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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: Mali

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.

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FINANCING OF UNIVERSAL HEALTH COVERAGE AND FAMILY PLANNING

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

MALI

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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.

6. MALI

6.1 Country Snapshot

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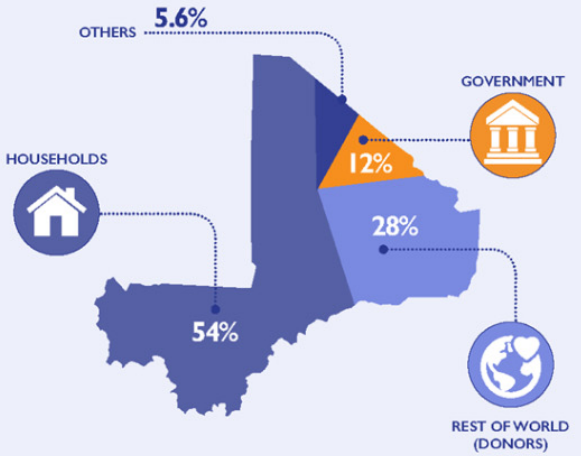
FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

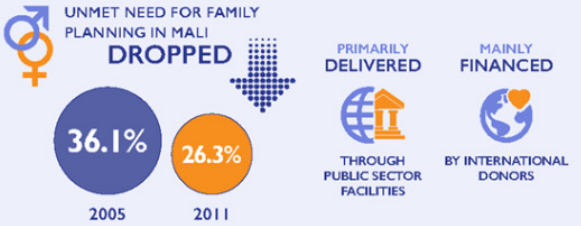
Mali

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 1: 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

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
• 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

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
• 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	✓	✓	✓

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.

Abt

6.2 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 Mali and other West African countries. This chapter describes the health financing landscape in Mali 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.

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.

6.6 Sources

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