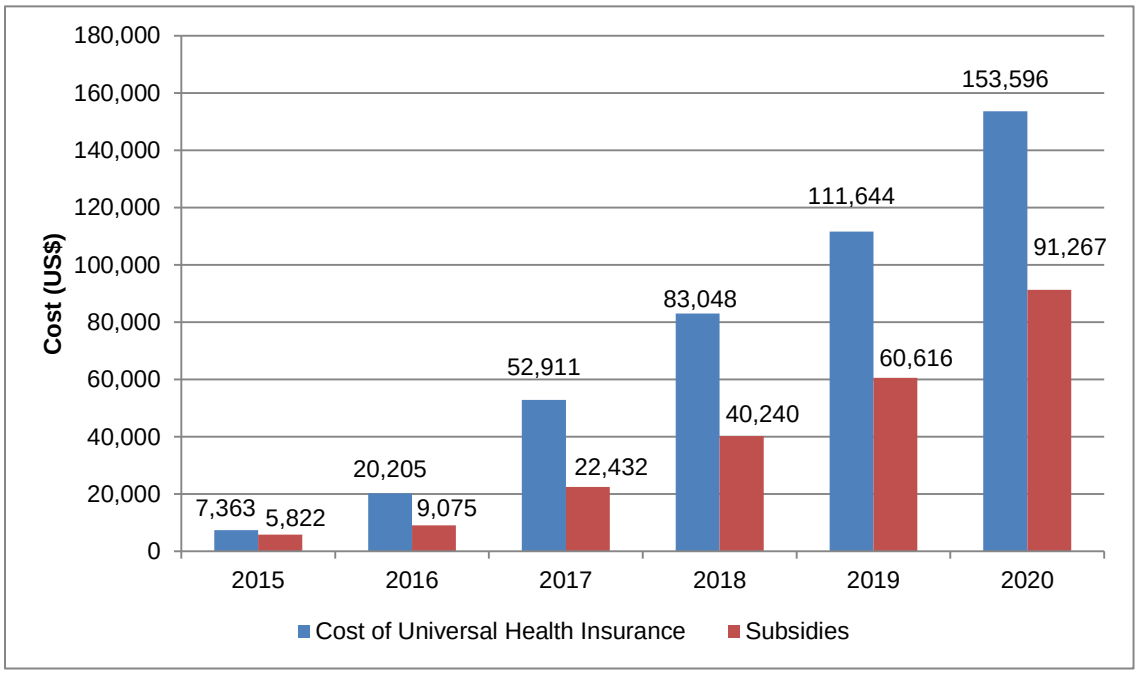
3.5 Opportunities in Health Financing

Burkina Faso has acquired experience through pilots for CBHI and pilots that reimburse facilities based on performance. The end of the CBHI pilot in 2017 will provide a unique opportunity to take stock of what has and has not worked well in order to increase enrollment of CBHI. For example, existing "regional groups" of CBHI schemes, which currently seem to serve mostly an administrative purpose, could be integrated to increase the size of the CBHI risk pools. Benefit packages provided by CBHI should take into consideration the existing free or near-free services already provided by government facilities, to protect households from costlier health incidents or other financial barriers such as transport.

The financial gap highlighted by the ST-AMU (Figure 4) provides an opportunity for the government to clearly outline the mechanisms it will use to cover this gap. This includes how to

- finance subsidies for the large proportion of the population who cannot afford the premiums for pre-paid schemes (approximately 46% of the population is below the poverty line) (Zida, Ki-Ouédraogo, and Kouyaté 2012); and
- increase domestic resources for health; for example, contributions to health services by employers for their workers through a national insurance scheme or private health insurance (over and above social security).

Figure 4: Burkina Faso's Cost of Providing 50% of Population Access to Health Services with Financial Risk Protection



Source: ST-AMU 2015. Note: Exchange rate as of September 26, 2016.

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4. CAMEROON

4.1 Country Snapshot

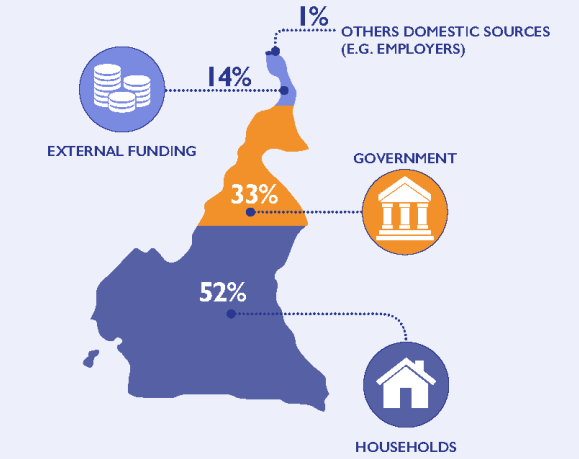
USAID FROM THE AMERICAN PEOPLE | Health Finance & Governance — Expanding Access. Improving Health.

FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

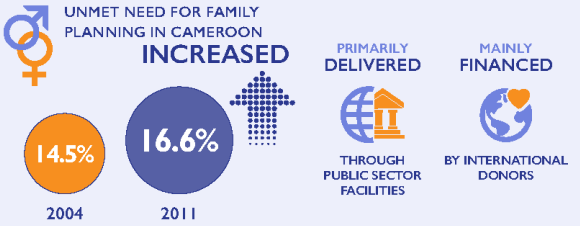
Cameroon

Cameroon's Strategies for Improving Coverage of Health Services

TOTAL HEALTH SPENDING BY SOURCE



FAMILY PLANNING



KEY INDICATORS

Indicator	Value (Year)
Population	23,344,200 (2015)*
General government expenditure on health as a percentage of total government expenditure	6% (2011)**
Total current health spending per capita	US$47 (2011)**
Private prepaid plans as a percentage of total expenditure on health	Not available
Unmet need for family planning	17% (2011)***
Married women currently using any modern method of contraception	14.4% (2011)***
Married women currently using long acting reversible contraceptives (IUD, injections or implants)	3.9% (2011)***
Sexually active unmarried women currently using any modern method of contraception	48% (2011)***

* World Health Organization. Global Health Observatory. http://www.who.int/gho/en. Accessed June 2016.

** http://apps.who.int/nha/database/Select/Indicators/en Accessed July 2016

*** Institut National de la Statistique (INS) et ICF International. 2012. Enquête Démographique et de Santé et à ndicateurs Multiples du Cameroun 2011. Calverton, Maryland, USA : INS et ICF International

Cameroon's primary strategy for achieving UHC is through community-based health insurance for the informal sector, which accounts for 40% of those living below the poverty line. In 2009, population coverage of community-based health insurance was 1.30%.[1] The 2011-15 National Health Development Plan aims to achieve 40% coverage by 2015 by setting up one community-based health insurance scheme in every district.[2] The government also provides subsidized health care to the indigent, free care to pregnant women through a voucher scheme, and free malaria treatment for children under five. A Ministry of Health Steering Committee is developing a road map for UHC. The road map will define the benefit package and establish a health financing strategy. Private health insurance in Cameroon is limited to a small number of wealthier households. There are 16 registered insurance companies that provide private health insurance; their annual premium for a four-member household is approximately USD 780, compared to USD 24 for community-based health insurance.[3] Several public-private partnerships exist in Cameroon, such as the Employers Group of Cameroon (GICAM) that joined forces with the Ministry of Health to establish a fund for anti-retroviral drugs. In 2011, 24 percent of women of reproductive age used a contraceptive method, half of which were obtained through a health facility and half through retailers, friends or relatives.[4] The private sector is active in the provision of contraceptives including through social marketing; it provides contraceptives to 27% of users.[5]

Challenges and Opportunities

Population coverage for community-based health insurance is very low and well below government targets. This is partly due to unaffordable premiums and lack of flexible payment schedules. There is mistrust of community-based health insurance schemes, and the general population widely considers insurance a product for the wealthy. Cameroon has an opportunity to bolster schemes to improve the value they offer to communities.

1 EPOS/ Service d'Appui aux Initiatives Locales de Développement. 2009. Etude diagnostique et cartographique des MS au Cameroun.
2 Ministry of Public Health. 2011. 2011-15 National Development Plan. Cameroon.
3 http://cameroon.thebeehive.org/content/22/1869. Accessed June 2016
4 Institut National de la Statistique (INS) et ICF International. 2012. Enquête Démographique et de Santé et à Indicateurs Multiples du Cameroun 2011. Calverton, Maryland, USA
5 Ibid.

Figure 5: Cameroon County Snapshot

Public and Private Sector Roles in Health Financing

The public and private sectors contribute to three main health financing functions:

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
THE PUBLIC SECTOR'S ROLE IN HEALTH FINANCING		
• General tax revenue (33% of THE) • Grants or loans from development partners (14% of THE)	• Health services available at public health facilities • Community-based health insurance schemes pool risks at the scheme level	• The government purchases these services for the population at public health facilities: • Central, regional and district governments pay for services through these mechanisms: » Partially subsidized care for the general population » Fully subsidized care for the indigent and pregnant women » Malaria treatment for children under 5 • The government is scaling up performance-based financing nationally (funded by the World Bank and Global Financing Facility)
THE PRIVATE SECTOR'S ROLE IN HEALTH FINANCING		
• Household out-of-pocket payments (51.4% of THE) • Household voluntary prepaid contributions (0.74% of THE)	• Private voluntary insurance schemes pool risk at the scheme level, although population coverage in Cameroon is low due to lack of affordability	• Households are the main private purchasers of health services

Health Financing Mechanisms by Population Segment

Health financing mechanisms available to population segments will vary:

PUBLIC SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Publicly-financed health services	✓	✓	✓
Voluntary community-based health insurance		✓	✓

PRIVATE SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Voluntary private health insurance	✓		
Out-of-pocket spending	✓	✓	✓

ABOUT THE SERIES

This country snapshot is one in a series of 15 produced by the Health Finance & Governance Project. The snapshots capture information on public and private financing programs for family planning and health services that support country plans to reach universal health coverage. View the series and a summary report at: www.hfgproject.org.

4.2 Background

Health financing is a core building block of a health system and a key enabler of progress toward universal health coverage and universal access to family planning. Governments often use a plurality of health financing mechanisms to advance toward universal health coverage. In Chapter 1, we presented trends across the health financing landscape across fifteen countries in multiple regions and drew lessons that may be applicable in Cameroon and other West African countries. This chapter describes the health financing landscape in Cameroon and identifies opportunities where the government and other stakeholders can develop, strengthen, and expand their health financing mechanisms to progress toward universal health coverage and access to family planning.

Health financing specialists from USAID's Health Finance and Governance project collected the information presented below. HFG performed desk research and in-country data collection (key stakeholder interviews, policy and planning document collection) to map public and private health financing mechanisms in the country and identify potential opportunities where the government might expand population, service, or financial coverage for health and family planning services.

Official policy documents from Cameroon that are currently available do not explicitly mention UHC as a goal. Since 2015, the government and donors have been working together to develop an official UHC strategy. A team of donors and government representatives is working on simplifying and merging a number of existing financial protection mechanisms so that this strategy can be operational in 2016 (Nchewnang-Ngassa 2015). Key informant interviews suggest that a steering committee led by the Ministry of Health is also finalizing a UHC action plan that includes the development of a health financing strategy, development of an institutional framework for UHC, definition of a benefit package for UHC, and clarification of the role of CBHI. The government's primary strategy for achieving UHC is through CBHI, since this can help provide financial risk protection to the biggest population groups (rural and informal sectors).

4.3 Cameroon's Health Financing Landscape

In Cameroon, the financing mechanisms that provide access to health services are government-subsidized services, the Social Assistance Scheme (*Régime d'Assistance Social*), social security, CBHI, private health insurance, and household out-of-pocket payments.

4.3.1 Government-financed health services

The Ministry of Health provides subsidized health services via a network of health centers and district and national hospitals. In May 2016, Cameroon received US $100 million from the World Bank and US $27 million from the Global Financing Facility (GFF) to improve reproductive, maternal, neonatal child, and adolescent health services (World Bank 2016a). Cameroon's GFF investment case supports family planning services that are part of the Strategic Plan for the National Multi-Sectoral Program for Combating Maternal, Newborn & Child Mortality in Cameroon (2014-2020).

Broadly, the GFF investment case will support "innovative high impact interventions, such as (i) a development impact bond to attract private financing to make increased resources available immediately to scale up Kangaroo Mother Care; (ii) cash transfers to support adolescent girls; (iii) results-based financing to enhance girls' education; and (iv) initiatives focused on strengthening community health structures" (GFF 2016). Cameroon has been piloting payments to providers based on pre-defined indicators of performance related to increasing access to, and improving quality of, maternal and child health services. This initiative is expected to be gradually extended to all regions in the country by 2021.

The *Deutsche Gesellschaft für Internationale Zusammenarbeit* (GIZ) is also helping to strengthen provision of family planning services in public facilities (GIZ n.d.).

4.3.2 *Régime d'Assistance Social* for vulnerable populations

The *Régime d'Assistance Social* provides full subsidies for vulnerable populations (e.g., the poor and orphans and vulnerable children) receiving care in government facilities. The scheme is funded by the Ministry of Social Affairs, which since 2010 has transferred funds to the local authorities (*Collectivités Territoriales Décentralisées*) to pay providers for health services on behalf of the indigent population. Services covered include surgeries, prescriptions, and medical evacuations.

4.3.3 Social Security *(Caisse National de Prévoyance Sociale)*

Caisse National de Prévoyance Sociale (CNPS) is obligatory for formal sector workers, civil servants, and their dependents. Premiums are paid in full by employers. CNPS covers work-related accidents (curative care, prosthetics and orthopedic care, transport) and a basic package of maternal health services (prenatal consultations, delivery, infant consultations until 6 months). Care is provided for free at CNPS's four facilities, but care through other health facilities is also reimbursed.

Many employer contributions to CNPS are overdue. In 2016, CNPS was owed nearly US $100 million in premium contributions (*Actu Cameroun* 2016). Between October and December 2016, CNPS has been cracking down on arrears from state, parastatal, and private companies.

4.3.4 Community-based health insurance

As of 2010, there were reportedly 158 CBHI schemes covering 251,062 beneficiaries, representing 1.3% of the population (PROMUSCAM 2010). A 2006-2015 Strategy for Promotion and Development of CBHI was developed and aims to establish: a minimum benefit package for universal coverage; a National Center for the Promotion of CBHI that will support a network of provincial centers; a steering committee for the strategic plan that includes the Ministries of Public Health, Labor, Finance, and Social Affairs and other partners; and a legal code and text for CBHI.

In general, the government does not subsidize premiums for CBHI, although in some *communes* (Kumbo and Bamenda) the local authorities have subsidized premiums for the indigent population. Members must pay co-pays at the time of care of up to 25% of the cost of care. The remainder is covered by the CBHI, with pre-defined limits for consultations, hospitalizations, deliveries, and surgeries.

The CBHI Technical Support Cell (*Cellule d'Appui aux Mutuelles de Santé,* CAMS) was established by the Ministry of Health in 2001 and is responsible for defining the strategy to support CBHI, maintaining a national directory of the CBHI schemes, and helping CBHI to negotiate contracts with health facilities. *Plateforme des Promoteurs des Mutuelles de Santé au Cameroun*, which promotes CBHI, was created in 2006 to provide technical support to CBHI schemes (e.g., facilitating information exchange, training) and to promote CBHI nationwide.

Other challenges to increasing the population coverage of CBHI include lack of flexible payment schedules, mistrust of CBHI and institutions that manage health insurance in general, and lack of capacity of staff who manage CBHI. There is a real need to increase demand for CBHI by promoting its benefits. Insurance is still seen as a product for the rich, and understanding of how insurance can help is lacking. Many question the value of making regular premium payments for a health episode that may never occur versus paying out later if and when it does occur. They may view their social networks as an adequate safety net, preferable to insurance.

CBHI schemes contract with public and private health providers. Development partners such as the World Bank, GIZ, and the African Development Bank have supported CBHI, by funding initial training, feasibility studies, operational costs, supervision, and monitoring and evaluation. Key informant interviews highlighted that a 2011 evaluation by GIZ found that CBHI schemes it supported were not financially viable. Following restructuring of CBHI, results have been more positive and the schemes were extended to other *communes* such as Boyo and Bamenda.

