POLICY BRIEF

Strategic Health Purchasing in Benin

A Summary of Progress, Challenges, and Opportunities

JUNE 2021

STRATEGIC HEALTH PURCHASING FOR UNIVERSAL HEALTH COVERAGE IN SUB-SAHARAN AFRICA

The Strategic Purchasing Africa Resource Center (SPARC), a resource hub hosted by Amref Health Africa with technical support from Results for Development (R4D), aims to generate evidence and strengthen strategic health purchasing in sub-Saharan Africa to enable better use of health resources. SPARC and its technical partners created a framework for tracking progress in strategic health purchasing and are applying it in countries across sub-Saharan Africa to facilitate dialogue on what drives progress and to promote regional learning.

BENIN AT A GLANCE

- Population (2019): **11.8 million**
- GDP per capita (2019): **US$1,219**
- Poverty headcount at $1.90/day (2015): **50%**
- Life expectancy (2018): **61 years**
- Current health expenditure (CHE) per capita (2018): **US$31**
- Domestic government expenditure as % of CHE (2018): **20%**
- Out-of-pocket expenditure as % of CHE (2018): **45%**
- External expenditure as % of CHE (2018): **30%**

Source: World Bank Databank

Health Financing Schemes in Benin

Since adopting a constitution in 1990 that calls for equal access to health care for all citizens, Benin has launched several health financing schemes at the national and community levels. More recently, the Beninese government has been redesigning the country's social protection systems to facilitate access to health care and accelerate progress toward universal health coverage (UHC). This is being rolled out within the President's flagship *Assurance pour le Renforcement du Capital Humain* (ARCH) program, which includes a health insurance scheme (AM-ARCH) targeting the poor that is currently in the pilot phase.

Benin has four main types of health financing schemes:

- **GOVERNMENT BUDGET–FUNDED FREE HEALTH CARE SCHEMES.** These include programs that provide free malaria care for young children and pregnant women, free cesarean sections, and free COVID-19 diagnostic services and treatment, as well as the Health Fund for the needy.
- **PUBLIC HEALTH INSURANCE SCHEMES.** There are two types of public health insurance schemes. Government-subsidized schemes include the health insurance scheme for students in the public sector and AM-ARCH. Compulsory contributory schemes include *Un Régime Spécial des Fonctionnaires en Activité* (Special Regime for Civil Servants), the National Social Security Fund, and the Benin National Retirement Fund.
- **DONOR-FUNDED SCHEMES.** These are health programs funded mostly by external funders, with or without government budget funding. They include free care for HIV and tuberculosis (TB) patients and the Expanded Program on Immunization.
- **VOLUNTARY INSURANCE SCHEMES.** Voluntary contributory schemes include the Benin Social Security Mutual Fund, the *mutuelles de santé*, and private insurance schemes.

Table 1 compares the purchasing functions in these schemes.

