POLICY BRIEF

Understanding the application of mandatory health insurance policies in Sub-Saharan Africa

: INSIGHTS FROM THREE FRANCOPHONE COUNTRIES

BENIN

BURKINA FASO

TOGO

JULY 2024

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Abstract

In 2005, the World Health Assembly passed a resolution urging member countries to ensure that health financing systems included pre-paid and shared risk mechanisms (1). Since then, Nations around the world have moved to implement political commitments and policy reforms to make progress towards Universal Health Coverage [UHC] goals (2). These reforms include implementing Social Health Insurance (SHI) to expand health insurance coverage for all citizens, with an aim to reduce out-of-pocket expenses and prevent impoverishment and catastrophic health costs.

The mandatory nature of SHI ensures that everyone is covered and requires compulsory enrollment. Participants must pre-pay a specified premium or receive coverage through government contributions. Despite the use of legislation to implement mandatory health insurance in many African countries, coverage remains low and the very poor population are still exposed to financial difficulties as they seek health care (3). This brief summarizes findings from a stakeholder engagement workshop and a rapid review of the application of SHI laws through mandatory health insurance, further examines the challenges, and opportunities in three francophone West African countries; Benin, Burkina Faso, and Togo, and offers policy recommendations.

Methods

The content in this technical brief is drawn from the proceedings of a stakeholder's workshop hosted by the *Strategic Purchasing Africa Resource Center* [SPARC] held on the 10-13th December 2023 in Abidjan, Cote d'Ivoire. The workshop brought together 20 participants including: policymakers from Benin, Burkina Faso, and Togo, our technical partners *Centre de recherche en Reproduction Humaine et en Démographie* (Cerrhud) based in Benin; and the *Recherche pour la Santé et le Developpement* [RESADE] based in Burkina Faso to review and identify key country-specific priorities on strategic health purchasing [SHP]. Additional information was gained through a literature review of publications, published policies and reports from government, development agencies, and non-governmental agencies.

Key challenges of implementing mandatory health insurance schemes in the three countries:

1.High poverty levels, high rates of informal sector workers and low GDP per capita pose significant challenges in the implementation of mandatory health insurance for all. Table 1 presents the three country profiles using selected socio-economic indicators.

In the three countries (Benin, Burkina Faso and Togo), enforcement of mandatory health insurance for all citizens was limited by a) the high citizen poverty rates at 38.5%, 40% and 49.2% [2022 figures] respectively (meaning that citizens may not raise the required premium needed for mandatory health insurance as households), b) the high levels of informal sector employees (in all the three countries it was estimated at more than 70% of the total population in 2022). Informality in the labor force is often characterized by irregular, low and unreliable wages c) low GDP per capita which limits the government's ability to meet the costs per household through public funding, especially for the poor.

Benin is a democracy and has had successive governments since gaining its' independence in 1960. The country has had relatively peaceful transfers of power through democratic elections, which is notable in a region often plagued by political instability. The current President took office in 2016 and began implementing multiple political and institutional reforms including those affecting the health sector under the Government Action Plan [2016-2021] and [2021-2026].

Table 1: **Country profiles by social-demographic details**

Country	Population Millions [2023]	HDI ranking [2024]	GDP $ (Billions) [2022]	The proportion of informal workers [2022]	GDP per capita $ [2022]	Population below the poverty line [2022]
Benin	13,712,828	173/191	$ 17.14	97.00%	$ 1,319.15	>38.5%
Burkina Faso	23,571,485	185/191	$ 19.74	70.10%	$ 893.08	>40%
Togo	9,053,799	163/191	$ 8.41	90.70%	$ 973.21	>49.2%

Source: Various - WB, UNDP, WHO, ILO, countries publications and analysis by the authors

Burkina Faso has had multiple governments since it gained its' independence in the 1960s from the French and is currently led by a military leader following the coup of 2022. Initiatives under the National Economic and Social Development Plan (PNDES) [2016-2020] and [2021-2025] have been continued.