4.3.5 Private health insurance

There were 190,408 health insurance policy holders in 2014, representing less than 1% of the population (Ministry of Public Health 2016). Family planning is excluded from the benefit package. Private insurance is affordable for the wealthiest; average annual premiums cost FCFA 155,000 (US $265) per adult, versus average annual premiums for CBHI of FCFA 15,000 (US $26) for a family of four. Most private health insurance is purchased by private employers, on behalf of employees. In general, members must pay co-pays at the time of care of up to 25% of the cost of care.

In 2012, sixteen companies provided health insurance products. Health insurance accounted for 25% of total insurance revenue in Cameroon in 2012. Private health insurance companies are overseen by the Ministry of Finance and regulated by the Inter-African Conference on Insurance Markets.

4.3.6 Household out-of-pocket

Households are the biggest contributor to health financing, with out-of-pocket spending representing 52% of total health spending.

4.4 Progress Toward Universal Health Coverage and Universal Access to Family Planning

The government of Cameroon is expanding CBHI to provide health services to rural and informal sector households. The 2011-2015 National Health Development Plan aimed to increase the population coverage of CBHI to 40% by 2015, by creating at least one CBHI scheme in every district. CBHI is seen as a key mechanism to provide financial risk protection to the informal sector, which accounts for more than 80% of the employed population (and 40% of the population who live below the poverty line; Nkoa and Zogo n.d.). This compares with less than 2% of the population who were covered by a financial risk protection scheme in 2010 (PROMUSCAM 2010).

The health sector in Cameroon benefits from several public-private partnerships between the Ministry of Public Health and companies in sectors such as telecommunications, extractive industries, and insurance. To increase private sector financing for health care, the Employers' Group of Cameroon signed a public-private partnership with the Ministry of Public Health to establish a fund for anti-retroviral drugs. This fund will be used to procure drugs from vetted suppliers (Brunner et al. 2014).

In family planning, ProFam is a network of more than 100 private and faith-based clinics that use social franchising to provide family planning services. Clinics are admitted to PROFAM after verification that they provide quality services and employ qualified personnel and agree to undergo regular control and supervision. The PROFAM network conducts regular social mobilization campaigns toward targeted populations using social marketing techniques. The Cameroon National Association for Family Welfare (CAMNAFAW), an International Planned Parenthood Foundation (IPPF) affiliate, also provides family planning and reproductive health services in its network of private clinics and conducts social mobilization campaigns. IPPF typically supplies CAMNAFAW with family planning commodities, and the United Nations Population Fund has provided supplies during stock outages (Brunner et al. 2014).

The 2015-2020 National Family Planning Action Plan calls for a framework for cooperation with the private sector so that more private facilities can offer family planning services. The government would like to increase social franchises by 100 for each year of the plan. Tariffs for contraceptives were set by the government in August 2014; patients typically pay for the consultation and enjoy subsidized prices for commodities. But these subsidies are not being applied in all facilities, creating a financial barrier for adolescents. It is unclear whether and how family planning services will be incorporated into the benefit package for CBHI going forward. By 2021, the government is expected to support 50% of total family planning needs (World Bank 2016b).

4.5 Opportunities in Health Financing

Premiums for CBHI still remain unaffordable for the poorest. If population coverage for CBHI is to increase, many people will require partial, if not full, subsidies. The upcoming health financing strategy will need to respond to this challenge. Coalition 15%, a civil society organization, has called for a 0.3% tax on all government revenues that would be earmarked for universal health coverage. Integrating existing mechanisms into one risk pool could help the financial sustainability of these schemes by reallocating resources from population groups who use fewer health services to those who need them more.

As CBHI scales up, it is important to clearly outline the operational aspects. This includes understanding utilization patterns and costs of health services in order to calculate tariffs that are financially sustainable; collecting regular premiums from people such as agricultural workers who do not have a regular salary (e.g., through health savings accounts); using biometric identification cards to prevent fraud; and providing health facilities with the legal authority to sign contracts with CBHI schemes (Ministry of Public Health 2016). Strengthening umbrella organizations such as CAMS and *Plateforme des Promoteurs des Mutuelles de Santé au Cameroun* to provide technical—and financial—support will also help.

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5. GUINEA

5.1 Country Snapshot

USAID FROM THE AMERICAN PEOPLE
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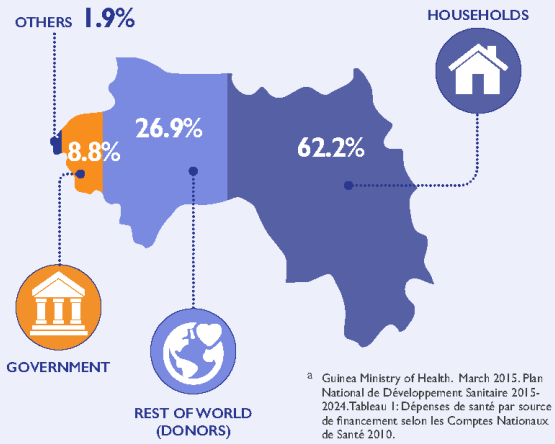
Expanding Access. Improving Health.

FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

Guinea

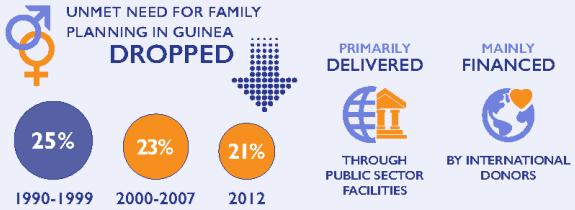
Guinea's Strategies for Improving Coverage of Health Services

TOTAL HEALTH SPENDING BY SOURCE[a]



[a] Guinea Ministry of Health. March 2015. Plan National de Développement Sanitaire 2015-2024.Tableau 1: Dépenses de santé par source de financement selon les Comptes Nationaux de Santé 2010.

FAMILY PLANNING



KEY INDICATORS

Indicator	Value (Year)
Population	12,608,600
General government expenditure on health as a percentage of total government expenditure	(2015)*
Total health spending per capita	6.77% (2012)**
Private prepaid plans as a percentage of total expenditure on health	US$68 (2014)*
Unmet need for family planning	Not available
Married women currently using any modern method of contraception	23.7% (2012)**
Married women currently using long acting reversible contraceptives (IUD, injections or implants)	4.6% (2012)**
Current use of any modern method of contraception (sexually active unmarried women)	1.6% (2012)**

* World Health Organization. Global Health Observatory. http://www.who.int/gho/en. Accessed June 2016.

** ICF International. 2012.The DHS Program STATcompiler. http://www.statcompiler.com. Accessed July 2016.

Guinea's universal health coverage (UHC) strategy is described in its *Plan National de Développement Sanitaire 2015-2024 (PNDS)* and its national health financing strategy for UHC.The PNDS illustrates Guinea's commitment to technical monitoring, piloting, and implementation of UHC programs.[1] The national health financing strategy for UHC presents high-level objectives of improving quality and access to health services, reducing financial risk, and reducing risks that impact health in order to achieve UHC.[2] Community-based health insurance schemes, at present, cover just 0.5% of the population. The government seeks private sector engagement to improve population health, particularly in urban areas outside of Conakry. The majority (62.2%) of total health spending is private as household out-of-pocket spending. Private health insurers primarily cover formal sector workers and expatriates.

The government recognizes the importance of family planning, establishing a 2014-2018 plan to increase demand, availability, use, monitoring and coordination of family planning services.[3] Unmet need for family planning in Guinea has fluctuated, averaging 25% from 1990-1999, 21% from 2000-2007 and 23.7% as of 2012.[4] Family planning commodities are financed primarily by international donors.

Challenges and Opportunities

Guinea faces significant health system challenges following the Ebola epidemic. It has limited capacity to mobilize domestic resources with estimates of general government expenditure on health between 2.3% and 6.77%[5,6]. Further, approximately 60% of health care spending is concentrated in urban areas, highlighting potential challenges with resource distribution and access to care in rural areas. Finally, private sector engagement is largely nonexistent. The PNDS sets aggressive targets for incrementally increasing contraceptive prevalence from 19% in 2015 to 51% in 2024. Priority actions for achieving these targets, such as implementing an integrated package of services at the community level and providing public and private structures with management tools, could benefit the entire health sector.

1 Guinea Ministry of Health. March 2015. Plan National de Développement Sanitaire 2015-2024.
2 Guinea Ministry of Health and Public Hygiene. 2016. Stratégie Nationale de Financement de la Santé vers la CSU.
3 Guinea Ministry of Health and Public Hygiene, National Directorate of Family Health and Nutrition. 2013.
4 World Health Organization. African Health Observatory. Profil Analytique Complète: Guinée, 2014. http://www.aho.afro.who.int/profiles_information/index.php/Guinea:Index. Accessed July 2016.
5 International Monetary Fund. July 2013. Guinée: Stratégie de réduction de la pauvreté.
6 World Health Organization. African Health Observatory. Guinea Factsheet, 2014.

Figure 6: Guinea Country Snapshot

Public and Private Sector Roles in Health Financing

The public and private sectors contribute to three main health financing functions:

RESOURCE MOBILIZATION

RISK POOLING

PURCHASING

THE PUBLIC SECTOR'S ROLE IN HEALTH FINANCING

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
• General tax revenue (note that tax revenues are quite small given the limited ability of much of the population to pay taxes) • Grants or loans from development partners (26.9% of THE)	• Health services available at public health facilities and from community health workers • Community-based health insurance schemes pool risk at district level • Social health insurance will pool risk of all formal sector employees and their families at national level	• Central, regional and district governments purchase services provided at publicly owned health facilities and by salaried community health workers • Central, regional and district governments pay for services through these mechanisms: » User fee exemptions for some essential services » User fee waivers for all services for the poorest households » Premium subsidies for community-based health insurance » Purchase of services by community-based health insurance schemes on behalf of enrollees » Purchase of services by social health insurance scheme on behalf of enrollees (scheduled to start in 2016)

THE PRIVATE SECTOR'S ROLE IN HEALTH FINANCING

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
• Household out-of-pocket payments (37.7% of THE) • Household voluntary prepaid contributions (marginal amount) • Payroll taxes from private sector employers will contribute to their employees' social health insurance premiums	• Private health insurance companies pool risk at the scheme level, although penetration in Ethiopia is low and only amounted to 1.25% in 2010/2011[4]	• Households are the main private sector purchasers of health services in Ethiopia

Health Financing Mechanisms by Population Segment

Health financing mechanisms available to population segments will vary:

PUBLIC SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Publicly-financed health services	✓	✓	✓
Mandatory social health insurance	✓ (the CNSS, which has an overall 23% contribution rate of which 6.5% goes to health insurance)		
Voluntary community-based health insurance	✓	✓	✓)

PRIVATE SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Voluntary private health insurance	✓	✓	
Out-of-pocket spending	✓	✓	✓

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5.2 Background

Health financing is a core building block of a health system and a key enabler of progress toward universal health coverage and universal access to family planning. Governments often use a plurality of health financing mechanisms to advance toward universal health coverage. In Chapter 1, we presented trends across the health financing landscape across fifteen countries in multiple regions and drew lessons that may be applicable in Guinea and other West African countries. This chapter describes the health financing landscape in Guinea and identifies opportunities where the government and other stakeholders can develop, strengthen, and expand their health financing mechanisms to progress toward universal health coverage and access to family planning.

Health financing specialists from USAID's Health Finance and Governance project collected the information presented below. HFG performed desk research and in-country data collection (key stakeholder interviews, policy and planning document collection) to map public and private health financing mechanisms in the country and identify potential opportunities where the government might expand population, service, or financial coverage for health and family planning services.

5.3 Guinea's Health Financing Landscape

Guinea uses five major health financing mechanisms. Each mechanism is described in more detail below.

5.3.1 Government financing for health services

Government financing for health services provides the population some degree of financial protection from health costs. According to the government of Guinea's *Plan National de Développement Sanitaire 2015-2024* (PNDS; National Health Development Plan), the state is constitutionally obliged to provide free health services to all. Fiscal constraints inhibit the state's ability to fully implement this mandate, however. Still, government financing for health services subsidizes the cost of health services at public health facilities; this represents the majority of facility-based service provision to Guineans, irrespective of income level. Guineans are thereafter subject to point-of-service user fees; government employees who access health services at public facilities are eligible for nominal reimbursement of these user fees.

The state is the main provider of health services across primary, secondary, and tertiary facilities, though approximately 60% of public health spending is concentrated in the capital and other urban areas (Ministry of Health 2013). Many services provided through public health facilities are often unavailable or are too expensive for most citizens to access through private health facilities; private health facilities, both for-profit and not-for-profit, represent a small fraction of health care provision in Guinea and are also concentrated in the greater Conakry area (World Bank and Ministry of Health 2006).

With its National Health Financing Strategy toward Universal Health Coverage (NHFS for UHC; *Stratégie nationale de financement de la santé vers la CSU*), the government aims to enhance its purchasing capacity to more adequately subsidize health care at public health facilities for the poor, who comprise slightly more than half of Guinea's population. Donor-funded performance-based financing that finances health worker salaries is currently being tested in the Mamou and Kindia regions.

Grants or loans from development partners are an important component of government financing for health services. According to the PNDS, development partner contributions made up some 26.9% of total health expenditure in Guinea as of 2010. Such financing supports the state in managing and distributing resources across the health care system. It also funds operation of public health facilities, purchase of facility and community health worker public health services, and provision of more accessible, low- or no-cost care to indigent people and vulnerable populations such as children under age 5.

In the wake of Ebola, this public financing has focused not only on direct response and recovery but also on strengthening the public health system as a whole (World Bank Group 2016).

5.3.2 Social health insurance

Mandatory social health insurance is available only to private and para-public sector employees under an obligatory pension fund that includes health insurance. This scheme, the *Caisse Nationale de Sécurité Sociale* (CNSS; National Social Security Fund), is overseen by the *Ministère des Affaires Sociales de la Promotion Féminine et de l'Enfance* (Ministry of Social Affairs for the Promotion of Women and Children). CNSS is financed through a compulsory salary contribution of 23%, comprising 18% employer and 5% employee contributions. Of this, 6.5% goes toward health insurance; the remainder goes toward family allowances and other, non-health insurances (CNSS 2016). Contributory payments are to be made monthly or quarterly by the employer to CNSS; HFG research found that contribution collection rates are low, and there is insufficient capacity to manage fraud within the CNSS system. CNSS penetration is low, at about 3%.

Information on inclusion of family planning services was inconclusive at the time of the HFG study.

5.3.3 Community-based health insurance

In Guinea, community-based health insurance schemes are overseen by a focal point within the Ministry of Health. As of 2015, some ninety-three schemes were recorded, fifty-five of which were operational. Of these, several are part of CBHI scheme networks, which promote CBHI through support from state and development partners. Benefits and contributions are constant across CBHI schemes within a CBHI scheme network. Though the number of CBHI schemes in Guinea has grown from twenty-eight in 2005 to nearly 100 in 2015, population coverage remains low at 0.5% (some 69,609 individuals) (Bah 2015).

5.3.4 Private health insurance

Private health insurance penetration is very low in Guinea (0.5% of total health expenditure). There are a total of nine private insurance companies in Guinea, though at present only four offer health insurance. Participation in private health insurance is voluntary; the majority of enrollees are employed by private sector entities and bilateral and multilateral cooperation agencies (Ministry of Health 2014).

According to the HFG's in-country research, family planning coverage is not a covered service in private health insurance policies, but including it may be negotiable.

5.3.5 Household out-of-pocket spending

Household out-of-pocket spending comprises 62.2% of total health expenditure in Guinea. This high rate of household-level expenditure signifies the high exposure to financial risks associated with accessing health services for most citizens; financial protection for health services is limited. At present, penetration of public and private health insurance schemes is very low, mainly due to unaffordability of premiums for the majority of the population given that the poverty rate is some 55.2% (Ministry of Health 2014). As efforts to enhance financial risk protection mechanisms reach more people, out-of-pocket spending may shift to regular premium payments to risk pooling schemes offered by the government, employers, the community, or private insurers.

5.4 Progress Toward Universal Health Coverage and Universal Access to Family Planning

The government's NHFS for UHC centers on achieving universal health coverage through increasing financial risk protection for the population, reducing risks that affect health, and improving the quality and distribution of health services across the country. However, to meet these objectives, the document recognizes the need to first mobilize sufficient resources. The PNDS and the *Stratégie de réduction de la pauvreté* 2013 (Poverty Reduction Strategy) both mention that less than 3% of the state budget was allocated to health. The PNDS notes that the nation's economic state, coupled with the high poverty level, is its top health system challenge. The Ministry of Health's resource mobilization strategies include enhanced inter-ministerial and external advocacy, alternative financing strategies (e.g., taxation), and better coordination within the Ministry of Health as well as with development partners. Ultimately, the Ministry of Health aims to reach the Abuja Declaration target of 15% of the nation's budget being allocated to health by 2020.

