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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: Togo

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

TOGO

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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.

9. TOGO

9.1 Country Snapshot

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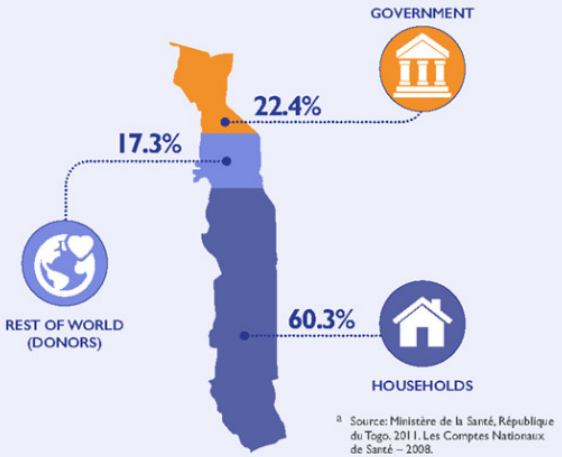
FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

Togo

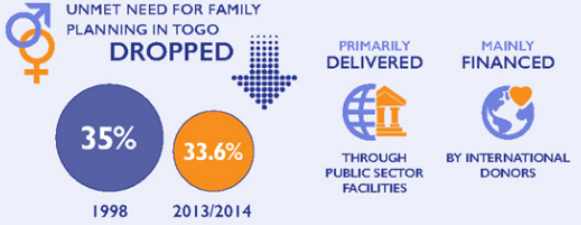
Togo's Strategies for Improving Coverage of Health Services

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 Sanitaire (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 1: 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	✓	✓	✓

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.

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.[1]

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.

[1] 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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