2.Enforcement of legislation regarding mandatory health insurance is sub-optimal to translate coverage especially for the very poor. A lot more is needed from all actors. The World Health Organization (WHO) has consistently urged countries to transition from voluntary contributions to mandatory insurance contributions to enhance the predictability of health financing, increase prepayments for financial risk protection and enhance pooling arrangements (4). The sources of funding for mandatory health insurance are usually from the following; taxes (various forms eg. direct and indirect), payroll deductions from salaried workers, and mandatory contributions from the general population. Table 2 presents background information on the laws, managing agencies, national health insurance schemes and progress of the mandatory health insurance schemes in each of the three countries.

Table 2: **Country profiles by mandatory health insurance**

Country	Mandatory health insurance laws	National social health scheme/program	Managing agency	Year SHI started	Progress so far
Benin	Law no. 2022-17 modifying Law 37 of 2020	Assurance pour le Renforncement du Capital Human [ARCH]	Agence Nationle de Protection Sociale (NDRL: National Agency for Social Protection) [ANPS]	•Policy enacted in 2017 •Pilot started in 2019 •Made mandatory in 2021	Largely focused on informal sector starting from the poorest
Burkina Faso	060/2015/ CNT of 2015	Régime d'Assurance naladie Universelle (NDRL:Universal Health Insurance Scheme) [RAMU]	Caisse Nationale d'Assurance Maladie Universelle (CNAMU)	•Started in 2015	Largely focused on the formal sector, with a small population indigent supported
Togo	New Labour Code of June 2021	Universal Health Insurance (Assurance Maladie Universelle – AMU) that incorporates both RAMO [private & public sector workers] and subsidies for the poor regime d'assistance medicale-RAM	National Health Insurance Institute (INAM)	•Initially began in 2011 but scaled up in 2021	Largely focused on the formal sector

Source: Various government documents and analysis by the authors

Two main challenges emerged regarding the enforcement of mandatory health insurance in the three countries.
First, it was noted that there were no clear ways of enforcing mandatory health insurance noting that in all the three countries there are still significant challenges in collecting optimal taxes. Tax collection in Sub-Saharan Africa (SSA) is low with an average of 14% in collection of taxes as a share of the GDP (5).

> *" The large proportion of informal sector employees who lack payrolls and are not registered are difficult to track as you seek to implement the mandatory health insurance."*
> *Policymaker, Togo*

Second, while a lot of political goodwill is invested in the formulation of the laws, a lot more is needed in the enforcement including support for the development of the necessary governance structures.

> *" While the drafting and enactment of the laws on mandatory health insurance are long and politically sensitive, the battle for enforcement of the letter and spirit of the law is even greater and more challenging"*
> *Policymaker, Benin*

> *" Our taxes are still too low to be applied to cater for the large population that lives below poverty line"*
>
> *Policymaker, Burkina Faso*

3. All the three countries still have relatively low public funding to health sector even though public funding remains the only hope for financing health coverage for the poor.

The three countries [Benin, Burkina Faso, and Togo] have mixed sources of revenue for the health sector. By 2021, the government funding levels were 9.1%, 42.76%, and 6.22% respectively highlighting that they still depend on a significant level of external funding (6). The SHI coverage is still significantly low at 5.38%, 0.05%, and 3.71% respectively despite the legislation being in place over several years. Table 3 highlights the country profiles by source of funds for the health system over time.

Togo has a unique political history marked by long-term leadership having had two Presidents since it gained independence in 1958.

Table 3: **Country profiles by sources for health financing**

Benin	**2001**	**2006**	**2011**	**2016**	**2021**
Government	38.58%	33.15%	23.94%	19.87%	9.10%
External	2.32%	16.86%	29.45%	19.77%	30.06%
Private Health	4.18%	3.46%	2.04%	1.79%	1.97%
OOP	54.91%	46.53%	43.51%	51.41%	51.51%
SHI	0.00%	0.00%	1.05%	5.38%	5.38%
Burkina Faso	**2001**	**2006**	**2011**	**2016**	**2021**
Government	32.39%	30.08%	24.68%	23.18%	42.76%
External	21.30%	35.39%	41.42%	24.67%	18.08%
Private Health	3.96%	1.44%	3.40%	10.90%	4.40%
OOP	42.16%	42.16%	30.17%	36.03%	34.65%
SHI	0.05%	0.05%	0.05%	0.05%	0.05%
Togo	**2001**	**2006**	**2011**	**2016**	**2021**
Government	11.26%	16.38%	23.52%	12.20%	6.22%
External	4.50%	9.27%	8.39%	15.35%	16.18%
Private Health	8.40%	7.49%	5.41%	6.40%	5.00%
OOP	76.81%	66.54%	62.17%	63.23%	69.00%
SHI	0.00%	0.00%	0.00%	2.76%	3.71%

Sources: WHO Global Health Expenditure data

Although there was a significant rise in public funding for health in Burkina Faso in 2021, the health financing arrangements in the three countries are still notably characterized by unreliable financing for significant progress towards UHC.