Another main strategy from the NHFS for UHC is the establishment of a mandatory health insurance scheme—*l'Assurance Maladie Obligatoire* (AMO; Compulsory Health Insurance)—to promote financial risk protection. At the time of the HFG study, the AMO was not yet functional, although its governing body, *l'Institut National d'Assurance Maladie Obligatoire* (National Institute of Compulsory Health Insurance), had been established and operating since late 2014. In establishing the AMO, the Ministry of Health plans to conduct actuarial and costing studies, define vulnerable populations and contributory financing mechanisms, and promote risk protection through risk-pooling entities such as CBHI schemes.

Other strategies from the NHFS for UHC include studying and addressing social and environmental determinants of health and establishing an entity to lead the coordination, monitoring, and evaluation of UHC efforts across sectors and government ministries.

Guinea mobilized donor resources for its UHC-oriented PNDS by subscribing to the International Health Partnership (IHP+) in 2012. The state also mobilized donor resources for the development of the NHFS for UHC, which explicitly focuses on achieving UHC. Implementation of the NHFS for UHC will further be supported by the Harmonization for Health in Africa collaborative of development partners. Lastly, donors participating in post-Ebola recovery efforts are providing resources for overall health systems strengthening.

In 2014, the government collaborated with national and international technical experts to develop the *Plan d'Action National de Repositionnement de la Planification Familiale en Guinée 2014-2018* (National Action Plan for Repositioning Family Planning in Guinea 2014-2018). Strategies to reposition and increase access to family planning include social and behavior change communications strategies; education—particularly for youth and rural populations; integrating family planning services into general and disease-specific health services; mobile health strategies; and health care provider trainings. The plan also aims to improve both monitoring and coordinating of family planning services.

Engagement with the private sector is described as nonexistent but a priority in the PNDS. The state seeks to coordinate with the private health sector on matters of resource mobilization, contracting out, health services coverage, and overall public-private partnership. At the time of the PNDS publication, the lack of public-private partnership was considered a principal problem in the state of population health (Ministry of Health 2014).

5.5 Opportunities in Health Financing

HFG's analysis of the health financial landscape in Guinea revealed several areas where the government might focus efforts to develop, strengthen, and expand health financing mechanisms to progress toward UHC and access to family planning.

The government has an opportunity to enhance financial protection for use of health services by increasing enrollment in health insurance schemes, including its mandatory social health insurance scheme, AMO, once that has been established. While CNSS, CBHI schemes, and private health insurance mechanisms do exist in Guinea, they collectively cover only about 5% of the general population; those covered are largely formal and para-public sector employees and their households.

The majority of the population, comprising informal sector and poor and vulnerable sub-populations, have few to no insurance options. Reliance on out-of-pocket spending renders health services inaccessible, as even the nominal user fees that public health facilities are allowed to charge are prohibitive. All citizens, even those covered by health insurance schemes, are exposed to financial risk through benefit exclusions and user fees (*Essentiel International*, 2016). The government is in the process of determining how to increase its budget allocation for health—approximately 3% at present—toward the Abuja target of 15% in order to implement and establish AMO.

As it plans AMO implementation, the government has a few opportunities to incorporate lessons learned from the current health financing landscape. It might determine, for instance, whether and how it will absorb, govern, and/or coordinate with the CNSS, private health insurance, and CBHI schemes. Further, the government may also have the opportunity to address fragmentation within and across these three schemes to ensure adequate financial protection irrespective of which health insurance scheme an individual enrolls in. Moreover, in anticipation of similar issues with AMO, the government has an opportunity to better understand why CNSS is contending with low contribution collection rates and barriers to increasing its fraud management capacity, especially because the government will need to identify, enroll, and collect contributions from a far larger, more difficult to reach population than the CNSS covers.

The government also has an opportunity to harmonize its policy plans around family planning, contained in two main documents: the *Plan d'Action National de Repositionnement de la Planification Familiale en Guinée 2014-2018* (National Action Plan for Repositioning Family Planning in Guinea 2014-2018), which details several strategies for improving family planning coverage, and the PNDS, which sets aggressive targets for increasing the national contraceptive prevalence rate to 51% by 2024 (it was 19% in 2015).

Lastly, the government has an opportunity to define public-private engagement initiatives and engage the private health sector in its health system reform plans.

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6. MALI

6.1 Country Snapshot

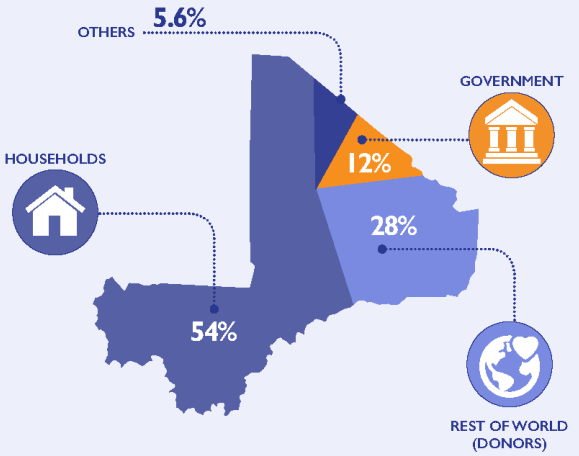
USAID FROM THE AMERICAN PEOPLE
Health Finance & Governance
Expanding Access. Improving Health.

FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

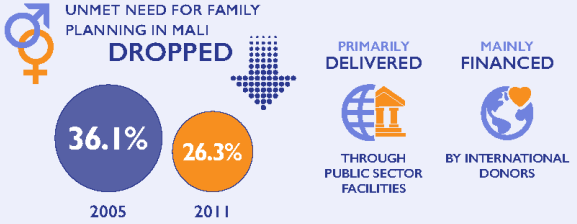
Mali

Mali's Strategies for Improving Coverage of Health Services

TOTAL HEALTH SPENDING BY SOURCE



FAMILY PLANNING



KEY INDICATORS

Indicator	Value (Year)
Population	17,599,700 (2015)*
General government expenditure on health as a percentage of total government expenditure	12.1% (2013)**
Total health spending per capita	US$36 (2013)**
Private prepaid plans as a percentage of total expenditure on health	0.2%**
Unmet need for family planning	26% (2012-13)***
Married women currently using any modern method of contraception	9.9% (2012-13)***
Married women currently using long acting reversible contraceptives (IUD, injections or implants)	6.9% (2012-13)***
Sexually active unmarried women currently using any modern method of contraception	33.5% (2012-13)***

* World Health Organization. Global Health Observatory. http://www.who.int/gho/en. Accessed June 2016

** Ministry of Health and Public Hygiene, UNFPA, WHO. 2015. 2013 Health Accounts.

*** ICF International. 2012. The DHS Program STATcompiler. http://www.statcompiler.com. Accessed August 2016.

Mali's financing strategy for UHC, in development since 2002, is three-pronged and managed by the Ministry of Social Protection. The first financing mechanism is the Obligatory Health Insurance scheme (AMO) that covers civil servants, members of Parliament and National Assembly, army, retirees, and their family members. The second is the Health Insurance Scheme (RAMED) that provides full financial protection for indigents. The government established these two schemes by law in 2009. The third mechanism, community-based health insurance, has been in place since 2002 and aims to increase financial protection for the informal sector and agricultural workers. The government provides premium subsidies for community-based health insurance to the poorest households. The 2014-23 Health and Social Development Plan (HSDP) outlines ambitious objectives to increase the population coverage of these schemes by 2023. Specifically, the HSDP targets population coverage of AMO to increase from 3.4% to 16%; RAMED to increase from 0.2% to 5%; and community-based health insurance to increase from 4.1% to 20%).[1] These three schemes are being rolled-out in the context of decentralization, where the *collectivites territoriales* will be expected to play a bigger role in managing, and raising resources for them.

Family planning will be a key consideration for the package of services provided. Mali has one of the world's highest fertility rates, at 6.1.[2] Nine and a half percent of women of reproductive age use a modern contraceptive method. Nearly three quarters of modern method users access contraceptives through the public sector, although there is poor access at the community level. Family planning spending is low, representing 0.7% of current health spending in 2013.[3]

Challenges and Opportunities

Mali faces challenges in creating awareness of the benefits of insurance to mitigate the financial risk of health shocks. The informal sector still has limited financial capacity to contribute to insurance schemes. The government is working to integrate fragmented community-based health insurance schemes, to create larger and more stable risk pools and reduce administrative costs.

1 Government of Mali. 2014-23 Decennial Plan for Health and Social Development. Mali
2 Cellule de Planification et de Statistique (CPS/SSDSPF), Institut National de la Statistique (INSTAT/MPATP), INFO-STAT et ICF International, 2014. Enquête Démographique et de Santé au Mali 2012-2013. Maryland, USA
3 Ministry of Health and Public Hygiene. 2015. 2013 Health Accounts. Mali.

Figure 7: Mali Country Snapshot

Public and Private Sector Roles in Health Financing

The public and private sectors contribute to three main health financing functions:

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
THE PUBLIC SECTOR'S ROLE IN HEALTH FINANCING		
• General tax revenue (12% of THE) • Grants or loans from development partners (28% of THE) • Payroll taxes from public employers for social health insurance (1.5% of THE)	• The government pools risk at the national level by financing public health facilities • AMO pools risk of all civil servants, members of Parliament and National Assembly, army, retirees, and their family members • RAMED pools risk across the indigent population • Community-based health insurance schemes manage risk at the community level	• The government purchases services delivered to the population at public health facilities through: » Fixed input-based payments » Fee-for-service payments according to negotiated fee schedules (for AMO and RAMED), » User fee exemptions for pregnant women and children under 5 years • The government is piloting performance-based payments to public health providers in Koulikoro region • Community-based health insurance schemes purchase services using fee-for-service payments, according to a negotiated fee schedule
THE PRIVATE SECTOR'S ROLE IN HEALTH FINANCING		
• Household out of pocket payments (54% of THE) • Household voluntary prepaid contributions (0.12% of THE)	• Voluntary private insurers pool risk at the scheme level, although penetration in Mali is low and amounted to less than 0.2% in 2013	• Households are the main private sector purchasers of health services • Private insurers purchase health services on behalf of enrollees

Health Financing Mechanisms by Population Segment

Health financing mechanisms available to population segments will vary:

PUBLIC SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Publicly-financed health services	✓	✓	✓)
Mandatory social health insurance	✓ (Assurance Maladie Obligatoire)		
Voluntary social health insurance			✓ (Regime d'Assistance Medicale. Premium and co-payment exemptions if found eligible)
Voluntary community-based health insurance		✓	

PRIVATE SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Voluntary private health insurance	✓		
Out-of-pocket spending	✓	✓	✓

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Health financing specialists from USAID's Health Finance and Governance project collected the information presented below. HFG performed desk research and in-country data collection (key stakeholder interviews, policy and planning document collection) to map public and private health financing mechanisms in the country and identify potential opportunities where the government might expand population, service, or financial coverage for health and family planning services.

Mali's path to universal health coverage is integrated in social protection. The 2002 National Social Protection Policy expresses the right of all citizens to social protection, which the Ministry of Solidarity and Humanitarian Action (MSHA) will implement. Two key health financing schemes—the Compulsory Health Insurance scheme *(Assurance Maladie Obligatoire,* AMO) for government civil servants, including the army and security agents, and the Medical Assistance Mechanism (*Régime d'Assistance Médicale*, RAMED) for the indigent population—were established as part of this policy. Mali also has a strong history with community-based health insurance, which is regulated by law since 1996. Mali has ambitious plans to (i) increase population coverage of RAMED and CBHI, and, eventually, (ii) expand the benefit package covered by CBHI to harmonize with those of AMO and RAMED.

6.3 Mali's Health Financing Landscape

These schemes represent the primary avenues through which Mali aims to achieve UHC. More details on these, and other health financing mechanisms that currently exist, are described below.

6.3.1 Government-financed health services

The government provides health services to the population via a network of 1,204 community health centers, sixty-three referral health centers, eight secondary hospitals, and five tertiary hospitals. These services are funded by the government through input-based budgets to facilities. Performance- or output-based financing was piloted in Koulikoro—five districts in 2015 and ten in 2016—with some positive results. Some services are free to all; for example, caesarean sections and tuberculosis and leprosy services. All services for the indigent population are free, as is malaria treatment for children under age 5. These free services are provided alongside AMO, RAMED and CBHI. For all other services, users are expected to pay a consultation fee.

Family planning services form part of the minimum package of services available at public facilities. Family planning is a significant area of need: Mali's population is growing by 3% every year, with a fertility rate of more than six births per woman (World Bank 2016). Some 26% of the population of reproductive age has an unmet need for family planning (ICF International 2012). The 2014-2018 National Action Plan for Family Planning aims to increase the contraceptive prevalence rate from 9.9% (in 2013) to 15% in 2018 (MPHH 2014). The 2014-2023 Health and Social Development Plan (HSDP) highlights inequitable access to family planning services across the country. HSDP aims to ensure the availability of services at the health facility and community levels; extend contracting with private providers; increase demand for

family planning services by men, women, and adolescents; and increase the availability of long-acting contraceptive methods.

6.3.2 Compulsory health insurance (AMO) for government workers

AMO was established by law in 2009. It covers civil servants, members of Parliament (National Assembly), the army, retirees, and their family members. The scheme is financed by employee/retiree contributions and employer contributions. In 2014, AMO covered 3.4% of the population, compared with its target of 17% (Joint Learning Network 2016). AMO covers ambulatory care (including diagnostic tests and imaging), inpatient care, deliveries, and drugs. It does not reimburse for care that is already free in government facilities (see above), overseas treatment, non-essential care such as cosmetic surgery, and eyeglasses. AMO subsidizes 80% of hospitalization costs and 70% of ambulatory care costs across a network of 1,529 facilities, and members pay the remainder at the time of care.

It is managed by the National Health Insurance Fund (*Caisse Nationale d'Assurance Maladie,* CANAM), which is responsible for verifying that services are covered and that tariffs do not exceed pre-agreed rates, determining the payment amount, and paying the provider. CANAM reports to the Ministry of Solidarity and Humanitarian Action, which is based at the central level. Due to all verification taking place at the central level, reimbursement is often delayed.

6.3.3 Régime d'Assistance Médicale (RAMED) for indigent population

RAMED, also established by law in 2009, provides fully subsidized health care to the poorest population. It provides full financial risk protection; members do not make a contribution, and there are no co-payments. Members need to be certified with indigent status by their mayor. RAMED also covers the member' spouse, children under age 14, students ages 14-21, and handicapped children, prisoners, and residents of charitable institutes and orphanages. In 2014, just 0.5% of the population was covered by RAMED, compared with a target of 5% (Joint Learning Network 2016).

RAMED is accepted in a network of public, private, and faith-based health facilities. It is financed by the government (approximately 65%) and local authorities (35%), although the latter's contribution is expected to increase as the country is fully decentralized. Despite the scheme's being free for members, population coverage is still low. Possible causes are that potential beneficiaries do not know they are eligible and do not know how to enroll. Unwillingness of local authorities to issue indigent cards, because they worry the community will have to pay any unpaid bills, has also been cited as a challenge. The National Agency for Medical Assistance (*Agence Nationale d'Assistance Médicale*) manages RAMED and reports to the Ministry of Solidarity and Humanitarian Action. The National Agency for Medical Assistance is responsible for collecting revenue, registering members, ensuring provider compliance, verifying reimbursement requests, and processing provider payments.

6.3.4 Community-based health insurance

Historically, CBHI schemes in Mali were developed for civil servants in the education sector, railway staff, military, and police. These still exist, but the government is now using the schemes to provide financial risk protection to informal sector households, too (those not covered by AMO or RAMED). This group represents 78% of the population. In 2014, only an estimated 4.1% of the total population was covered by CBHI (Joint Learning Network 2016).

