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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: Benin

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

BENIN

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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.

2. BENIN

2.1 Country Snapshot

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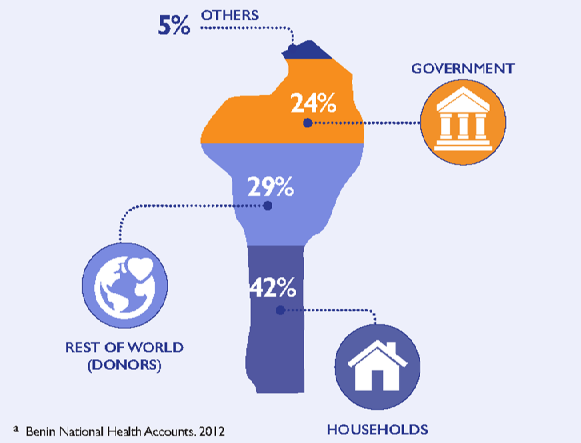
Benin

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

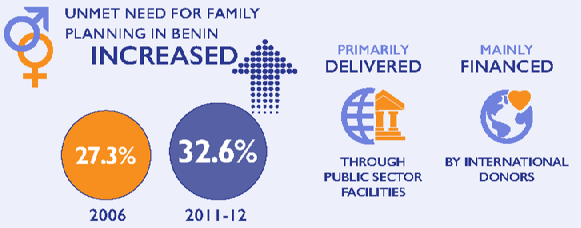
Benin's Strategies for Improving Coverage of Health Services

TOTAL HEALTH SPENDING BY SOURCE[a]



[a] Benin National Health Accounts. 2012

FAMILY PLANNING



KEY INDICATORS

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

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

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

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

Challenges and Opportunities

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

1 Benin Ministry of Health. September 2009. Plan National de Développement Sanitaire 2009-2018.
2 Health Finance and Governance Project. 2015. HFG at Work in Benin. https://www.hfgproject.org/where-we-work/africa/benin. Accessed 6 July 2016.
3 Benin Ministry of Health. May 2013. Etat Des Lieux du Systeme du Financement de la Santé au Benin. Cotonou, Benin
4 Benin Ministry of Health. 2013. Politique Nationale de Santé.
5 ICF International. 2012. The DHS Program STATcompiler. http://www.statcompiler.com. Accessed June 2016. Benin Ministry of Health. 2013. Plan d'Action National Budgétisé pour le Repositionnement de la Planification Familiale 2014-2018 au Benin.
7 United Nations Population Fund (UNFPA). April 2015. Benin: UNFPA Supports the Improvement of Family Planning Services.

Figure 1: Benin Country Snapshot

Public and Private Sector Roles in Health Financing

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

THE PUBLIC SECTOR'S ROLE IN HEALTH FINANCING

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

THE PRIVATE SECTOR'S ROLE IN HEALTH FINANCING

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

Health Financing Mechanisms by Population Segment

Health financing mechanisms available to population segments will vary:

PUBLIC SECTOR

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

PRIVATE SECTOR

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

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

2.2 Background

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

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

2.3 Benin's Health Financing Landscape

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

2.3.1 Government financing for health services

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

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

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

2.3.2 Social health insurance

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

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

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

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

2.3.3 Community-based health insurance

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

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

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

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

2.3.4 Private health insurance

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

Family planning is not covered by private health insurance products.

2.3.5 Household out-of-pocket spending

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

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

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

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

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

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

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

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

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

2.5 Opportunities in Health Financing

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

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

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

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

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

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

2.6 Sources

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