4. Continued fragmentation of pooling arrangements for the funding in the health sector means that most of the population only accesses benefits from pools based on their ability to pay and not by need.

There has been notable progress over the years in all three countries with multiple social protection programs already in place such as Community Based Health Insurance (CBHIs /mutuelles) that are generally voluntary, free maternal health services (to cater for delivery or specifically catering for cesarean section), mandatory health insurance programs largely restricted to the formally employed (especially the civil servants) and whose contributions are mainly raised from the staff salaries among others.
While in each of the three countries there is progress in reaching out to the poor through use of subsidies, it was highlighted that there was poor linkage between these subsidy programs and the national health insurance coverage goals. For example, Burkina Faso has been implementing the gratuite a program that removed user fees exemption for services for maternal child and newborn health (MNCH) services since 2006 (7). There is need to consolidate existing pools to reduce fragmentation and hence increase the opportunities for citizens especially the poor to enjoy cross-subsidization. Efforts in this direction is seen in Benin where the health insurance component of ARCH has already absorbed targeted exemption schemes (C-section fee exemption scheme in 2022) and is expected to absorb other schemes.

5. A variety of technical and political limitations slowed down the implementation of the mandatory SHI in each of the three countries

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It was reported that several technical and political limitations slowed down the implementation of mandatory health insurance policies such as change of the Burkinabe government through a coup, capacity gaps among policymakers, and lack of government funding to increase payments of premiums through the national budgets. For example, the implementation of the universal health insurance scheme (RAMU) in Burkina Faso began in 2008, and a framework was established in 2011. Although the government's commitment to its implementation is not in doubt some of the challenges reported to have limited its implementation include capacity gaps within MoH, Finance and RAMU, lack of adequate incentives for implementation which compromised implementation fidelity and led to low subscription, utilization, and uncertainty on sustainability (7). Respondents reported that despite its launch in 2015, RAMU in Burkina Faso still largely covers the formal employees [mainly select civil servants who pay for premiums through salary deductions and employer contributions] and selected mutuelles paid by the government in the interim to cater for the poor and vulnerable population.
In Togo, Mandatory Health Insurance (MHI) has been implemented since 2011 but after more than 10 years it is characterized by low coverage at 3.71% (8). The premiums remain high and out of reach for many poor and those who work in the informal sector (8).

It is worth noting that all the three countries' performance on UHC ranks below the regional (in Africa) and global averages, hence there is still a lot to be done.

Countries offer numerous essential services for health promotion, prevention, treatment, and care. Service coverage indicators which measure the proportion of people receiving the necessary services may be used to track progress towards UHC (9). Table 4 presents country profiles by UHC service coverage index (SCI).
Table 4: Country profiles by Universal health coverage (UHC) service coverage index (SCI), Sustainable Development Goal (SDG) 3.8.1, 2000 - 2021

Table 4: **Country profiles by Universal health coverage (UHC) service coverage index (SCI), Sustainable Development Goal (SDG) 3.8.1, 2000 - 2021**

Country	2000	2005	2010	2015	2017	2019	2021
Benin	21%	22%	33%	35%	34%	35%	38%
Burkina Faso	15%	21%	30%	35%	38%	38%	40%
Togo	19%	25%	30%	40%	43%	41%	44%
Global average	45%	50%	58%	65%	67%	68%	68%
Regional average	23%	28%	36%	42%	44%	45%	44%

Source: UHC Progress Monitoring Report (2023)

Although the performance of the three countries measures favorably against the regional average, it is still way below the global average. It is worth noting that the Service Coverage Index (SCI) does not seek to evaluate whether these interventions are of sufficient quality and quantity to achieve the intended health outcomes. While various methods for measuring effective coverage have been proposed, they are ultimately limited by data availability (9). Despite these challenges, advancing the measurement of effective coverage remains essential for improving the assessment of progress towards UHC.