Benefits offered by CBHI are less generous than those of AMO or RAMED; they cover basic services such as preventive care, essential curative care, and patient transportation. CBHI schemes contract with public and private health providers (mainly community health centers). At the end of 2014, some 186 CBHI schemes had enrolled 308,354 members (Joint Learning Network 2016). CBHI schemes are

financed by member contributions and (for some members) government subsidies. The government pays 60% of outpatient care costs and 75% of inpatient care costs for all members; members pay the remainder at the time of care. CBHI schemes collect contributions from members at CBHI office locations. This in-person collection process is cumbersome and costly, particularly for members in remote rural areas. The CBHI Technical Unit in Mali (*Union Technique de la Mutualité Malienne,* UTM) launched a mobile money application for Mali's CBHI schemes in 2013. As of June 2014, more than 300 CBHI members across the country had paid premiums via mobile money.

There are challenges to enrolling in a CBHI scheme. Making regular premium payments can be difficult for informal, rural workers with seasonal incomes. CBHI schemes have a 3-month waiting period during which members are ineligible to claim benefits. While a waiting period reduces adverse selection (the tendency for people to enroll when they expect to use services), it also can deter potential members who are healthy from enrolling. For some CBHI schemes, new members have to travel to a health facility that accepts the CBHI in order to sign up and pay membership fees: this poses a burden for some households and transportation is an additional cost they associate with CBHI.

6.3.5 Household out-of-pocket

Households paying out of pocket are the biggest source of financing for the health sector; in 2013, some 54% of total health spending came from household out-of-pocket spending. This is one of the highest rates of out-of-pocket spending in West Africa. According to the World Health Organization, rates higher than 50% contribute to catastrophic spending or impoverishment for 5% of households (Ke et al. 2010).

6.4 Progress Toward Universal Health Coverage and Universal Access to Family Planning

The 2014-2023 HSDP developed by the Ministries of Public Health and Hygiene (MPHH), Labor, Solidarity and Humanitarian Action (MSHA), and Women, Child and Family Promotion (MWCFP) sets out a vision to provide universal access to quality services. The objectives of universal population coverage, access to a package of services, and financial risk protection are spelled out. For example, the plan aims to increase the population covered by CBHI from 4.1% to 20%; by AMO from 3.4% to 16%; and by RAMED from 0.2% to 5%, all by 2023 (Government of Mali 2015a). Collectively, these schemes should guarantee at least 45% of the population access to a basic package of services by 2023.

Most recently, the third Programme for Social and Health Development (2014-2018, PRODESS III) explicitly states UHC as a goal and establishes AMO, RAMED, and CBHI as the key mechanisms to achieve this. These schemes are the responsibility of MSHA. The Planning and Statistics Unit (*Cellule de Planification et de Statistique,* CPS), shared by MPHH, MWCFP, and MSHA, is expected to play an important role in linking MPHH with MSHA for coordinating the rollout of CBHI, and both are expected to be actively engaged in the CBHI development.

A draft of Mali's 2014-2023 Health Financing Strategy for UHC has been developed and is being finalized. Broadly, it aims to increase government (central and decentralized levels) contributions to health and link households' contributions to their ability to pay. That means automatic pre-payment for the formal sector, full subsidy for the neediest and limited contributions for the informal worker non-poor sector. A challenge is to reduce the dependency on donor spending (accounting for 28% of health spending in 2013) and the rate of households paying out of pocket (MPHH 2015). The government aims to reduce financing from these two sources by expanding CBHI across the country. PRODESS III initially planned for sixty new CBHI schemes per year during its period of implementation, but has subsequently reduced this target to ten per year.

Mali's UHC strategy aims to increase risk pooling by unifying fragmented risk pools. Currently, each CBHI scheme operates and pools risk independently, as do AMO and RAMED. The strategy also calls for more strategic purchasing mechanisms to improve efficiency. Decentralization, for health financing and health service delivery, is a key part of health sector reform in Mali. Local authorities will be expected to contribute more financial resources to make health services for their communities more affordable.

The 2014-2018 National Action Plan for Family Planning highlights the challenges faced in providing universal access to family planning services. On the supply side, the rural population has low levels of access to family planning services (37% of health workers are in rural areas to serve 78% of the population). Family planning is part of the essential package of health services in government facilities. But in 2012, only 82% of facilities offered basic family planning services (pills, injectables, condoms) and less than 10% of facilities offered the full range of contraceptives.

Family planning spending represented 0.7% of health spending in 2013 (Government of Mali 2015b). The 2013 National Health Account report does not break down spending for family planning, but reproductive health was predominantly financed by external donors (75%), government (4%), and other domestic sources such as households and NGOs (20%). The 2014-2018 National Action Plan for Family Planning aims to increase the role of the private sector by developing a strategy for greater involvement of the private sector in family planning service provision and to expand social franchising with the private sector in all regions. Family planning is not included in AMO's benefit package, so the 2014-2018 plan also proposes to develop a policy for introducing a third-party payer for family planning services on behalf of adolescents and poor women. The 2014-2018 plan will cost US $33 million to implement. The Mali government has committed to supporting 10% of the total costs of contraceptives in its facilities. This contribution, with donor commitments, will cover 76% of the plan's total costs.

6.5 Opportunities in Health Financing

As highlighted above, there are many ministries involved in strengthening the health sector and pushing toward UHC. While this multi-sectoral approach is laudable, it requires strong coordination to ensure an effective response. The 2015 Health Sector Assessment highlights that the Ministry of Public Health and Hygiene struggles to coordinate activities of all actors within the health sector (technical and financial partners, private sector providers, insurance companies, CBHI). This is further complicated by the need to coordinate with other ministries. However, Mali is further advanced than some other West African countries in that numerous multi-stakeholder coordination mechanisms already exist at the national and sub-national level to plan, coordinate, and monitor the implementation of PRODESS III and UHC more broadly. These mechanisms provide an excellent opportunity to further the UHC agenda.

Technical and organizational capacity-building to help technical working groups to design and expand CBHI schemes and to plan the expansion of CBHI in more detail will help to accelerate reforms. Technical capacity-building may focus on defining and refining the benefit package, improving processes to determine member eligibility for subsidy, consolidating CBHI schemes into regional (and eventually national) risk pools, and involving community-level actors to advocate for CBHI.

Despite more than 20 years of CBHI in Mali, population coverage is very low with a long way to go to achieve the government's target of 78%. Mali's strong culture of solidarity has cultivated informal financial risk protection mechanisms, such as donations or loans from social networks that include family and friends. Currently, CBHI schemes are not widely publicized, and many informal workers are not aware of or do not understand how CBHI can help with health costs and reduce risk of financial hardship due to a health shock. A culture of social solidarity provides a common basis to introduce

CBHI by educating the population about the benefits that insurance, a more formal risk-management mechanism, provides.

Technology offers exciting new opportunities to make CBHI more attractive to members and health facilities; for example, by using mobile phones to facilitate enrollment and registration, premium payment, and provider payment. Improving the operations of CBHI and making them user-friendly will also help recruit and retain members and reduce administrative costs of the scheme.

Discussions around the 2015 Health Sector Assessment highlighted insufficient representation of the private sector in Mali's institutional frameworks that govern the health sector at the national and sub-national levels (including faith-based organizations, civil-society organizations, and other private sector actors). This may be partly due to the long-running perception of the private sector as focused on profits over the health and well-being of the population. PRODESS III calls for government resources dedicated to developing an official public-private partnership strategy; this effort will be important to ensure that the government takes advantage of the strengths of the private sector to achieve UHC.

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7. NIGER

7.1 Country Snapshot

USAID FROM THE AMERICAN PEOPLE
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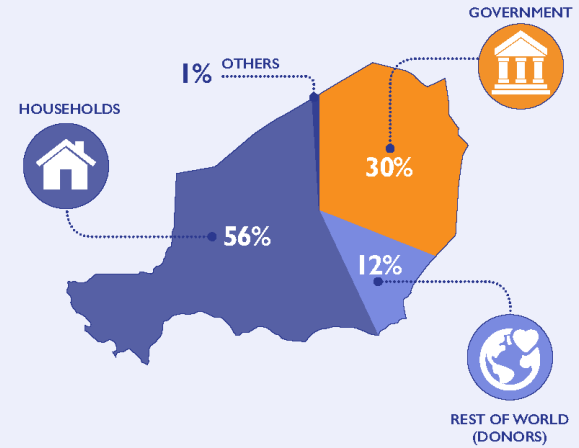
FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

Niger

Niger's Strategies for Improving Coverage of Health Services

TOTAL HEALTH SPENDING BY SOURCE



FAMILY PLANNING

UNMET NEED FOR FAMILY PLANNING IN NIGER
REMAINED STABLE

16%
2006-2012

PRIMARILY DELIVERED
THROUGH PUBLIC SECTOR FACILITIES

MAINLY FINANCED
BY INTERNATIONAL DONORS

KEY INDICATORS

Indicator	Value (Year)
Population	19,899,100 (2015)*
General government expenditure on health as a percentage of total government expenditure	10% (2013)**
Total health spending per capita	US$26 (2013)**
Government spending for family planning as % of total family planning spending	1%**
Private prepaid plans as a percentage of total expenditure on health	0.3%**
Unmet need for family planning	16% (2012)***
Married women currently using any modern method of contraception	12.2% (2012)***
Married women currently using long acting reversible contraceptives (IUD, injections or implants)	2.5% (2012)***
Sexually active unmarried women currently using any modern method of contraception	39.9% (2012)***

* World Health Organization. Global Health Observatory. http://www.who.int/gho/en/ Accessed July 2016.
** Niger National Health Accounts. 2013.
*** ICF International. 2012. The DHS Program STATcompiler. http://www.statcompiler.com/. Accessed July 2016.

Niger's universal health coverage (UHC) strategy is described in its *Plan de Développement Sanitaire 2011-2015* (PDS)[1] and its 2012 National Health Financing Strategy for UHC.[2] The PDS includes strategies for expanding access to health services while the government's health financing strategy prioritizes establishing mechanisms to advance toward UHC through supporting community-based health insurance schemes *(mutuelles)*, promoting uptake of health insurance to reduce exposure to catastrophic health care costs, and establishing a fund for health. Currently, less than 3% of the Nigerien population is enrolled in any type of health insurance; private health insurers cover less than 1% of the population. Consequently, the government aims to engage the private sector to expand health care service delivery and to establish private health professionals in areas with insufficient coverage. Public-private partnerships are also seen as mechanisms to strengthen information and communication systems as well as pharmaceutical regulation. Currently, 56% of total spending for health is private, mostly out-of-pocket household spending on health services and pharmaceuticals.[3]

Niger's second strategic health priority is improving reproductive health services including family planning.[1] The PDS aims to promote large-scale and community based distribution of contraceptives across public and private facilities by integrating family planning into the national package of essential health services. Unmet need for family planning in Niger has remained stable at about 16% from 2006 to 2012. At present, family planning commodities are financed primarily by international donors.

Challenges and Opportunities

Niger's challenges lie in low levels of public health spending (5.8% of total budget), weak infrastructure for social protection (public and private), and delays in implementing the health financing strategy established in 2012. *Mutuelles* are mainly organized by sector (e.g., energy, health care) while community-based health insurance schemes tend to be poorly managed, resulting in low enrollment. The development of social health insurance, regulation of existing *mutuelles*, and extension of *mutuelles* to the informal sector have potential to expand population health coverage and reduce the currently high out-of-pocket spending by households.

1 Niger Ministry of Public Health. January 2011. Plan National de Développement Sanitaire 2011-2015.
2 Niger Ministry of Public Health and WHO. June 2012. Stratégie Nationale de Financement de la Santé en vue de la Couverture Universelle en Santé au Niger.
3 Niger National Health Accounts. 2013.

Figure 8: Niger Country Snapshot

Public and Private Sector Roles in Health Financing

The public and private sectors contribute to three main health financing functions:

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
THE PUBLIC SECTOR'S ROLE IN HEALTH FINANCING		
• General tax revenue (30% of THE) • Grants or loans from development partners (12% of THE)	• The government pools risk at the national level through financing of public health facilities • Community-based insurance schemes pool risk at the community level	• The government purchases services delivered to the population at public health facilities through: » Fee-for-service payments to facilities based on the service provided, the facility's level in the health system (primary, secondary, or tertiary) and location (urban/rural), and client socioeconomic status » User fee exemptions for pregnant women and children under 5 for family planning, prenatal care, cesareans, antiretroviral therapy, malaria, tuberculosis, dialysis, and certain cancers » User fee reductions for: – Government officials and healthcare workers – Individuals with a certificate of indigence obtained through social worker evaluation » Subsidies for generic essential medicines » Results-based payments to health workers in the Dosso region
THE PRIVATE SECTOR'S ROLE IN HEALTH FINANCING		
• Household out-of-pocket payments (56% of THE)	• Private voluntary insurers pool risk at the scheme level, although penetration in Niger is extremely low. Private insurers only manage 0.3% of total expenditure on health.	• Households are the main private sector purchasers of health services in Niger • Households pay out-of-pocket for family planning services, typically provided at no- or low-cost by NGOs and development partners through public and private facilities

Health Financing Mechanisms by Population Segment

Health financing mechanisms available to population segments will vary:

PUBLIC SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Publicly-provided health services	✓	✓	✓ including enhanced subsidies for the designated poor)
Voluntary community-based health insurance	✓	✓	✓

PRIVATE SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Voluntary private health insurance	✓	✓	
Out-of-pocket spending	✓	✓	✓

ABOUT THE SERIES

This country snapshot is one in a series of 15 produced by the Health Finance & Governance Project. The snapshots capture information on public and private financing programs for family planning and health services that support country plans to reach universal health coverage. View the series and a summary report at: www.hfgproject.org.

7.2 Background

Health financing is a core building block of a health system and a key enabler of progress toward universal health coverage and universal access to family planning. Governments often use a plurality of health financing mechanisms to advance toward universal health coverage. In Chapter 1, we presented trends across the health financing landscape across fifteen countries in multiple regions and drew lessons that may be applicable in Niger and other West African countries. This chapter describes the health financing landscape in Niger and identifies opportunities where the government and other stakeholders can develop, strengthen, and expand their health financing mechanisms to progress toward universal health coverage and access to family planning.

Health financing specialists from USAID's Health Finance & Governance project collected the information presented below. HFG performed desk research and in-country data collection (key stakeholder interviews, policy and planning document collection) to map public and private health financing mechanisms in the country and identify potential opportunities where the government might expand population, service, or financial coverage for health and family planning services.

7.3 Niger's Health Financing Landscape

Niger uses four major health financing mechanisms. Each major mechanism is described in more detail below.

7.3.1 Government financing for health services

Government financing for health services is an important health financing mechanism because it has the potential to provide some degree of financial protection from health costs for Nigerien citizens who access care at public health facilities. However, the government faces considerable health financing challenges because of the nation's economic state. According to the government of Niger's *Plan de Développement Sanitaire 2011–2015* (PDS; Health Development Plan), the high level of poverty limits access to and use of health services. Some 62% of the population lives below the poverty line, including 66% of the rural and 52% of the urban population.

Public health services currently employ user fees, exposing individuals to a high level of financial risk. Moreover, the government is exposed to poor cost recovery when individuals are unable to pay these user fees (MSP 2011). There are some user fee exemptions for treatment of specific priority diseases (e.g., HIV/AIDS), to support vulnerable population segments (e.g., indigent people accessing hospital care, rural poor), and to address priority health concerns (e.g., free family planning services). The government purchases services based on inputs as well as outputs, largely focused on infrastructure, direct financing for health services, and performance incentives. Health workers are salaried, and there are no results-based financing programs for providers.

7.3.2 Community-based health insurance

In Niger, most active CBHI schemes are organized by sector (e.g., *Société Nigérienne des Produits Pétroliers* (Nigerien Petroleum Products Company) for petroleum, *Société Nigérienne d'Electricité* (Nigerien Electricity Society) for electricity); there are also geographically based CBHI schemes, but HFG research found these to be low-functioning. As of 2015, the *Federation des mutuelles de santé* (Federation of CBHI Schemes) was established to improve coordination and penetration of CBHI schemes nationwide. CBHI schemes in Niger subscribe to regulations from the multinational government-affiliated entity *l'Union Economique et Monétaire Ouest Africaine* (UEMOA; West African Economic and Monetary Union).

Benefits and contributions vary across CBHI schemes. Subscribers present with identification at the point of service.

Family planning services in public health facilities are free of charge.

7.3.3 Private health insurance

Private health insurance penetration is well under 3% in Niger. Indeed, private health insurance accounts for just 0.3% of all health spending (Niger Health Accounts 2013). Participation in private health insurance is voluntary and is dominated by private sector, employer-based health coverage. Only a few private insurance companies exist; they are centrally operated and reimburse health services that may be accessed in public or private facilities as policy terms dictate.