Table 1. **Purchasing Functions in Benin's Health Financing Schemes**

	***Gratuité de la Césarienne* (Free Cesarean Program)**	***Assurance Maladie du Projet d'Assurance pour le Renforcement du Capital Humain* (AM-ARCH)**	***Un Régime Spécial des Fonctionnaires en Activité* (Special Regime for Civil Servants)**	***Mutuelles de Santé***	**Private Health Insurance**
% of Current Health Expenditure (2015)*	39% (all publicly funded schemes)			5% (private voluntary insurance schemes)	
Main Purchaser(s)	*L'Agence Nationale pour la Gratuité de la Césarienne* (ANGC) (National Agency for the Management of Free Cesarean Sections)	*Unité de Gestion du Projet ARCH* (UGP-ARCH); *Agence Nationale de Protection Sociale* (ANPS) will replace UGP-ARCH in the future	Ministry of the Economy and Finance (MOEF) (Budget Directorate)	*Mutuelles de santé*	Private insurers
Governance	ANGC, established by decree, carries out purchasing functions and is supervised by the Ministry of Health (MOH). Public facilities have limited autonomy to allocate *Gratuité* funds, according to MOEF guidelines for the use of public funds.	ARCH is led by UGP-ARCH, which reports to the President's Office but is supervised by the Ministry of Social Affairs and Microfinance. UGP-ARCH is the management unit that oversees purchasing functions. Public facilities have limited autonomy to allocate AM-ARCH funds, according to MOEF guidelines for the use of public funds.	MOEF collects contributions and transfers them to the treasury, which pays claims from providers. Public facilities have limited autonomy to allocate these funds, according to MOEF guidelines for the use of public funds.	Each *mutuelle* develops its own laws and regulations using the West Africa Economic and Monetary Union as a guidance document. The committee of *mutuelles*, *Conseil National des Structures d'Appui aux Mutuelles Sociales du Bénin* (COSAMUS), provides support and capacity building for *mutuelle* functions. COSAMUS mobilizes resources from donors and allocates them to the *mutuelles*. Public facilities have limited autonomy to allocate *mutuelle* funds, according to MOEF guidelines.	The *Conférence Interafricaine des Marchés d'Assurances* (Inter-African Conference of Insurance Markets) sets private insurance policy. Private insurers are autonomous and carry out all purchasing functions. Public facilities have limited autonomy to allocate private insurance funds, according to MOEF guidelines.
Financial Management	The annual budget is based on the projected number of services and historical expenditure. Budget overruns occur. Deficits are carried over to subsequent years, delaying payment to providers and accumulating arrears.	The annual budget is based on projected revenue from the government subsidy for the subsidized members; in the future, it will also include projected revenue from member contributions. No budget overruns yet in the pilot phase.	The annual budget is based on projected member contributions. Budget overruns occur and cause delays in provider payment.	The annual budget is based on projected member contributions. Budget overruns occur and are covered by borrowing from other *mutuelles*.	The annual budget is based on projected member contributions. Budget overruns, which occur rarely, affect profitability and are offset by other profits from the insurance company's other lines of business.
Benefits Specification	Explicit package that covers medical and transportation costs for cesarean section delivery (with treatment guidelines and gatekeeping requirements specified)	Explicit package of 26 interventions, including primary care and hospital care and with a focus on children under age 5 and pregnant women	Hospital services only; excludes medicines	Implicit package that is limited to services offered at health centers, with some *mutuelles* covering hospital care as well, and with well-defined cost-sharing arrangements	Different benefit packages that include primary care and hospital care
Contracting Arrangements	Selective contracting with public and private facilities	Selective contracting with public facilities only during the pilot phase	Loose agreements with public providers only	Contracting with mostly public providers	Contracting with public and private providers
Provider Payment	Case-based payment	Fee-for-service	Fee-for-service	Fee-for-service	Fee-for-service
Performance Monitoring	Regular monitoring of claims by medical doctors and onsite monitoring of services	Regular monitoring of claims by the medical council and onsite monitoring of services	No defined monitoring system; monthly "health bulletins" sent by providers to MOH, which summarizes care provided to beneficiaries	No defined monitoring system	Clinical audits, supervision visits, customer complaint mechanisms

** National Health Accounts 2015/16*

Progress and Challenges in Strategic Health Purchasing

Benin has made progress in strategic health purchasing through its health financing schemes by prioritizing services and targeting the poor and vulnerable in the new AM-ARCH program and developing benefit packages that meet their most pressing health needs. The *Gratuité de la Césarienne* program also uses output-based payment that is linked to the service delivery objective of increasing access to skilled providers for complicated deliveries.

Highlights of progress and remaining challenges in each of the purchasing functions are described below.

GOVERNANCE. In all schemes, purchasing functions have an institutional home that has a clear mandate for purchasing functions. Public providers have limited financial autonomy, and all revenues from user fees and reimbursements from private and public schemes are consolidated at the facility level and used according to Ministry of Economy and Finance guidelines. These guidelines stipulate that revenues are to be used in the following ways: 50% for medicines, 35% retained for facility operations, 10% sent to the health district and regional health office, and 5% for equipment and facility infrastructure improvements. Public providers have little autonomy to negotiate contracts and often accept low reimbursement rates and charge patients informal fees, even under subsidized programs such as the free cesarean section program.

FINANCIAL MANAGEMENT. In all schemes, purchasing arrangements incorporate mechanisms to ensure budgetary control, but these are not well enforced and budget overruns occur frequently. Public schemes are financially constrained because their budgets are dependent on government allocations and may vary depending on government priorities. The *Gratuité de la Césarienne* scheme and *Un Régime Spécial des Fonctionnaires en Activité* carry over deficits into the next financial year. Budget overruns affect the sustainability of *mutuelles de santé* and the profitability of private insurers. *Mutuelles de santé* get support from the federation of *mutuelles de santé*, which mobilizes resources from donors and allocates them to the *mutuelles*. Private insurers are able to offset losses through other insurance business lines.

BENEFITS SPECIFICATION. The government-funded schemes have defined benefit packages that generally reflect population health needs but are not well aligned with purchasing mechanisms. Benefit packages vary across public schemes but are often based on national-level health priorities (such as malaria and TB), gaps in coverage of health services, and/or the cost of services. Treatment guidelines and gatekeeping criteria specify access to services for the *Gratuité de la Césarienne* scheme. *Un Régime Spécial des Fonctionnaires en Activité* and *mutuelles de santé* define explicit benefit packages with clear guidelines on cost sharing and access to care. The *mutuelles de santé* set guidelines and gatekeeping criteria for each level of care (primary, secondary, tertiary) to control costs and the demand and supply of care.