POLICY DISCUSSIONS:

The topic of mandatory health insurance has garnered attention with many low- and middle-income countries (LMICs) implementing it a policy commitment to make progress towards UHC. Multiple studies provide evidence that reforms to strengthen access to health insurance has not always resulted in increased health insurance coverage. In any case, major efforts to achieve UHC progress has lagged in many African and Asian countries (3) with a majority of SSA countries struggling to expand voluntary health insurance schemes to raise finances towards achieving UHC (10)(11). This requires more reflections from stakeholders on the realities that limit or affect the increase of health insurance in SSA.

Furthermore, evidence has shown that the introduction of contributory health insurance schemes has not effectively increased revenues for the health sector or aided LMICs in achieving UHC (12). Equity and efficiency in the health sector can be enhanced by replacing out-of-pocket expenses with pre-paid pooling mechanisms. However, this is best accomplished through budget transfers rather than contributory insurance, which ties payment to specific sub-population entitlements (12). The use of contributory health insurance therefore is not strong enough to mobilize the needed resources to increase coverage and the administrative effort to apply it is much more than anticipated by the governments in Africa.

The findings from this brief therefore mean that beyond formulation of the laws on mandatory health insurance, there is need for policy-makers to appreciate the significance of the challenges and barriers that make it challenging for its' application. In all the three countries, the spirit of the law desired that all people have health insurance coverage. However, it is possible that there are more political and technical challenges that need to be overcome to make this a reality. A closer look at three of the main high-income countries (HICs) that have implemented mandatory health insurance to cover whole populations reveals that its' application is both an interplay of political and technical considerations and that the journey to increasing coverage for all is long and requires continuance adaption to the local country context. Table 5 presents a summary of main models of mandatory health insurance in selected HICs.

Table 5: **High Income Country profiles by Models of SHI**

Model of SHI adopted	Year it began	Countries	Qualities	How the scheme has evolved?
1.''Bismark''	1883	Germany Austria Switzerland Czech Republic	Financed through -Mandatory contributions (salary, employer contribution) -State subsidies to cater for the poor households	•Based on the principle of solidarity, effective pooling and application of cross subsidization •Started off as an insurance mechanism for the workers and later adopted as primary political reform
2.''Semashko''	1917	Former Soviet Union countries e.g. Russia	- Budget funded, - Centralized single payer, - High state control - Mainly through the public health systems	•Started as coverage for Primary Health care before incorporating the specialist and hospital care. •It was a major political reform
3.''Beveridge''	1948	United Kingdom	-Publicly funded and provides coverage for all through tax -Strong state administration for both PHC and specialist care -Low private health insurance (mainly for the rich)	•Initially only focused on hospital care but has been reviewed to include PHC and general practitioners
4.''Private health insurance''	1965	United States of America	-Market-based system with a heavy role in the private health sector, -Private Health Insurance for those who can afford, -Targeted population groups [e.g. older population] have targeted insurance systems	•Began with a focus on the middle working class and their families, it has then evolved to include other groups
5.National Health Model (this is a hybrid between Beveridge and Bismark, incorporating both public and private health sectors	1983 (South Korea)	Taiwan and South Korea	-Payments come from Government -Includes all citizens for coverage -Single-payer -Cheaper than the private health insurance -Negotiates for medicines	•The system has elements of both Beveridge and Bismarck.

Sources: Various publications analysed of the authors

The above models reveal the intricate interplay of technical and political considerations. Further, they have been implemented for many years with multiple iterations of reform. SSA countries can begin with the law but ensure that progress is being made to put health at the center of political and technical discourse.

Cross-learning from other countries is useful

Although country contexts may differ, lessons from other African countries provide unique practical insights. SPARC provides opportunities for countries to learn practical solutions from each other. Rwanda for example has made great progress in improving coverage for all through a unique method of combining multiple approaches e.g. the Rwandaise d'assurance Maladie (mandatory health insurance for those in the formal employment e.g. civil servants), Military Medical Insurance (targeting the military officers and their families), Community Based Insurance - mutuelle system (13) (14).

