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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: Guinea

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.

January 2017

Cooperative Agreement No: AID-OAA-A-12-00080

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Recommended Citation: Wright, Jenna, Karishmah Bhuwanee, Ffyona Patel, Jeanna Holtz, Thierry van Bastelaer, and Rena Eichler. 2016. *Financing of Universal Health Coverage and Family Planning: A Multi-Regional Landscape Study and Analysis of Select West African Countries*. Report prepared by the Health Finance & Governance Project. Washington, DC: United States Agency for International Development.

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FINANCING OF UNIVERSAL HEALTH COVERAGE AND FAMILY PLANNING

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

GUINEA

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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

ACKNOWLEDGEMENTS

This study was funded by the United States Agency for International Development (USAID), and implemented by the Health Finance and Governance Project.

Mr. Abdoulaye Ba, Senior Health Financing Consultant, supported data collection and key informant interviews in Cameroon, Guinea, Mali, and Senegal. Dr. Birahime Diongue, Senior Health Financing Consultant, supported data collection and key informant interviews in Benin, Niger, and Togo. Dr. André Zida, Senior Health Financing Specialist, supported data collection and key informant interviews in Burkina Faso.

The leadership, support, collaboration, and input of USAID/West Africa Regional Health Office (WARHO) colleagues were critical in completing this landscape study and analysis. The authors are grateful for the support provided by Dr. Eleonore Rabelahasa, Senior Health Systems Strengthening and Policy Advisor (WARHO), and Ms. Rachel Cintron, Health Office Director (WARHO). The authors recognize the active participation and collaboration of USAID Missions and multiple implementing partners and non-governmental institutions in Benin, Burkina Faso, Cameroon, Guinea, Mali, Niger, Senegal, and Togo. The authors are also grateful for the input and collaboration provided by Ministries of Health and other government agencies in these countries. The authors are grateful to all the key informants, who shared their time and wisdom (see Annex C for the list).

Finally, the authors are thankful to Bry Pollack (Abt Associates) for editing, Alain Schuster and Julie Verbert (ASJV Associates) for translating, and Erin Miles and Audrey Hanbury (Abt Associates) for designing the report.

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.

5. GUINEA

5.1 Country Snapshot

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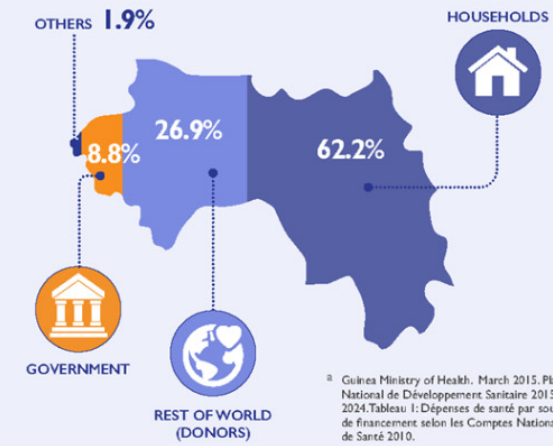
FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

Guinea

Guinea's Strategies for Improving Coverage of Health Services

TOTAL HEALTH SPENDING BY SOURCE[a]



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

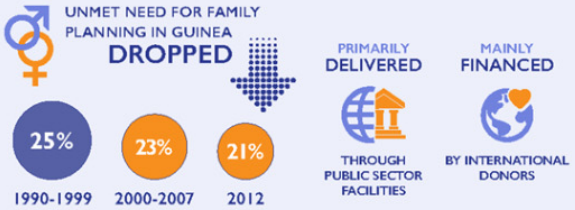
KEY INDICATORS

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

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

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

FAMILY PLANNING



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

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

Challenges and Opportunities

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

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

Figure 1: Guinea 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 (note that tax revenues are quite small given the limited ability of much of the population to pay taxes) • Grants or loans from development partners (26.9% of THE)	• Health services available at public health facilities and from community health workers • Community-based health insurance schemes pool risk at district level • Social health insurance will pool risk of all formal sector employees and their families at national level	• Central, regional and district governments purchase services provided at publicly owned health facilities and by salaried community health workers • Central, regional and district governments pay for services through these mechanisms: » User fee exemptions for some essential services » User fee waivers for all services for the poorest households » Premium subsidies for community-based health insurance » Purchase of services by community-based health insurance schemes on behalf of enrollees » Purchase of services by social health insurance scheme on behalf of enrollees (scheduled to start in 2016)

THE PRIVATE SECTOR'S ROLE IN HEALTH FINANCING

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

Health Financing Mechanisms by Population Segment

Health financing mechanisms available to population segments will vary:

PUBLIC SECTOR

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

PRIVATE SECTOR

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

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

5.2 Background

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

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

5.3 Guinea's Health Financing Landscape

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

5.3.1 Government financing for health services

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

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

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

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

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

5.3.2 Social health insurance

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

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

5.3.3 Community-based health insurance

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

5.3.4 Private health insurance

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

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

5.3.5 Household out-of-pocket spending

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

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

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

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

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

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

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

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

5.5 Opportunities in Health Financing

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

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

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

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

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

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

5.6 Sources

Bah, Thierno Hady (Consultant). 2015. État des lieux des Textes Régissant la Protection Sociale et les Mutuelles de Santé en République de Guinée: Rapport final. Plateforme des Promoteurs de la Protection Sociale en Guinée et Solidarité Mondiale/ Mutualité Wredlssolidariteit. Conakry, Guinea.

Caisse Nationale de Sécurité Sociale en Guinée. 2012. *Caisse Nationale de Sécurité Sociale: Ressources.* Accessed October 2016 at http://www.cnssguinee.org/content_manager.asp?CategoryID=118.

Essentiel International. 2016. *Guinée: Projet Santé Pour Tous: santé, protection sociale et dynamique concertée.* Accessed July 2016 at http://essentiel-international.org/nos-actions/guinee/.

Ministère d'Etat chargé de l'Économie et des Finances, Secrétariat Permanent de la Stratégie de Réduction de la Pauvreté (SP-SRP). 2013. Document de Stratégie de réduction de la pauvreté DSRP III (2013-2015).

Ministry of Health, Guinea. 2014. Plan National de Développement Sanitaire 2015-2024. Conakry, Guinea.

Ministry of Health, Guinea, World Health Organization, UNICEF, UNFPA, European Union, and USAID. 2014. *Stratégie de financement de la santé vers la couverture sanitaire universelle en Guinée.* Conakry, Guinea.

World Bank and Ministry of Health of Guinea. 2006. *Guinea: A Country Status Report on Health and Poverty.* African Region Human Development Working Paper Series No. 45. Accessed July 2016 at http://siteresources.worldbank.org/INTAFRREGTOPEDUCATION/Resources/444659-1212165766431/H_CSR_Guinea.pdf.

World Bank Group. 2016. "World Bank Group Ebola Response Fact Sheet." Accessed July 2016 at http://www.worldbank.org/en/topic/health/brief/world-bank-group-ebola-fact-sheet.