7.3.4 Household out-of-pocket spending

Household out-of-pocket spending is high, at 56% of health expenditure, signaling that most Nigerien citizens have poor financial protection for health services. As more Nigerien citizens gain access to and enroll in financial protection mechanisms such as health insurance, some household spending will likely shift from out-of-pocket spending to regular premium payments to risk-pooling schemes offered by the government, employers, the community, or private insurers.

7.4 Progress Toward Universal Health Coverage and Universal Access to Family Planning

The government of Niger's *Plan de Développement Sanitaire 2011-2015* included several strategies to enhance the government's financial capacity to meet population health demands and reduce household out-of-pocket payments. Two notable financing strategies revolve around enhancing internal and external resource mobilization efforts and developing innovative risk-pooling mechanisms. Resource mobilization is a critical strategy for the Nigerien government because a large proportion of the population that lives below the poverty line can access only no- or low-cost health services. Resource mobilization strategies include enhancing intragovernmental advocacy efforts to reach the Abuja Declaration target of 15% of the state's budget allocation for health, as well as advocating for donor support for strategic plan development for UHC.

The PDS expected that supporting the development and expansion of risk-pooling mechanisms such as CBHI schemes would complement the government's efforts to provide free, or at least highly subsidized, services and expand financial risk protection to the population. HFG learned that the Ministry of Health is commissioning several department-level personnel to explore issues with and potential strategies for achieving UHC under the next PDS, for 2016-2020. These managers will advise the Prime Minister accordingly. This suggests high-level, intragovernmental interest in addressing population health needs through UHC.

Other strategies from the PDS 2011-2015 included determining how to more efficiently use existing resources and developing a social fund to cover health services for indigent people. The PDS also identified the development and adoption of a sector-wide CBHI strategic plan as a priority intervention. This plan would elaborate on the structure of CBHI schemes and how they would contract with facilities for health service provision, though details were not provided on when this plan would be developed.

Aside from the PDS, the government worked with development partners to finalize its *Stratégie Nationale de Financement de la Santé en vue de la Couverture Universelle en Santé au Niger* (National Health Financing Strategy for Universal Health Coverage in Niger) in 2012. The strategy re-emphasizes the PDS

2011-2015 financing strategies of increasing resource mobilization and using resources more efficiently. The health financing strategy also explicitly lists universal health coverage as a strategic aim. At the time of this HFG study, implementation of this 2012 strategy had not yet begun.

Niger mobilized donor support through the International Health Partnership (IHP+) in 2009. It signed a country compact with eleven development partners plus civil society organizations in 2011 to support the development of the PDS 2011-2015, as well as a roadmap for strengthening monitoring and evaluating and a national health plan. Niger has remained engaged with IHP+ through participation in multiple rounds of IHP+ results monitoring. Niger has also mobilized resources through USAID's family planning access initiatives and with support from the Ouagadougou Partnership to advance family planning in francophone West Africa for the development of *Planification Familiale au Niger: Plan d'Action 2012-2020* (National Family Planning Action Plan) (USAID 2016).

The PDS includes explicit aims to integrate family planning services at large into Niger's package of essential services and to promote nationwide, community-level distribution of contraceptives at public and private health facilities. It outlines six priority strategies including community-based distribution of contraceptives, mobile and outreach strategies, and provision of contraceptives free of charge at all public services.

The PDS highlights several aims for private provider engagement through developing public-private partnerships, improving pharmaceutical regulation, and promoting private health insurance.

7.5 Opportunities in Health Financing

HFG's analysis of the health financial landscape in Niger revealed several areas where the government might focus efforts to develop, strengthen, and expand health financing mechanisms to progress toward UHC and access to family planning.

Overall, the government has the opportunity to improve efficiency of its financial risk protection efforts by expanding the availability of health insurance schemes. While existing health financing mechanisms provide some degree of protection from financial risk, their concentration among the formal sector subpopulation, combined with high (56%) out-of-pocket spending nationwide, suggests financial protection against health shocks is poor or absent for many. Niger is the lowest-ranking country on the 2013 Human Development Index. High poverty levels and high fertility rates contribute to a low-performing health system. Dependence on out-of-pocket spending negatively affects both access to and use of health services in Niger. Even the smallest user fees can be prohibitive, presenting an opportunity to expand coverage and efficiencies of existent health insurance schemes—CBHI and private health insurance.

The government has opportunities to shape its policy efforts around UHC. First, the new *PDS 2016-2020* has been developed, but the validation process began only in July 2016. With validation and subsequent implementation of that plan, Niger may choose to strategize on efficiently achieving its PDS priorities for UHC. Second, this could be an opportune time for Niger to re-energize health financing strategy efforts, given that only a relatively small share of Niger's budget (5.8%) is allocated to health and the implementation of its 2012 health financing strategy has been delayed for reasons unknown. Moreover, given limited social protection mechanisms Niger could use this time of PDS validation to determine how to develop and coordinate technical research, planning, strategy, and advocacy efforts dedicated to promoting UHC. This could include plans to include the private sector in health sector development, which was considered important in the PDS. The above-listed opportunities could be realized through the establishment of a concrete policy and strategy to progress toward UHC.

The government also has opportunity to increase financial protection for informal, rural, and indigent populations. HFG found evidence of wide variation in processes for identifying indigent people in

communities. This could be an important gap to understand and address given the significant implications for financial risk protection of individuals. Exploring this further could lead to reduced incidence of fraud at the point of care and more-efficient government financing of health services for indigent people. Moreover, the government may have the opportunity to address limitations to CBHI. Not only is enrollment in CBHI schemes very low (less than 3%), but it is often largely limited to the formal sector. Also, HFG analysis found that management and oversight of CBHI schemes is poor despite the 2015 creation of a national agency to regulate them. This suggests gaps in effective strategy, implementation planning, and capacity to reinforce and regulate CBHI schemes.

Last, the government has the opportunity to improve access to family planning across public and private sectors. Family planning commodities are free only in the public sector, with the exception of private providers that are part of a donor or NGO's procurement network. As the private health sector develops in Niger, the government can explore potential implications for how, where, and at what cost (if any) family planning commodities are provided across the health system.

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8. SENEGAL

8.1 Country Snapshot

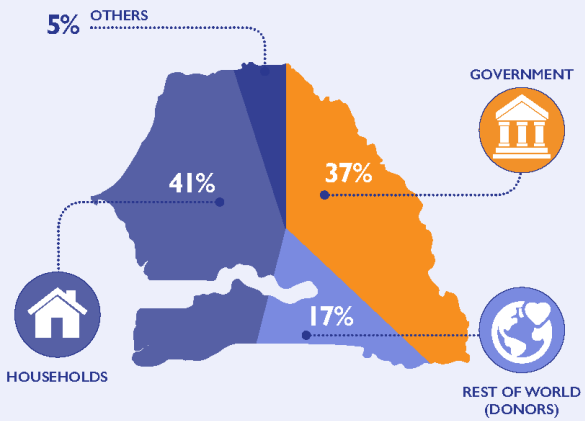
USAID FROM THE AMERICAN PEOPLE | Health Finance & Governance — Expanding Access. Improving Health.

FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

Senegal

Senegal's Strategies for Improving Coverage of Health Services

TOTAL HEALTH SPENDING BY SOURCE



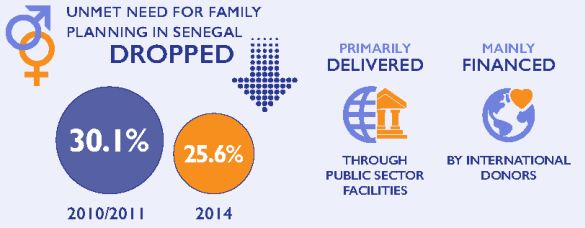
KEY INDICATORS

Indicator	Value (Year)
Population	15,129,300 (2015)*
General government expenditure on health as a percentage of total government expenditure	7.6% (2013)*
Total health spending per capita	Not available
Private prepaid plans as a percentage of total expenditure on health	Not available
Unmet need for family planning	25.6% (2014)**
Married women currently using any modern method of contraception	20.3% (2014)**
Married women currently using long acting reversible contraceptives (IUD, injections or implants)	14.0% (2014)**
Sexually active unmarried women currently using any modern method of contraception	51.9% (2014)**

* World Health Organization. Global Health Observatory. http://www.who.int/gho/en. Accessed June 2016

** ICF International. 2012. The DHS Program STATcompiler: http://www.statcompiler.com. Accessed August 2016.

FAMILY PLANNING



Senegal adopted a universal health coverage (UHC) strategic plan covering 2013 – 2017. The strategic plan acknowledged that while the country has decades of experience with delivering care through public health facilities and providing coverage through mandatory social health insurance, the informal sector and the poor (approximately 80% of the population) continue to face barriers to access care.[1] In 2012, the Ministry of Health launched a National Consultation on Health and Social Action to build national consensus on reforms in the health and social welfare sector. Based on these consultations, Senegal is pursuing universal health coverage by: a) expanding basic health coverage through community-based health insurance; b) improving the government's ability to target certain populations and monitor progress; c) improving access to care for disabled people; and d) improving financial protection.

Senegal's family planning strategy aims to generate demand for family planning and increase distribution of commodities through the private sector. The majority of family planning users in Senegal obtain commodities and information from a public sector source. Unmet need for family planning dropped from 30.1% in 2010/2011 to 25.6% in 2014.

Challenges and Opportunities

Senegal faces challenges with low enrollment in community-based health insurance schemes by the informal sector and rural households, likely due to a mismatch between the benefits offered by schemes and community needs, making schemes unattractive to potential members. These and other social and private health insurance schemes had enrolled approximately 13.6% of the population in 2012, well below the target of 65.5% by 2017 established in the National Economic and Social Development Strategy 2013 – 2017. Nonetheless, spending through private pre-paid insurance schemes is significant (21.1% of total health expenditure in 2013) due to government regulations that require large private employers and employees to participate in a social insurance scheme managed by private insurers. Public spending is still low. In 2011, the World Health Organization deemed that Senegal had made insufficient progress toward reaching the Abuja target of allocating 15% of its annual budget to improve the health sector.[2] The country has opportunities to further reduce out-of-pocket spending by increasing enrollment in insurance and expanding subsidies for health services.

1 Ministère de la Santé et de l'Action Sociale, République du Sénégal. 2013. Plan stratégique de développement de la Couverture Maladie Universelle au Sénégal 2013-2017. Dakar.

2 World Health Organization. 2011. The Abuja Declaration: Ten Years On.

Figure 9: Senegal Country Snapshot

Public and Private Sector Roles in Health Financing

The public and private sectors contribute to three main health financing functions:

RESOURCE MOBILIZATION

RISK POOLING

PURCHASING

THE PUBLIC SECTOR'S ROLE IN HEALTH FINANCING

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
• General tax revenue collected by the central government (37% of THE) • Grants or loans from development partners (17% of THE)	• Health services available at public facilities • Health services available from community health workers • Social health insurance scheme for civil servants pools risk at national level • Social health insurance scheme for retirees pools risk at national level • Community-based health insurance schemes pool risk at the community level	• Central government purchases services from public and private primary, secondary and tertiary health facilities • Central government pays for services through: » User fee exemptions and vouchers for some essential services, and full exemptions for certain groups » Purchase of services by publicly-managed social health insurance schemes on behalf of enrollees » Purchase of services by community-based health insurance on behalf of enrollees

THE PRIVATE SECTOR'S ROLE IN HEALTH FINANCING

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
• Household out-of-pocket payments (41% of THE) • Household voluntary prepaid contributions • Premiums paid by private employers to social health insurance schemes	• Private health insurers pool risk at the scheme level • Community-based health insurance schemes pool risk at the scheme level	• Households purchase health services through direct payments for services or through prepaid contributions • Private employers purchase insurance on behalf of employees and their families

Health Financing Mechanisms by Population Segment

Health financing mechanisms available to population segments will vary:

PUBLIC SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Publicly-financed health services	✓	✓	✓ (including enhanced subsidies for certain sub-populations)
Mandatory social health insurance	✓		
Voluntary community-based health insurance		✓	✓ (including premium subsidies for the poorest households)

PRIVATE SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Mandatory social health insurance	✓		
Voluntary private health insurance	✓	✓	✓
Out-of-pocket spending	✓	✓	✓

ABOUT THE SERIES

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Abt

8.2 Background

Health financing is a core building block of a health system and a key enabler of progress toward universal health coverage and universal access to family planning. Governments often use a plurality of health financing mechanisms to advance toward universal health coverage. In Chapter 1, we presented trends across the health financing landscape across fifteen countries in multiple regions and drew lessons that may be applicable in Senegal and other West African countries. This chapter describes the health financing landscape in Senegal and identifies opportunities where the government and other stakeholders can develop, strengthen, and expand their health financing mechanisms to progress toward universal health coverage and access to family planning.

Health financing specialists from USAID's Health Finance and Governance project collected the information presented below. HFG performed desk research and in-country data collection (key stakeholder interviews, policy and planning document collection) to map public and private health financing mechanisms in the country and identify potential opportunities where the government might expand population, service, or financial coverage for health and family planning services.

8.3 Senegal's Health Financing Landscape

Senegal uses six major health financing mechanisms. Each mechanism is described in more detail below.

8.3.1 Government financing for health services

Government financing for health services is an important mechanism for providing the population financial protection from health costs in Senegal. Results-based financing is being piloted in six regions. The government offers several enhanced subsidy programs for certain vulnerable populations and for certain services. A recent government policy document mentioned an intention to increase the financial resources for the free health care initiatives in the country.

One of the largest such programs is *Plan Sésame*. Established in 2006, *Plan Sésame* provides user fee exemptions for people age 60 and over. Beneficiaries are required to present a national ID card at the point of service. A study from 2011 reported that there was no formal communication plan to promote the scheme at that time. Even so, 48% of surveyed older people were actually enrolled in *Plan Sésame*; those who were vulnerable and more likely to be socially excluded were less likely to be (Parmar et al. 2016). *Plan Sésame* is funded through a government budget line item. The program also uses some funds from the *Institut de Prévoyance Retraite et Sociale*, the old-age pension fund, and the *Fonds National de Retraite* (the national contingency/pension fund for formal employees in the private sector) (Parmar et al. 2016).

Other free health care initiatives financed by the government include caesarean sections in all Senegalese hospitals outside of the capital region; certain services for children under age 5 (vaccinations, provision of therapeutic foods to treat malnutrition, free Vitamin A supplements, and parasite removal); anti-retroviral drugs and anti-tuberculosis treatment; and anti-malarial drugs.

The "*Bajenu Gox*" program is a community health worker program for the promotion of maternal, newborn, and child health. Through the program, 12,000 community health workers are responsible for identifying pregnant women and promoting pre- and post-natal care, child immunization, and family planning. *Bajenu Gox* community health workers are also part of committees targeting beneficiaries of *bourses de sécurité familiale* (family assistance grants) and also participate as committee members of CBHI

schemes. *Bajenu Gox* will soon join the *Alliance du Secteur Privé de la Santé du Senegal* (Private Sector Alliance for Health of Senegal).[E]

Government financing for health services is a critical financing mechanism for supporting distribution of family planning commodities and delivering family planning services in Senegal. The public sector is the main provider of modern methods of family planning. Some 85% of modern method users obtained their family planning method in the public sector in 2013-2014 (Brunner et al. 2016).

8.3.2 Social health insurance

There are three major forms of social health insurance in Senegal. The *Institution de Prévoyance Maladie* (IPM; Sickness Insurance Institution) is a social welfare organization in charge of health insurance for public or private sector workers and their families. The *Institution de Prévoyance Retraite et Sociale* is social health insurance for workers who previously held salaried jobs and their families. *L'imputation budgetaire* (budgetary allocation) is a mechanism by which the state pays 80% of cost of health care for civil servants.

Creating an IPM business or becoming a member of a joint IPM is an obligation of employers of more than 300 employees. IPMs cover 40% to 80% of the cost of covered medical care and drugs. In total, IPMs managed 41% of health spending by all insurers, according to the 2005 NHA report, although IPMs covered only 24% of the total insured population. For comparison, private insurers managed 26% of health spending by all insurers but covered only 8% of the total insured population; *l'imputation budgetaire* for civil servants managed 24% of health spending by all insurers but covered 40% of the total insured population. These statistics imply that IPMs manage and spend less money per enrollee than do fully private insurance schemes, but they manage and spend more money per enrollee than does *l'imputation budgetaire.*

IPRES was established by decree in 1975. In this scheme, a sickness contribution is regularly levied on pensions; in return, IPRES partially covers medical expenses of its beneficiaries.