Additionally, countries would benefit by regularly evaluating their national health systems using already existing frameworks to ensure that the health financing functions are aligned to the best practices.

This allows continuance improvement and alignment towards making progress in meeting the coverage goals of UHC i.e. utilization relative to need, financial protection and equity in finance and access to quality of care.

Conclusion:

Governments in LMICs need to do more than enact mandatory health insurance policies to make progress towards achievement of UHC goals. These will include system wide reforms that address the high poverty rates, low tax base, inclusion of the informal workers - who are the majority, de-fragmentation of pooling arrangements and adopting a proactive approach towards the use of pooled resources in government budgets to solve persistent coverage challenges and low public health funding towards more sustainable financing for health. In addition, political goodwill needs to be matched with technical capacity for effectiveness of health financing policy design and implementation. Countries will further benefit by ensuring that reforms on the UHC interventions target all the main health financing functions including resource mobilization, pooling and purchasing for the health sector.

Recommended citation Mbuthia Boniface, Nyawira Lizah, Hounkpatin Hashim "Understanding the application of mandatory health insurance policies in Sub-Saharan Africa: Insights from three francophone countries – Benin, Burkina Faso and Togo; Nairobi Kenya.
SPARC is a project that Amref Health Africa is implementing in partnership with technical partners (learning institutions and research organizations) in more than fourteen (14) countries, with support from a grant from the Bill & Melinda Gates Foundation. For more information, please visit our website at https:// https://sparc.africa. For questions, please write to us at info@sparc.africa.

REFERENCES

1.World Health Assembly. Sustainable health financing, universal coverage and social health insurance. 2005.
2.World Health Organization, African Union. UHC-in-Africa-from-Conception-to-Action. 2014;
3.Ekubu Otim M, Pannarunothai S, Tafadzwa Lukwa A, Husni Jamal M, Firzah Abdul Aziz A, Noor Aizuddin A, et al. Successes and obstacles in implementing social health insurance in developing and middle-income countries: A scoping review of f-year recent literatures [Internet]. Available from: https://worldpopulationreview.com/country-
4.World Health Organization. Social health insurance [Internet]. 2004 [cited 2024 Jul 8]. Available from: https://apps.who.int/gb/ebwha/pdf_files/EB115/B115_8-en.pdf
5.Okunogbe O, Santoro F. Increasing Tax Collection in African Countries [Internet]. 2022. Available from: http://www.worldbank.org/prwp.
6.World Health Organization. Global Health Expenditure Database [Internet]. [cited 2024 Jul 8]. Available from: https://apps.who.int/nha/database/Select/Indicators/en
7.Banke-Thomas A, Offosse MJ, Yameogo P, Manli AR, Goumbri A, Avoka C, et al. Stakeholder perceptions and experiences from the implementation of the Gratuité user fee exemption policy in Burkina Faso: a qualitative study. Health Res Policy Syst. 2023 Dec 1;21(1).
8.Djahini-Afawoubo DM, Aguey ST. Mandatory health insurance and health care utilization in Togo. BMC Health Serv Res. 2022 Dec 1;22(1).
9.World Health Organization. Tracking Universal Health Coverage 2023 Global Monitoring Report. World Health Organization; 2023.
10.Kodali PB. Achieving Universal Health Coverage in Low-and Middle-Income Countries: Challenges for Policy Post-Pandemic and Beyond. Vol. 16, Risk Management and Healthcare Policy. Dove Medical Press Ltd; 2023. p. 607–21.
11.Mori AT. Mandatory health insurance for the informal sector in Tanzania—has it worked anywhere! Frontiers in Health Services. 2023;3.
12.Yazbeck AS, Soucat AL, Tandon A, et al. Addiction to a bad idea, especially in low- and middle-income countries: Contributory health insurance. Soc Sci Med . 2023;
13.Chemouni B. The political path to universal health coverage: Power, ideas and community-based health insurance in Rwanda. World Dev. 2018 Jun 1;106:87–98.
14.Umuhoza SM, Musange SF, Nyandwi A, Gatome-Munyua A, Mumararungu A, Hitimana R, et al. Strengths and Weaknesses of Strategic Health Purchasing for Universal Health Coverage in Rwanda. Health Syst Reform. 2022;8(2).