CONTRACTING ARRANGEMENTS. Contracting arrangements vary among public and private providers, but most schemes use selective contracting with providers that is linked to achievement of specific objectives. The *Gratuité de la Césarienne* scheme uses criteria such as the type of health facility, geographic location, infrastructure and equipment, and cost to select providers. The *mutuelles de santé* mostly contract with private providers and use criteria such as the type of health facility, geographic location, and cost to select providers.

PROVIDER PAYMENT. Schemes use output-based payment, but only the *Gratuité de la Césarienne* scheme links payment to service delivery goals. Fee-for-service is the most commonly used payment system across schemes. In the *Gratuité de la Césarienne* scheme, providers are paid using case-based payment—a lump sum for each cesarean section performed. This bundles services to improve efficiency and manage costs. Private insurers set payment ceilings to prevent overprovision of services; beneficiaries also need preauthorization from the insurer for certain services. Open-ended fee-for-service and case-based payment mechanisms contribute to budget deficits and threaten financial sustainability, particularly in public schemes.

PERFORMANCE MONITORING. Performance monitoring is generally weak across all of the schemes, with little automation and minimal analysis at the provider and system levels. Most schemes use their own separate paper-based health information system, which leads to fragmentation of information and contributes substantially to inefficiencies. The current information systems have no way to link payment to the quality of care provided. AM-ARCH uses a digital identification system, which facilitates enrollment and monitoring of service provision and helps inform service improvements.

Table 2 summarizes progress made in strategic purchasing functions along the dimensions of progress defined by SPARC for the main schemes in Benin. (See the annex for a detailed explanation of how the levels of progress are indicated using ○, ●●, and ●●●.)

Table 2. **Progress Made Across Purchasing Functions in Benin**

Purchasing Function	Indicators of Strategic Purchasing	*Gratuité de la Césarienne*	AM-ARCH	*Un Régime Spécial des Fonction-naires en Activité*	*Mutuelles de Santé*	Private Insurers
Governance	Purchasing functions have an institutional home that has a clear mandate and allocation of functions.	●●	●●	○	●●	●●
	Providers have autonomy in managerial and financial decision-making and are held accountable.	●●	●●	●●	●●	●●
Financial Management	Purchasing arrangements incorporate mechanisms to ensure budgetary control.	○	●●*	○	●●	●●
Benefits Specification	A benefit package is specified and aligned with purchasing arrangements.	●●●	●●	○	●●	○
	The purchasing agency further defines service delivery standards when contracting with providers.	●●●	●●	○	●●	○
Contracting Arrangements	Contracts are in place and are used to achieve objectives.	●●	●●	○	●●	●●
	Selective contracting specifies service quality standards.	●●	●●	○	●●	●●
Provider Payment	Provider payment systems are linked to health system objectives.	●●	●●	●●	●●	●●
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	●●	○	○	●●	●●
Performance Monitoring	Monitoring information is generated and used at the provider level.	○	○	○	○	○
	Information and analysis are used for system-level monitoring and purchasing decisions.	○	○	○	○	○

** AM-ARCH is in the pilot phase and has not had any budget overruns so far.*

Benin's health purchasing arrangements have a number of weaknesses and challenges that hamper progress in strategic purchasing. The multiple health financing schemes are not always complementary and reflect different strategies and objectives. Fragmentation limits the purchasing power of individual schemes, leads to overlaps and significant gaps in coverage, promotes inequity in access to care, and leads to inefficient use of resources. Benin lacks a strategic health purchasing framework, and the laws and regulations governing the implementation of health insurance schemes are fragmented. Common challenges across schemes include delays in payment and weak or incoherent provider incentives. Weak gatekeeping and a weak referral system enable patients to seek care at any level, which leads to bypassing of primary care. Health information systems are fragmented and do not support purchasing decisions.

Opportunities to Improve Health Purchasing

Through AM-ARCH, Benin aspires to shift from passive to strategic health purchasing and achieve UHC and a more efficient health system. If fully implemented, AM-ARCH will expand access to quality health services, ensure financial risk protection for the population, and reduce fragmentation in the health financing system. This will consolidate purchasing functions for better allocation of resources and better information management, leading to greater efficiency through more harmonized benefit packages and provider payment across schemes. Strategies for achieving this goal include subsidized premiums for low-income individuals and families and potentially a mixed public/private health insurance ecosystem.

Benin also aims to improve information systems and integrate several existing schemes under AM-ARCH and create an integrated information system that provides timely data. This integration will occur gradually, starting with the public schemes whose benefit packages overlap with those of AM-ARCH.