These mandatory programs cover less than 20% of Senegal's population. According to the Ministry of Health and Social Action, coverage under these social health insurance schemes is only partial and requires significant patient cost sharing.

8.3.3 Community-based health insurance

CBHI schemes have been active in Senegal since the early 1990s, and over the last 20 years have undergone periodic reform. In 2009, the government issued regulations for CBHI schemes, and then in 2012 established a central support unit for them. There is currently a push to implement at least one CBHI scheme in each community and one union of CBHI schemes in each department as part of the government's universal health coverage strategy. (The section "Current Efforts and Strategies to Progress toward Universal Health and Family Planning Coverage" below describes this reform effort.)

Some CBHI schemes in Senegal are sector based. *Transvie,* for example, is a large CBHI scheme available to workers in the transportation sector. However, *Transvie* does not receive any support from the government, and therefore does not appear to fit within the government of Senegal's framework for CBHI recently defined in its UHC strategy. Key informant interviews determined that sector-based CBHI schemes such as *Transvie* are seeking more clarity from the government to confirm whether they are subject to regulations for CBHI.

[E] It is not clear whether the government pays these community health workers and whether they are considered part of the public sector delivery system, given that they are joining the private sector alliance.

Family planning is listed as a service under the basic benefits package that the CBHI schemes regulated through the government of Senegal's framework are required to cover.

8.3.4 Private health insurance

Participation in private health insurance in Senegal is voluntary. Private insurers generally offer generous benefit packages for wealthier households. In 2005, private insurers covered just 8% of the insured population in Senegal but collected and paid out a quarter of all insurance health funds.

According to the draft 2008 NHA report, private health insurers pay out the most money to private pharmacies, followed by public hospitals, private clinics, and laboratories for analysis and medical imaging.

The micro health insurance pool (*Le pool micro-assurance santé,* PMAS) is a partnership of private insurance companies seeking to provide affordable health insurance to low-income people and workers in the informal sector. Six private insurers established PMAS, registering it as an association in June 2012. PMAS acts as a third-party administrator of insurance products, which are offered to organized groups, associations, student groups, women's organizations, and others. PMAS contracts with a mix of public and private sector providers, and its products cover the basic services that are provided in public health centers and the complementary package offered in public hospitals.

The PMAS model appears to be unique to West Africa. The project was designed to provide health insurance products to 108,000 people, but sales and enrollment have proven difficult; to date only about 5,000 people are covered. PMAS offers similar coverage as CBHI schemes but requires higher prepayments from enrollees because it does not receive the same subsidies as CBHI schemes. To be viable, PMAS would require 20,000 enrollees. It is currently operating at a deficit, and the private insurers bear the financial risk. The experience of Senegal could inform how to replicate the model with greater success in other settings.

8.3.5 Household out-of-pocket spending

Households are important financiers and managers of health care funds in Senegal, according to the draft 2008 NHA report. Private sector sources financed 46% of total health expenditure in 2008, and 87% of private sector financing comes from households. Some 13% of household health funds were managed by insurers (IPMs, CBHI schemes, or other private insurers), and the remainder was managed by households in the form of out-of-pocket spending for goods and services.

Households spent the largest portion of their health care funds at private pharmacies, followed by spending at national public hospitals. Nearly 50% of household health care funds were spent on medicines in 2008. Hospital inpatient curative care (excluding drugs, lab services, and radiology) was the next largest portion at 20%. Household spending on family planning services was not specified in the draft 2008 NHA report.

8.3.6 Other health financing mechanisms

Worksite health programs are also part of Senegal's health financing landscape and appear to be unique to this country in the region, based on HFG's literature review and in-country data collection. In *2006, the government decreed that companies with more than 400 employees must have a full-time doctor on site to provide preventive care and avoid occupational, sanitary, and other health risks. Companies in the same vicinity with fewer than 100 workers may share a worksite doctor.*

Companies must provide the doctor's services free of charge. Many companies also provide free services to family and community members. In reality, many worksites employ just a full-time nurse, and a doctor might come once or twice a week. At worksites with many women, a gynecologist might also visit from time to time. However, enforcement of this government decree is weak, and services tend to be quite limited (Brunner et al. 2016).

8.4 Progress Toward Universal Health Coverage and Universal Access to Family Planning

The government of Senegal aims to improve the depth of health coverage that the population currently enjoys through either free and subsidized care programs (Sésame and other free care programs) or compulsory insurance schemes for formal sector workers. IPMs in particular have faced administrative and financial sustainability challenges. An update of the legal framework for IPMs in 2012 aimed to adapt IPM regulations to better position the schemes in the current economic and social context.

The government has also adopted strategies to expand population coverage to reach 100% by 2017 through CBHI. The Ministry of Health and Social Action's Strategic Plan for the Development of Universal Health Coverage in Senegal (2013-2017) describes how the government will promote the growth of coverage through a new governance framework for CBHI. The government created a Universal Health Coverage Agency to implement and oversee the framework. Basic CBHI schemes at the community level will cover entire families and will provide a minimum benefit package. The governance framework also establishes risk pools at the department level through department-level unions. Department-level unions manage benefits provided at level 1 hospitals and provide technical support to CBHI schemes. A regional CBHI union then pools risk at the regional level and manages benefits provided at regional and national hospitals.

To streamline management of newly mobilized UHC funds, the government will establish two financing instruments: the National Health Solidarity Fund (*Fonds National de Solidarité Santé*) and the Independent Fund for Universal Social Protection (*Caisse Autonome de Protection Sociale Universelle*). The funds will become the primary financing mechanisms for expanding coverage in the informal sector by transferring funds to subsidize free care for exempt groups. They will fulfill the following functions: (i) provide subsidies to CBHI schemes to help them expand their benefit packages and promote risk pooling at the local level; (ii) provide targeted subsidies to cover indigent and vulnerable groups through CBHI; and (iii) promote group enrollment by supporting partnerships between CBHI schemes and decentralized micro-financing institutions.

HFG interviews with key stakeholders revealed that the government sees the following next steps for advancing its UHC strategy: establish a legal framework and institutional support; strengthen and professionalize communication surrounding the UHC strategy; and strengthen management of existing CBHI schemes. Despite the National Consultations on Health and Social Action initiative in September 2012 to build consensus on reforms in the health sector and social action, interviews revealed that private sector insurers and associations consider the level of communication and engagement weak.

Compared with other countries in West Africa, the size and scope of Senegal's private health sector is relatively large and is growing. The Ministry of Health and Social Action is currently implementing a contracting policy. The most commonly cited examples of the implementation of this policy were the contracts given to *Santé Familiale* (an NGO that supported workplace clinics) and Action and Development (an NGO with polyclinics in multiple locations) to offer health services with reimbursement schemes. The Private Health Sector Alliance of Senegal (*Alliance du Secteur Privé de la Santé du Senegal)*, created in 2014, helps private health sector organizations including associations and unions form a unified voice (Brunner et al. 2016). A memorandum of understanding was signed between the Alliance and Ministry of Health and Social Action on May 10, 2016.

As part of signing on to the Family Planning 2020 movement, the government of Senegal is implementing its *Plan d'action national de Planification Familiale* (National Action Plan for Family Planning) 2012-2015. The major objectives of the *Plan d'action* are to reposition family planning, help meet the Millennium Development Goals, and reach 27% contraceptive prevalence. Many of the fifty-one strategic actions laid out in the *Plan d'action* relate to strengthening and broadening family planning distribution within the private sector:

- Establishing a multi-sectoral structure dedicated to public-private partnerships
- Broadening the range of social marketing products
- Effective implementation of product delivery by the *Pharmacie Nationale d'Approvisionnement*
- Systematic integration of private data
- Setting up mobile units
- Establishing social franchises
- Increasing the number of points of service in the private sector
- Improving the regulatory framework
- Better regulating the market
- Direct training of private actors, especially for long-lasting methods
- Insurance support for family planning services by CBHI and social security

The plan also noted the desire to revitalize the *Bajenu Gox* program to improve community-based distribution of family planning services.

8.5 Opportunities in Health Financing

HFG's analysis of the health financial landscape in Senegal revealed several areas where the government might focus efforts to develop, strengthen, and expand health financing mechanisms to progress toward UHC and access to family planning.

The government has an opportunity to improve efficiency of the health sector by increasing enrollment in health insurance schemes. While Senegal's rate is higher than in many countries in the region, only about one-fifth of the population has health insurance. The enrolled population comprises mainly formal sector workers and wealthy households. Cost-sharing requirements remain significant under many of these schemes, which may pose a barrier to households seeking promotive and preventive services. The informal sector and poor/vulnerable populations have few options for insurance. The government is implementing an ambitious plan to ramp up coverage to 100% through CBHI, as well as to expand the benefit package available to members of CBHI schemes, by 2017. The government is in the process of mobilizing funds to provide subsidies to CBHI schemes and to department-level CBHI unions.

The government may also identify opportunities to update and adapt government laws and regulations to the existing health financing landscape. PMAS, the organization attempting to bring private health insurance products to the informal sector, has faced difficulties enrolling people due to competition from CBHI schemes that receive government subsidies. Additionally, certain CBHI models such as *Transvie* may also be excluded from current regulations and subsidy programs. IPMs reportedly experience financial difficulty because they are legally obligated to offer a more generous benefit package than the risk pool can finance.

Finally, the government has an opportunity to involve private sector stakeholders in health system reforms. Senegal has relatively robust civil society engagement in health system management, but communication and engagement surrounding CBHI reform could be stronger.

8.6 Sources

Brunner, Bettina, Jeffrey Barnes, Andrew Carmona, Arsène Kpangon, Pamela Riley, Erin Mohebbi, and Leslie Miles. 2016. *Senegal Private Health Sector Assessment: Selected Health Products and Services.* Report prepared by Abt Associates. Washington, DC: United States Agency for International Development, Strengthening Health Outcomes through the Private Sector (SHOPS).

Parmar, Divya, Gemma Williams, Fahdi Dkhimi, Alfred Ndiaye, Felix Ankomah Asante, Daniel Kojo Arhinful, and Philipa Mladovsky. 2014. Enrolment of Older People in Social Health Protection Programs in West Africa—Does Social Exclusion Play a Part? *Social Science & Medicine* 119: 36-44. http://dx.doi.org/10.1016/j.socscimed.2014.08.011.

9. TOGO

9.1 Country Snapshot

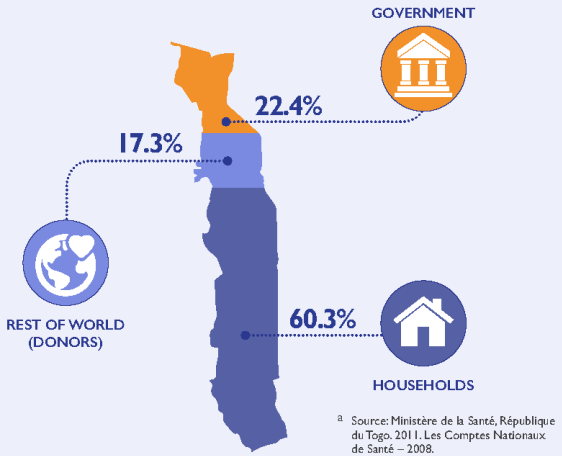
USAID FROM THE AMERICAN PEOPLE | Health Finance & Governance — Expanding Access. Improving Health.

FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

Togo

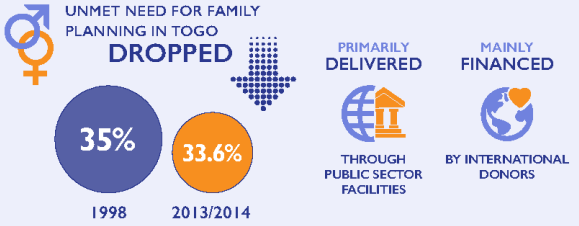
Togo's Strategies for Improving Coverage of Health Services

TOTAL HEALTH SPENDING BY SOURCE[a]



[a] Source: Ministère de la Santé, République du Togo. 2011. Les Comptes Nationaux de Santé – 2008.

FAMILY PLANNING



KEY INDICATORS

Indicator	Value (Year)
Population	7,304,600 (2015)*
General government expenditure on health as a percentage of total government expenditure	6.07% (2016)**
Total health spending per capita	$41 (2016)**
Private prepaid plans as a percentage of total expenditure on health	2% (2002)***
Unmet need for family planning	33.6% (2013/2014)*****
Married women currently using any modern method of contraception	17.3% (2013/2014)*****
Married women currently using long acting reversible contraceptives (IUD, injections or implants)	12.6% (2013/2014)*****
Sexually active unmarried women currently using any modern method of contraception	38.4% (2013/2014)*****

* World Health Organization. Global Health Observatory. http://www.who.int/gho/en/. Accessed June 2016.

** Ministère de la Santé, République du Togo. 2016. Rapport de l'evaluation du Plan National de Developpement Santitaire (PNDS) 2012 – 2015. Lome.

*** Ministère de la Santé, République du Togo. 2005. Les Comptes Nationaux de Santé – Periode 2002.

**** ICF International. 2012. The DHS Program STATcompiler. http://www.statcompiler.com/. Accessed August 2016.

In 2011, Togo established a mandatory social health insurance scheme managed by *l'Institut National d'Assurance Maladie* (a semi-autonomous agency under the Ministry of Health and Social Protection) for civil servants, civil servant retirees and their families. In establishing the scheme and the agency to oversee it, Togo is developing expertise in risk pooling and health insurance management. The proportion of the population covered by this scheme is small given eligibility is limited to civil servants. The Ministry of Health is evaluating the requirements and feasibility of expanding social health insurance for other population groups such as other formal sector and informal sector workers. Togo presented additional strategies to improve financial coverage of health services in its *Plan National de Developpment Sanitaire (PNDS) 2012 – 2015*. These include increasing domestic resources for health, mobilizing resources from the private sector, and scaling up community-based health insurance with subsidies for the poor. The 2016 evaluation of the Plan reported stagnation in allocation of domestic resources for health and recommended the government gradually increase the percentage over time. It also recommended that the government develop a national health financing strategy for universal health coverage (UHC). A few private insurance companies operate in Togo, but mainly offer accident coverage or complementary benefits for the social health insurance scheme and are only accessible to formal sector workers. Fewer than 30 community-based health insurance schemes exist – often with limited benefits and low enrollment.

The public sector supplies the majority of family planning services and commodities in Togo; private health facilities and pharmacies supply about one fifth. The public sector is highly dependent on donor financing of family planning commodities. Unmet need for family planning dropped marginally from 35.0% in 1998 to 33.6% in 2013/2014.

Challenges and Opportunities

Togo faces challenges with low levels of public health spending, high out-of-pocket spending and low enrollment in prepayment schemes. The PNDS advocated for increasing the government budget allocation for health to 10%, but that is still well below the Abuja target of 15%. While the government has stated its commitment to achieving UHC, there is an opportunity to accelerate progress by developing and implementing an updated formal strategy and financing plan for UHC.

Figure 10: Togo Country Snapshot

Public and Private Sector Roles in Health Financing

The public and private sectors contribute to three main health financing functions:

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
THE PUBLIC SECTOR'S ROLE IN HEALTH FINANCING		
• General tax revenue collected by federal and state governments (22.4% of THE) • Grants or loans from development partners (17.3% of THE) • Payroll taxes from public employers	• Health services available at public health facilities • Social health insurance (INAM) pools risk at the national level	• National government purchases services provided at public primary, secondary and tertiary health facilities • National government pays for services through these mechanisms: » Subsidies for services delivered at public facilities » Purchase of services by social health insurance on behalf of enrollees
THE PRIVATE SECTOR'S ROLE IN HEALTH FINANCING		
• Household spending, mainly through out-of-pocket payments (60.3% of THE)	• Private health insurers pool risk at the scheme level, although market penetration in Togo is low (<2% of the population is enrolled)	• Households are the main private purchasers of health services in Togo

Health Financing Mechanisms by Population Segment

Health financing mechanisms available to population segments will vary:

PUBLIC SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Publicly-financed health services	✓	✓	✓
Mandatory social health insurance	✓ (public sector employees and retirees only)		

PRIVATE SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Voluntary private health insurance	✓ (supplementary coverage for social health insurance enrollees)		
Out-of-pocket spending	✓	✓	✓

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9.2 Background

Health financing is a core building block of a health system and a key enabler of progress toward universal health coverage and universal access to family planning. Governments often use a plurality of health financing mechanisms to advance toward universal health coverage. In Chapter 1, we presented trends across the health financing landscape across fifteen countries in multiple regions and drew lessons that may be applicable in Togo and other West African countries. This chapter describes the health financing landscape in Togo and identifies opportunities where the government and other stakeholders can develop, strengthen, and expand their health financing mechanisms to progress toward universal health coverage and access to family planning.

