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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: Burkina Faso

January 2017

This publication was produced for review by the United States Agency for International Development.
It was prepared by Jenna Wright, Karishmah Bhuwanee, Ffyona Patel, Jeanna Holtz, Thierry van Bastelaer, and Rena Eichler for the Health Finance and Governance Project.

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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FINANCING OF UNIVERSAL HEALTH COVERAGE AND FAMILY PLANNING

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

BURKINA FASO

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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.

3. BURKINA FASO

3.1 Country Snapshot

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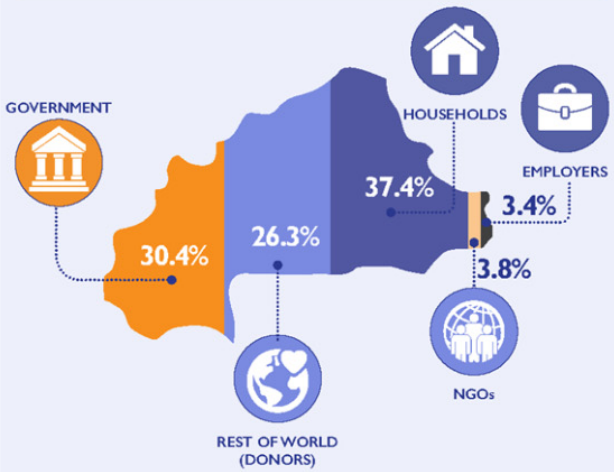
Burkina Faso

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



KEY INDICATORS

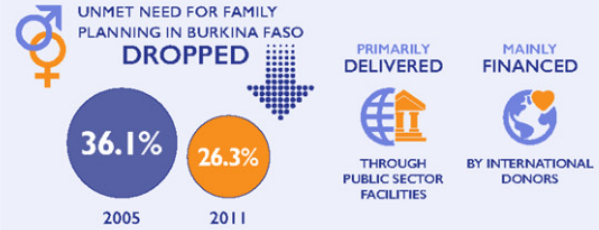
Indicator	Value (Year)
Population	18,105,600 (2015)*
General government expenditure on health as a percentage of total government expenditure	12% (2013)**
Total health spending per capita	$41 (2013)**
Private prepaid plans as a percentage of total expenditure on health	1.5% (2013)**
Unmet need for family 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.

FAMILY PLANNING



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.
3 Institut National de la Statistique et de la Démographie (INSD) et ICF International. 2012. Enquête Démographique et de Santé et à Indicateurs Multiples du Burkina Faso 2010. Calverton, Maryland, USA
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 1: 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		
• 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		
• 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	✓	✓	✓

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.

3.2 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 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.

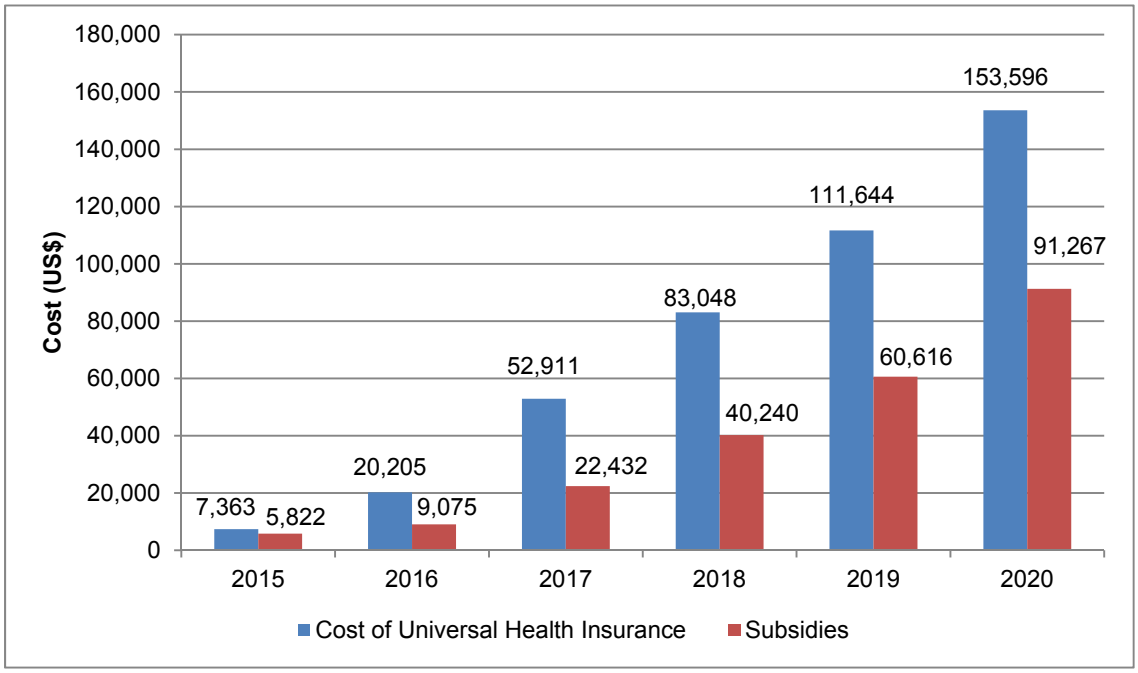
3.5 Opportunities in Health Financing

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 2: 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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