*SPARC and its technical partners view strategic purchasing as a way to improve resource allocation, provide coherent incentives to providers, and improve accountability for health resources. As next steps, SPARC's partners in Benin—*Centre de Recherche en Reproduction Humaine et en Démographie *(CERRHUD)—will validate the SPARC findings with Beninese stakeholders and determine appropriate actions to make further progress in strategic purchasing as a way to achieve UHC in Benin.*

Strategic Purchasing Africa Resource Center (SPARC)

Amref Wilson Airport, Lang'ata Road
Nairobi, Kenya

info@sparc.africa
www.sparc.africa

SPARC
STRATEGIC PURCHASING AFRICA RESOURCE CENTER

RESULTS FOR DEVELOPMENT

CERRHUD COTONOU

Annex. **Strategic Purchasing Progress Indicators**

Governance	**Purchasing functions have an institutional home that has a clear mandate and allocation of functions.**	○	An agency or agencies have responsibility for carrying out one or more purchasing functions, but mandates are not clearly defined and capacity is weak.
		●●	An agency or agencies have responsibility for carrying out most or all purchasing functions and capacity is improving, but some overlaps and gaps in responsibilities remain. Mechanisms are in place for stakeholder engagement.
		●●●	An agency or agencies have responsibility for carrying out all purchasing functions, capacity is strong, and there are no overlaps or gaps in responsibilities. There is inclusive and meaningful stakeholder engagement.
	Providers have autonomy in managerial and financial decision-making and are held accountable.	○	Public providers have no autonomy or extremely limited autonomy to carry out financial and managerial functions, and they have limited ability to respond to financial incentives created by provider payment systems.
		●●	Public providers are given a larger degree of financial and managerial autonomy, but accountability mechanisms are weak.
		●●●	Public providers are given a large degree of financial and managerial autonomy, and accountability mechanisms are effective.
Financial Management	**Purchasing arrangements incorporate mechanisms to ensure budgetary control.**	○	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending, but these mechanisms are not well enforced.
		●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, but budget overruns routinely occur.
		●●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, and budget overruns rarely occur.
Benefits Specification	**A benefit package is specified and aligned with purchasing arrangements.**	○	A benefit or service package is defined and reflects health priorities, but it is not well specified, is not a commitment, and/or is not aligned with purchasing mechanisms.
		●●	A benefit or service package is defined, reflects health priorities, and is a commitment, but it is not well specified and/or not aligned with purchasing mechanisms.
		●●●	A benefit or service package is defined, reflects health priorities, is a commitment, is well specified, and is aligned with purchasing mechanisms, and a transparent process for revision is specified.
	The purchasing agency further defines service delivery standards when contracting with providers.	○	The purchaser defines some general standards for delivering services in the package (e.g., for gatekeeping), but enforcement through contracts is weak.
		●●	The purchaser defines some general service delivery standards and some specific service delivery standards (e.g., number of prenatal care visits) that are enforced through contracts.
		●●●	The purchaser defines general service delivery standards and specific service delivery standards in line with national service delivery policies and clinical protocols, and service delivery standards are enforced through contracts.
Contracting Arrangements	**Contracts are in place and are used to achieve objectives.**	○	Loose agreements are in place between the purchaser and public providers for specified services in exchange for payment instead of or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●	Formal agreements are in place between the purchaser and public providers for specified services in exchange for payment or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●●	Formal agreements are in place between the purchaser and public and private providers to help achieve specific objectives, and they are linked to performance.
	Selective contracting specifies service quality standards.	○	The purchaser has loose, nonselective agreements or contracts with all public providers and selective contracts with some private providers based on some definition of quality standards.
		●●	The purchaser contracts at least somewhat selectively with public and private providers based on accreditation or some other definition of quality standards.
		●●●	The purchaser contracts selectively with public and private providers based on uniformly applied quality standards.
Provider Payment	**Provider payment systems are linked to health system objectives.**	○	Some output-based payment is used.
		●●	Output-based payment is used, and payment systems are linked to specific service delivery objectives.
		●●●	Output-based payment is used and is linked to specific service delivery objectives; payment systems are harmonized across levels of care, and they allow purchaser budget management.
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	○	Provider payment rates are determined based only on the purchaser's available budget.
		●●	Provider payment rates are determined based on the purchaser's available budget and at least one other factor (e.g., cost information, priorities, or negotiation with providers).
		●●●	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.
Performance Monitoring	**Monitoring information is generated and used at the provider level.**	○	Some form of monitoring happens at the health provider level (e.g., supportive supervision visits, monthly activity reporting, claims audits, quality audits).
		●●	Provider-level monitoring is at least partially automated and is used for purchasing decisions.
		●●●	Provider-level information is automated, fed back to providers, and used for purchasing decisions.
	Information and analysis are used for system-level monitoring and purchasing decisions.	○	Some form of analysis is carried out at the system level (e.g., service utilization, medicines prescribed, total claims by service type).
		●●	System-level analysis is automated and carried out routinely.
		●●●	Information and analysis are used for system-level monitoring and purchasing decisions.