Health financing specialists from USAID's Health Finance and Governance project collected the information presented below. HFG performed desk research and in-country data collection (key stakeholder interviews, policy and planning document collection) to map public and private health financing mechanisms in the country and identify potential opportunities where the government might expand population, service, or financial coverage for health and family planning services. HFG also noted that the Togo Ministry of Health commissioned a study of the country's health financing mechanisms in 2013 (Bakusa 2013).

9.3 Togo's Health Financing Landscape

Togo uses five major health financing mechanisms. Each mechanism is described in more detail below.

9.3.1 Government financing for health services

Government financing for health services provides the population some degree of financial protection from health costs. According to the government of Togo's *Plan National de Développement Sanitaire 2012–2015* (PNDS; National Health Development Plan), the state provided 67% of health services in 2009.

Many services are often unavailable through public health facilities, and they are too expensive for most Togolese to access through private health facilities. Government financing for health services plays an important role in subsidizing care for citizens who access it at public health facilities. However, these subsidies do not cover the full cost of providing health care; health facilities may also charge user fees set by the government to recover some costs from households. User fee exemptions are in place for specific priority diseases (e.g., tuberculosis and HIV/AIDS) or for indigent people. The purchasing mechanism is primarily input based, meaning that the government pays for inputs such as health worker salaries, commodities, and infrastructure, instead of paying for outputs such as number of services provided or number of patients treated. Health workers are salaried; currently there is no results-based financing program for providers.

9.3.2 Mandatory social health insurance

In 2011, the government of Togo enacted legislation establishing the *Régime obligatoire d'assurance maladie* (mandatory health insurance scheme) for civil servants, civil servant retirees, and up to six of their family members. The scheme is managed by the National Institute of Health Insurance (*L'Institut National d'Assurance Maladie*, INAM). INAM started offering benefits in 2012.

The scheme is financed through a compulsory levy of a civil servant's salary (3.5% of the salary from the public employer and 3.5% of the salary from the employee). Local governments and other public institutions are responsible for collecting premiums via payroll deductions and for transferring the funds to INAM monthly.

INAM aligned its provider payment rates with those of the Ministry of Health because private reimbursement rates were quite high and would not have been financially sustainable for the scheme. INAM reimburses or prepays facilities up to 80% of the official reimbursement rate for public sector facilities, whereas the insured member pays the remaining 20% (or higher) balance to the facility. The rate of coinsurance paid by members varies depending on the type of service (INAM 2016). INAM contracts with public and private health facilities, pharmacies, and eye care facilities. Some 193 private facilities comprise about half of all empaneled providers.

INAM mainly covers curative care. Covered treatments include cardiovascular illnesses, metabolic and endocrine diseases, nephrological diseases, systemic diseases, rheumatoid conditions, mental illness, bowel disease, cancer, malignancies of the lymphatic tissue, hematoma, ophthalmic diseases, and diseases of the ear, nose, and throat. General medicine, specialty consultations, prenatal consultations, and certain drugs and medical devices are also covered.[F]

Family planning commodities and services are not covered.

9.3.3 Community-based health insurance

In Togo, there is little coordination between the government and private CBHI schemes. Fewer than thirty CBHI schemes exist—often with limited benefits.

The number of CBHI schemes has been slowly growing since 1997. The Belgian Development Cooperation is currently supporting a census of CBHI schemes, as well as strengthening management capabilities of community-based schemes. The International Labor Organization and UNICEF have supported the development of standardized criteria for targeting indigents and vulnerable populations in Togo. These criteria were validated in December 2015, and they will likely be used for future universal health coverage initiatives.

Family planning commodities and services are not covered by CBHI schemes, according to in-country informants interviewed.

9.3.4 Private health insurance

Private health insurance penetration is low (<2%) in Togo. Participation in private health insurance is voluntary. Employer-sponsored health insurance (aside from mandatory social health insurance contributions from government employers) is negligible. A few private insurance companies exist, but they mainly offer accident or supplemental coverage for the social health insurance scheme.

9.3.5 Household out-of-pocket spending

Household out-of-pocket spending comprises around 40% of total health expenditure. This level of out-of-pocket spending suggests that many households lack adequate financial protection for health care costs. As more citizens gain access to and enroll in financial protection mechanisms such as health insurance, household spending will likely shift from out-of-pocket spending to regular premium payments to risk-pooling schemes offered by the government, employers, the community, or private insurers.

[F] For the full list of covered services, refer to the INAM public website: http://www.inam.tg/index.php/inam.

9.4 Progress Toward Universal Health Coverage and Universal Access to Family Planning

The PNDS presented several strategies to improve financial protection. Through social health insurance, Togo is developing domestic expertise in risk pooling and health insurance management. The Ministry of Health has commissioned studies to identify the requirements and feasibility of expanding social health insurance under the *Régime obligatoire d'assurance maladie* to other population groups such as workers in the informal and agricultural sectors. One study is under way to set criteria and determine the contributory capacities of populations, according to each professional category. Another study is under way with the support of UNICEF to define a minimum benefit package for the poor. At the time of this landscape study, an action plan to extend social health insurance to other populations had not been made public.

Other strategies from the PNDS included increasing domestic resources for health, mobilizing resources from the private sector, and scaling up CBHI with subsidies for the poor. A development plan for CBHI had not been made public at the time of this study.

The PNDS included an embedded health financing strategy. The strategy includes increased revenue for facilities resulting from scaling up risk-pooling schemes (such as universal health insurance) and scaling up CBHI. In addition, the strategy requires increasing government health spending to reach the Abuja Declaration target of 15% and increasing private sector participation in the financing of health services through cost recovery from households and through mobilization of resources from associations, NGOs, businesses, and private companies.

To mobilize resources for the PNDS, the government of Togo subscribed to the International Health Partnership (IHP+) in 2010. Togo and donors signed a compact for donors to support implementation of the PNDS through operational plans at all levels of the health sector. This movement has ensured joint funding by donors for the Mid-Term Expenditure Framework 2012-2014, which translated government strategies into public expenditure programs within a coherent multiyear macroeconomic and fiscal framework.

International donors have been collaborating with the government of Togo for health financing through other mechanisms, as well. Since 2011, the Providing 4 Health (P4H) Social Health Protection Initiative—to enhance collaboration between a broad mix of key development partners and investors in UHC and national governments—has been strategizing with Togo to advance UHC (P4H 2011). Its Priority 4 engagement strategy is to explore diverse health financing options and complementarities by proposing different options to extend coverage to the entire population. These options include exemptions, subsidized premiums, mandatory social health insurance or CBHI, equity funds and innovative financing options such as para-fiscal charges (e.g., mobile telephone tax), corporate social responsibility, and public-private co-investments.

To pursue universal access to family planning and join the Family Planning 2020 Movement, the government published and disseminated the *Plan d'Action pour le Repositionnement de la planification familiale de 2013-2017* (Action Plan for Repositioning Family Planning). Strategies to reposition and increase coverage of family planning include community-based distribution, mobile and outreach strategies for rural populations, and development of plans to secure and strengthen logistics and product management. The *Plan d'Action* acknowledged that although government has been contributing to financing of contraceptives since 2008, government financing of family planning remains low due to challenges convincing some policymakers that family planning should be financed by the government.

Currently, family planning activities and commodities are almost entirely financed by international donors, and the government contribution is lower in Togo than in comparable countries. The *Plan d'Action*'s financing strategy is to hold events with parliamentarians and other decision makers with

budgetary approval authority in order to advocate for government funding for family planning. The *Plan d'Action* identified several ways to engage the private sector in financing family planning: execute memoranda of understanding with civil society organizations to advocate for increased government funding; run public service announcements through private media outlets to increase demand for family planning; integrate family planning services in private clinics; develop a civil society and private sector engagement strategy; and contract with private sector providers.

In terms of collaboration with the private sector, a Ministry of the Private Sector has a basic framework for engagement. However, at the time of this landscape study, few partnerships related to the health system exist. USAID supported the private sector platform and provides support for the secretariat and office space.

9.5 Opportunities in Health Financing

Existing health financing mechanisms provide some financial protection for citizens, but on the whole, they do not ensure it adequately. The system's reliance on out-of-pocket spending leaves many poor and vulnerable households behind, as even the nominal user fees that public health facilities are allowed to charge can be prohibitive, even to access basic health services. The three insurance mechanisms discussed above cover a very small proportion of the population: according to the 2014 Demographic and Health Survey, less than 2% of women and men participate in health associations, community-based health insurance, or private health insurance, and only 4% of survey respondents reported employer-sponsored health insurance (MPDAT, MS, and ICF International 2015).

HFG identified some opportunities to strengthen and clarify policies related to health financing and expanding health coverage. The PNDS appeared somewhat inconsistent in its handling of private sector resource mobilization. One strategy cited was to partially finance the PNDS by increasing cost recovery from households; another simultaneously aimed to reduce household out-of-pocket spending for health. These two strategies are not necessarily contradictory, but to achieve both at the same time may be a challenge. The decrease in share of out-of-pocket spending would be through a gradual expansion of enrollment in mandatory social health insurance and voluntary private CBHI. At the time of HFG's analysis, an action plan to extend the mandatory social health insurance scheme to other populations was still under development. Furthermore, because benefit packages are limited to curative care, family planning services and other critical preventive and promotive services are excluded from coverage and are not reimbursed by social health insurance or private insurance programs.

Opportunities to strengthen implementation of health financing mechanisms include these:

- Identifying ways to spend existing funds for health care more efficiently (e.g., the 2016 evaluation of the PNDS reported that less than a third of the funds for family planning had been spent)
- Increasing transparency of health spending by publishing the delayed National Health Account report
- Increasing cooperation with private stakeholders through public-private partnerships and increased political dialogue
- Increasing capacity and improving access to care by contracting out health service delivery to private providers
- Establishing a supervising and coordinating mechanism for CBHI schemes
- Strengthening governance of social health insurance

9.6 Sources

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ANNEX A: SELECTION MATRIX

Potential "core" countries: Countries included in the USAID West Africa Regional Development Cooperation Strategy	Selection criteria				Score
	Potential high impact country for technical assistance Weight of criterion = 3	Country is in the Ouagadougou Partnership Weight of criterion = 2	Country is a USAID family planning priority country Weight of criterion = 2	Country does not have a USAID mission Weight of criterion = 1	
Benin	3	2			**5**
Burkina Faso	3	2		1	**6**
Cameroon	3			1	**4**
Cape Verde				1	**1**
Chad				1	**1**
Cote d'Ivoire		2		1	**3**
Equatorial Guinea				1	**1**
Gabon				1	**1**
Ghana*			2		**2**
Guinea	3	2			**5**
Guinea Bissau				1	**1**
Liberia			2		**2**
Mali	3	2	2		**7**
Mauritania		2		1	**3**
Niger	3	2		1	**6**
Nigeria*			2		**2**
Sao Tome & Principe				1	**1**
Senegal	3	2	2		**7**
Sierra Leone					**0**
The Gambia				1	**1**
Togo	3	2		1	**6**
*Ghana and Nigeria are being proposed as reference countries					
Selected = 8					

Short list of potential "reference" countries	Country is in broader Africa region (to facilitate possible twinning)	Country is a USAID family planning priority country	Potential for UHC, private insurance regulation and/or family planning learnings
Bangladesh		X	High level of involvement of private sector and NGOs to deliver FP
Ethiopia	X	X	CBHI and SHI
India		X	RSBY and NHM, FP learnings
Indonesia		X	JKN
Ghana	X	X	Ghana National Health Insurance Scheme
Kenya	X	X	Well-documented UHC strategy
Malaysia			UHC strategy does not include SHI and will elucidate an alternative model
Nigeria	X	X	Experience with national health insurance and public-private partnerships
Philippines		X	PhilHealth
Rwanda	X	X	Mandatory enrollment in *mutuelles*
Nepal		X	Clear UHC vision
South Africa	X		Strong regulatory framework over private insurance
Tanzania	X	X	Single national health insurer, national RBF scheme, GFF recipient
Selected = 7			

ANNEX B: DATA COLLECTION TEMPLATE

Case Study Matrix Template

Background and Approach

The USAID West Africa Regional Health Office (WA/RHO) Mission has asked the Health Finance & Governance Project (HFG) to lead a landscape study on health financing strategies being used to pursue Universal Health Coverage (UHC). The landscape study will synthesize lessons learned and findings will inform potential interventions that are implementable in the West Africa region. The study will also review the role of private health financing in achieving UHC and assess if and how family planning is included within UHC strategies.

HFG will gather comparable information for countries selected. This template will be completed for each country using desk-based research of documents available in the public domain, key informant interviews and in-country data collection for up to five selected "focus" countries. Sources of data will include health sector strategic plans and their annual / mid-term evaluations, health financing strategies, Health Accounts, costed implementation plans for family planning, peer-reviewed journal articles, gray literature and other documents available in the public domain.

Based on data gathered, HFG will prepare succinct country snapshots on the major health financing arrangements for each country, including their coverage of family planning. Findings from the data collection will be consolidated and summarized in a 10-15 page report that will include cross-country comparisons.

Objectives

1. To identify health financing strategies that are successfully being used to move towards UHC in 15 LMICs in Africa and Asia
2. To highlight the role of private health financing within these strategies
3. To highlight the extent to which these strategies are successfully expanding FP coverage in these countries
4. To identify which of these strategies have reasonable potential for successful implementation in West African contexts, and why

Health Policies Overview: Country Context

Please review the government's current or most recent health sector policy documents. Keep responses to one paragraph, and include citations.

Health Sector Strategic Plan (or equivalent):

What are the overarching vision and goals outlined in the document? Does the document mention UHC and its three components? If so, what is the strategy for moving towards UHC? How is the role of the private sector defined in this strategy? Does the document mention increasing coverage of FP services? If so, what is the strategy for moving towards better coverage of FP? Do the plans address the needs not only of public facilities and clients, but also private service providers?

1. **Health Financing Policy (or equivalent):** What are the overarching vision and goals laid out in the policy? If applicable, are UHC and FP specified? What technical approach(es) does the policy propose to achieve UHC and/or expand FP coverage?
2. **Reproductive Health or Family Planning Policy (or equivalent):** What are the overarching vision and goals for FP laid out in the policy? If applicable, how is UHC specified?
3. **All Documents / National Health Accounts:** As available, describe what is known about household spending on health and FP. For example: what is the household share of total health spending/family planning services; what is the per capita household spending on health/family planning services; what do households pay for (e.g., premium payments, out of pocket payments for services, etc.)?

Health Sector Overview

In this section, we will describe arrangements that provide partial or comprehensive health coverage to a portion or all of the population. These arrangements may have potential for contributing to UHC in the country. Under each distinct arrangement, we will review aspects of revenue collection, risk pooling, purchasing mechanisms, program performance and equity. Revenue collection refers to how resources are raised to fund health care goods and services. Risk pooling is the function that transfers collected revenues to organizations purchasing health care goods and services. Pooling ensures that the risk of paying for health interventions is borne equitably by all the members of the pool and not by each contributor individually, to increase financial protection of those who use services. For the purchasing function, the data collection will focus on payment mechanisms used by purchasing organizations (like health insurers or governments) to purchase health goods and services, for example input-based payments, fee-for-service, capitation. Provider payment mechanisms will help the team to assess the financial sustainability of the financing arrangements used to achieve UHC.

Each financing arrangement may be funded, managed or implemented differently. Examples of financing arrangements may include: Government direct funding of health facilities, government sponsored social health insurance, community-based health insurance, private health insurance (offered through insurance companies), employer-sponsored financing for health.

Enter "NA" in the matrix if the question on the left is not applicable to the program.

Population coverage and services		Financing arrangements				
Identify major arrangements that aim to reduce financial barriers and expand access to more and better health services for the population, when the program started and date of any major reforms. List one program per column.		**Government direct funding of health facilities (including public facilities and contracted private/FBO facilities)**	**Private commercial health insurance**	**[Social health insurance scheme]**	**[Community-based health insurance]**	**[Other arrangement]**
Population covered: • Who is eligible? Include key statistics such as number enrolled, others? • How are beneficiaries identified and targeted?	Poor/vulnerable. Define these groups (per program, if necessary)					
	Non-poor informal sector					
	Formal sector employees					
Benefits • Summarize main benefits • Summarize exclusions • Document family planning benefits, if any	Poor/vulnerable Define these groups (per program, if necessary)					
	Non-poor informal sector					
	Formal sector employees					

Population coverage and services		Financing arrangements				
Identify major arrangements that aim to reduce financial barriers and expand access to more and better health services for the population, when the program started and date of any major reforms. List one program per column.		**Government direct funding of health facilities (including public facilities and contracted private/FBO facilities)**	**Private commercial health insurance**	**[Social health insurance scheme]**	**[Community-based health insurance]**	**[Other arrangement]**
Service delivery • At what types of facilities are services provided, including FP services? • Can beneficiaries of government programs access private facilities? • What degree of choice/access does each program include? • What degree of choice do beneficiaries have to access FP services?						
Functions and characteristics of financing arrangements						
Resource mobilization	• From government e.g., general taxes, earmarked taxes, sin taxes, payroll taxes for formal sector workers? • From private sources, e.g., employer contributions, employer-subsidized program, beneficiary contributions? • Beneficiary cost sharing at the point of service?					

Population coverage and services		Financing arrangements				
Identify major arrangements that aim to reduce financial barriers and expand access to more and better health services for the population, when the program started and date of any major reforms. List one program per column.		**Government direct funding of health facilities (including public facilities and contracted private/FBO facilities)**	**Private commercial health insurance**	**[Social health insurance scheme]**	**[Community-based health insurance]**	**[Other arrangement]**
	• Relative percentage of national health services provided through program?					
Risk pooling	• How is risk pooling structured? E.g., is there one or multiple risk pools?					
Performance	• What are the successes and challenges of this program in contributing to UHC? • How financially viable is the program currently? • How does this program control costs (e.g., co-payments, provider payment strategies e.g., DRG or capitation, utilization reviews)?					

Population coverage and services		Financing arrangements				
Identify major arrangements that aim to reduce financial barriers and expand access to more and better health services for the population, when the program started and date of any major reforms. List one program per column.		**Government direct funding of health facilities (including public facilities and contracted private/FBO facilities)**	**Private commercial health insurance**	**[Social health insurance scheme]**	**[Community-based health insurance]**	**[Other arrangement]**
Institutional oversight	• Which entity/ agent/stakeholder manages/oversees revenue collection, pooling and purchasing? • Is there a regulatory body? • How are functions managed? • Are there known strengths & weaknesses?					
Purchasing—provider payment mechanisms	• Describe the provider payment mechanisms for outpatient health care (including preventive and promotive care and FP; consultations; diagnostics, pharmacy). • Describe the provider payment mechanisms for inpatient care.					

Population coverage and services		Financing arrangements				
Identify major arrangements that aim to reduce financial barriers and expand access to more and better health services for the population, when the program started and date of any major reforms. List one program per column.		**Government direct funding of health facilities (including public facilities and contracted private/FBO facilities)**	**Private commercial health insurance**	**[Social health insurance scheme]**	**[Community-based health insurance]**	**[Other arrangement]**
	• Are there provider incentive payments and, if so, how does this work? E.g., results-based financing, voucher programs					

Financial equity		Government direct funding of health facilities (including public facilities and contracted private/FBO facilities)	Private commercial health insurance	[Social health insurance scheme]	[Community-based health insurance]	[Other arrangement]
Subsidies for pre-payments	• Describe the program's approach to subsidies for pre-payments (i.e., premiums), if applicable. • To what extent are subsidies designed to improve equity (i.e., do the poor receive a higher subsidy than non-poor)? • Provide specific information about any separate features of subsidies covering poor and vulnerable people, the non-poor informal sector, and the formal sector.					
Financial protection at the point of care	• What is the general exposure of users of health services to out-of-pocket expenditure under this system? • Describe financial protection mechanisms for households under this system (e.g., user fee exemptions, vouchers for certain services, limits on cost sharing, etc.) How are these targeted, if at all? • Do households have to pay out of pocket for family planning benefits?					

ANNEX C: KEY INFORMANTS

Country	Name	Title	Office address	Office number	Mobile number	Email address(es)	Interviewed
Benin	Dr Toukourou Tidjani	*Présidente de la Plateforme du secteur sanitaire privé (PSSP)*	01 BP5355 Cotonou	229 65 01 40 05	229 95 33 85 20/95 95 20 66	tidjkr@yahoo.fr	Yes
Benin	Dr Dossou Gbete Lucien	*Vice Président PSSP ex Président de l'Association des cliniques privées du Bénin DG clinique Louis Pasteur Cotonou*	01 BP5355 Cotonou	229 65 01 40 05	229 95 96 38 32	luciendgl@gmail.com	Yes
Benin	Gainsi Epiphane	*PSSP*	01 BP5355 Cotonou	229 65 01 40 05	229 97 60 99 49	codgan9124@yahoo.fr	No
Benin	Mr Hugues B, M, Tchibozo	*Directeur Général adjoint de l'Agence Nationale de l'Assurance Maladie (ANAM)*	06 bp 3960 Cotonou	22997 60 11 01	229 95 45 41 25	htcourrier@yahoo.fr	Yes
Benin	Christian Marcel Lodjou	*Directeur des Partenariats Stratégiques, de la communication et de la Mobilisation des Ressources de l'Agence Nationale de l'Assurance Maladie (ANAM)*	03 BP 3245 Bénin		229 97 98 24 73	lodjou_christian@yahoo.fr	No
Benin	Dr Serge F, Hazoume	*Médecin cnseil NSIA Assurances*	08 BP 0258 TripostalCotonou	229 21 36 54 04		hazoumeserge@yahoo.fr	Yes
Benin	Mr Koto—Yérima Aboubakar	*Président du Conseil National des Structures d'Appui aux Mutuelles de Santé (CONSAMUS)*	03 BP 1151 Cotonou	229 97 84 86 47	229 95 84 37 58	kotoyerimaa@yahoo.fr	Yes
Benin	Dr A hounou D, Gaston	*Direction de la Santé de la Mère et de l'Enfant—Chef Division Planification Familiale et Santé des Adolescents et des Jeunes-Ministère de la Santé*		229 21 33 20 21	229 97 27 99 57	ahoudes2001@yahoo.fr	Yes
Benin	Justin Sossou	*Secrétaire Général Adjoint du Ministère de la Santé*			229 95 38 21 31/97193780	adanjus2014@gmail.com	
Benin	Léandre Hounhoui	*Chef Division Etudes Point Focal Comptes Nationaux de la Santé: Direction de la Programmation et de la Prospective—DPP-Ministère de la Santé*			229 96 48 57 04	leandrehounhoui@yahoo.fr	Yes

Country	Name	Title	Office address	Office number	Mobile number	Email address(es)	Interviewed
Benin	Mr Adam Tairou Yafradou	*Directecteur Général des Affaires Sociales et de la Solidarité Nationale—Ministère de la Famille*			229 67 00 96 47	yafradou@yahoo.fr	Yes
Benin	Mr Eustase Zounghan Cyrille	*Chef adjoint de la Cellule Suivi Evaluation de la DPP-Ministère de la Santé*			229 959576 97	eustcz2002@yahoo.fr	Yes
Benin	Mr Nicolas Ayedayo	*Chef de Service Bureau Budget et Comptabilité—Direction des Ressources Financières et Matériel (DRFM) Ministère de la Santé-*			229 97 11 27 88	niadjidayo@yahoo.fr	Yes
Benin	Mr Armand Yahounou	*Secrétaire Général Association des Assureurs Privés (SIG)*			229 97 47 20 75/ 95 95 15 12	armandyeh68@yahoo.fr	No
Benin	Pascal Soglohoun	*EX HFG projet USAID ANCRE*			229 97 49 12 70	psoglohoun@gmail,com	No
Burkina Faso	Dr Dipama S. Sylvain	*Directeur Général des études et des statistiques sectorielles, Ministere de la Sante*		+226 70 25 78 14		dipamas@yahoo.fr	
Burkina Faso	Dr Sanon Théophile	*Directeur de la prospective et de la planification opérationnelle*				theosan26@yahoo.fr	
Cameroon	Mr Djouldé Maina	*Chef Division Coopération*	Ministère de la Santé			mainadjoulde@yahoo.fr	No
Cameroon	Dr Cheumaga	*Directeur de la Promotion de la Santé*	Ministère de la Santé		675 37 51 97		No
Cameroon	Dr Fezeu Maurice	*Chef de la Cellule des Informations Sanitaires*	Ministère de la Santé		695 11 08 52	mauricefe@yahoo.fr	
Cameroon	Mme Djukam Germique Epouse Bouba	*Directrice de la Sécurité Sociale*	Ministère du Travail et de la Sécurité Sociale		696 87 24 29	germiqueb@yahoo.fr	No
Cameroon	Dramane Batchabi	*Protection Sociale*	Bureau International du Travail/Cameroun		655 35 00 58	batchabi@ilo.org	No
Cameroon	Mr Gaston De Foix Evina	*Chef Cellule Promotion de la Mutualité*	Ministère du Travail et de la Sécurité Sociale		696 60 05 83	gastondefoix2@yahoo.fr	No
Cameroon	Dr Matezou Jacqueline	*Coordinateur Secrétarait Technique du Comité de pilotage et de Suivi de la Mise en Oeuvre de la Politique Sectorielle de santé*	Ministère de la Santé		696 12 13 12	jumaz6@yahoo.com	No

Country	Name	Title	Office address	Office number	Mobile number	Email address(es)	Interviewed
Cameroon	Dr Okala	*Coordinateur de l'Unité de Coordination du Programme Conjoint Minsanté KfW/AFD*	Ministère de la Santé		656 40 25 05	perspectivesante2012@gmail.com	Yes
Cameroon	Mr Enandjoum Bwanga	*Coordinateur National du Projet d'Appui aux Investissements du Secteur Santé (PAIS)*	Ministère de la Santé		699 90 41 31	enandjoumbwanga@yahoo.fr	Yes
Cameroon	Mr Ngue David Emmanuel	*Directeur Technique Adjoint*	Caisse Nationale de Prévoyance Sociale (CNPS)	22 23 40 11	677 61 26 84	emmanuel.ngue@cnps.cm	No
Cameroon	Mr Otou Yves Lucien	*Chargé d'Etudes et Assistant*	Caisse Nationale de Prévoyance Sociale (CNPS)	22 23 40 11	699 77 20 43	yvesotou@gmail.com	No
Cameroon	Mr Hozier Nana	*Secrétaire Général*	Service d'Appui aux Initiatives Locales de Développement (SAILD)		99 93 17 81	hozier.nana@saild.org	Yes
Cameroon	Bernard Onambélé	*Service Clientèle*	Contrat sous gestion ASCOMA Cameroun 445, Bd du Gal de Gaulle	21 21 30 55		bernardonambele@yahoo.fr	Yes
Guinea	Dr Mohamed Faza Diallo	*Chef Service Formation et Perfectionnement*	Ministère de la Santé				No
Guinea	Dr Yéro Boye Camara	*Directeur Adjoint, Bureau de Stratégies et du Développement*	Ministère de la Santé		655 98 16 34	yeroboye@yahoo.fr	No
Guinea	Mme Aissatou Noumou Barry	*Secrétaire Générale*	DYNAM		657 97 04 15	aissatousidy@yahoo.fr	Yes
Guinea	Dr Madina Rachid	*Chef de Division SR*	Ministère de la Santé		664 25 64 70	mdinakebe@gmail.com	Yes
Guinea	Mohamed P. Sagno	*Directeur Santé*	UGAR—Activa		656 96 00 16	smohamedpeyrenamou@ugar-activa.com	Yes
Guinea	Dr Fodé Momo Cissé	*Directeur des Ressources Humaines*	Caisse Nationale de Sécurité Sociale		664 58 71 12	cissefodemomo@yahoo.fr	No
Guinea	Mr Haba Jules	*Chef Section Frais Médicaux et Pharmaceutiques*	Caisse Nationale de Sécurité Sociale		622 59 45 26	cissefodemomo@yahoo.fr	Yes

Country	Name	Title	Office address	Office number	Mobile number	Email address(es)	Interviewed
Guinea	Mr Moussa Traore	*Directeur National de l'Action Sociale*	Ministère de l'Action Sociale de la Promotion Féminine et de l'Enfance		621 54 70 56	traore592003@yahoo/fr	No
Guinea	Dr Mamady Kourouma	*Directeur National de la Santé faliliale et de Nutrition*	Ministère de la Santé		664 39 58 97	mamadykourouma@yahoo.fr	No
Guinea	Dr Yolande	*Chef d'Equipe Santé*	USAID/Guinée		664 23 36 61		No
Guinea	Dr Adzodo Mawuli	*Expert Sénior Systèmes de santé*	OMS Guinée		621 84 57 37	adzodom@who.int	No
Guinea	Dr Sékou CONDE	*Directeur National des Etablissements Hospitaliers et de Soins*	Ministère de la Santé		621 17 55 32	sekou53conde@gmail.com	No
Mali	Dr Salif Samake	*Conseiller Technique Ministère de la Santé et de l'Hygiène Publique*	Ministère de la Santé et de l'Hygiène Publique	76,111,606	76111606		No
Mali	Mme Koné Sissi Odile Dakouo	*Directrice Adjointe de la Protection Sociale et de l'Economie Solidaire*	Direction de la Protection Sociale et de l'Economie Solidaire	20237583	76111606	minjul2@yahoo.fr	No
Mali	Mamadou S. Ballo	*Coordonnateur Cellule d'Appui à la Décentralisation et à la Déconcentration*	Ministère de la Santé et de l'Hygiène Publique	20733126	76450543	balloomb@yahoo.fr	No
Mali	Sékou Oumar Tangara	*Directeur de Production*	Assurances Lafia, Hamdallaye ACI 2000	20,290,940		sekou.oumar@yahoo.fr	Yes
Mali	Mme Fadima I. Maiga	*Assistante au Service Commercial*	Assurances Lafia, Hamdallaye ACI 2000	2029040	66735328	zelpdgp@yahoo.fr	No
Mali	Saleck Ould Dah	*Advocacy &Campaign Advisor*	Save The Children, Hamdallaye ACI	20296135	96482572	saleck.dah@savethechildren.org	Yes
Mali	Mountaga Bouaré	*Directeur*	Cellule de Planification et de Statistiques SS—DS—PF	20733139	66720578	pa27mountag12debore@yahoo.fr	
Mali	Ankoundio Luc Togo	*Directeur Général*	CANAM, Bamako, Mali	44901987	66135555	togoluc52@yahoo.fr	Yes

Country	Name	Title	Office address	Office number	Mobile number	Email address(es)	Interviewed
Mali	Issa Bengaly	*1er Secrétaire Administratif*	Union Nationale de Travailleurs du Mali, Boulevard de l'Indépendance, Bamako	20222031		isbengaly@yahoo.fr	No
Mali	Issa Sissouma	*Directeur Général*	Union Technique de la Mutualité Malienne, Médina Coura, Rue 32, Bamako	20213349	66751650	sissoumaissa@yahoo.fr	Yes
Mali	Dr Marguerite Demblé Coulibaly	*Chef Division santé de la Reproduction*	Direction Nationale de la Santé, Bamako		666031245		No
Niger	Mr Galadima Abdoul. Karim Souley	*DRFM/Directeur des Ressources Financières et Matériels/ Direction Générale des Ressources/M.S.*	BP 623 Niamey	227 20 72 47 26	227 96 97 81 52/227 90 40 87 64	souleygala@yahoo.fr	Yes
Niger	Mr Djibo Garba	*directeur Directeur des Etudes et de la Programmation (DEP)/M,de la Santé*	BP 623 NIAMEY	227 20 72 47 26	96507078	djibogarba@yahoo.fr	Yes
Niger	Mme Ocquet Sakina	*chef Chef Division Etudes et Recherches/ DEP*	BP 623 NIAMEY	227 20 72 47 26	96 29 05 33	sakinahabou@yahoo.fr	Yes
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