POLICY BRIEF

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

INSIGHTS FROM THREE FRANCOPHONE COUNTRIES – BENIN, BURKINA FASO AND TOGO

BENIN

BURKINA FASO

TOGO

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Abstract

Health systems in Sub-Saharan Africa are complex, and numerous challenges impede universal access to healthcare. The introduction of mandatory health insurance has been proposed as a potential solution to enhance access to quality health services. Historical efforts to improve access and coverage since the 1960s have proven insufficient. In many countries within the continent, health insurance coverage has largely excluded poor and vulnerable populations, as well as the majority of employees in the informal sector. This brief aims to provide critical insights and lessons for stakeholders involved in implementing mandatory health insurance reforms, particularly in low- and middle-income countries, by examining the implementation of mandatory health insurance in three countries— Burkina Faso (since 2015), Benin (2020), and Togo (2021)—and documenting their experiences. The brief is a product of a stakeholder engagement with regional experts from these countries, which took place on December 10-13, 2023, in Abidjan, Côte d'Ivoire. Socio-economic dynamics, fragmented pooling arrangements, technical and political limitations influence the implementation of mandatory health insurance policies in the 3 countries. The findings indicate that governments need to do more than enact mandatory health insurance policies through adapting health financing reforms to country context, aligning technical competence with political interest, system-wide reforms that address the high rates of poverty, low tax base and inclusion of informal workers, leveraging government budgets to reduce reliance on contributory health insurance mechanisms, central-co-ordination of multiple pools and continuous assessment to ensure alignment with health financing best practices to solve persistent coverage challenges.

Background

In 2005, the World Health Assembly adopted a resolution urging member countries to incorporate pre-paid and shared risk mechanisms into their health financing systems (1). Since then, nations worldwide have enacted political commitments and policy reforms to advance towards Universal Health Coverage (UHC) goals (2).These reforms include implementing Social Health Insurance (SHI) to broaden health insurance coverage for all citizens, aiming to reduce out-of-pocket expenses and prevent impoverishment and catastrophic health costs.

The mandatory nature of SHI aims to achieve universal coverage through compulsory enrollment. Participants must pre-pay a specified premium or receive coverage through government contributions. Despite legislative efforts to implement mandatory health insurance in many African countries, coverage remains low, leaving the very poor still facing financial difficulties when seeking healthcare (3). As many countries in the region grapple with fragmented health systems and limited financial resources, successful implementation of these policies is seen as a pivotal step towards improving access to quality healthcare for all citizens. However, the application of mandatory health insurance in Sub-Saharan Africa (SSA) presents unique challenges, including high rates of informal employment, inadequate administrative frameworks, and financial constraints (3). This policy brief explores the current state of mandatory health insurance policies in the West African region, examines the successes and limitations experienced by three countries (Benin, Burkina Faso and Togo), and provides insights into the factors influencing effective implementation. By understanding these dynamics, policymakers, and stakeholders can better address the barriers to achieving comprehensive coverage and ensure that reforms are tailored to the specific needs and contexts of countries.

Methods

This technical brief is based on the proceedings of a stakeholder workshop hosted by the *Strategic Purchasing Africa Resource Center* (SPARC) from December 10-13, 2023, in Abidjan, Côte d'Ivoire. The workshop brought together 20 experts, including policymakers from Benin, Burkina Faso, and Togo, as well as researchers from the Centre de Recherche en Reproduction Humaine et en Démographie (CERRHUD) in Benin and Recherche pour la Santé et le Développement (RESADE) in Burkina Faso. The objective of the workshop was to review and identify key country specific priorities for strategic health purchasing (SHP). Expert perspectives were captured qualitatively, followed by a narrative analysis to identify themes, patterns, and implications. Additional information was obtained through a literature review of publications, policies, and reports from governments, development agencies, and non-governmental organizations.

Findings

This section highlights the progress and challenges in implementing mandatory health insurance policies in the 3 countries.

Progress

i. Establishment of legal frameworks for mandatory health insurance for UHC

Each of the countries has enacted mandatory health insurance laws providing a legal framework towards achievement of UHC. Benin introduced a new public health policy and regulations (Law no. 2022-17, modifying Law 37 of 2020) to expand service delivery and coverage as key interventions toward UHC. Burkina Faso enacted its law in 2015 (Law n°060-2015/CNT of September 5) to mandate the implementation of a social protection policy. Togo passed its law on October 12, 2021, establishing the framework for UHC implementation.

ii. Establishment of Agencies to drive UHC Implementation

In Benin, the law established the National Agency for Social Protection (Agence Nationale de Protection Sociale – ANPS) in 2019 under the broader national priority of the Insurance for Strengthening Human Capital (Assurance pour le renforcement du capital humain – ARCH). The agency, AM-ARCH, is mandated to increase health insurance coverage for all residents. In Burkina Faso, the law led to the establishment of the Universal Health Insurance Scheme (RAMU), implemented by the National Health Insurance Fund (Caisse Nationale d'Assurance Maladie – CNAMU) in 2018. In Togo, the law created the National Health Insurance Institute (INAM) in 2021, with a clear mandate to increase coverage for illness, non-occupational accidents, and maternity for public employees and their dependents. INAM was also integrated as a branch of the National Social Security Fund (CNSS) to provide administrative support for both pension and health insurance for the formal and informal sectors.

Challenges

Despite firm commitments from respective governments, the implementation of mandatory health insurance was noted to be hindered by several factors :-

i) Countries' socioeconomic dynamics impede effective implementation of mandatory health insurance policies

Firstly, high poverty rates Benin, Burkina Faso and Togo - 38.5%, 40%, and 49.2% respectively (2022 figures)—indicate that a significant number of citizens may not afford the required premiums for mandatory health insurance. Furthermore, these countries are among the lowest on the Human Development Index, with rankings of 173, 185, and 163, out of 193 (Table 1).

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	173/193	$ 17.14	97.00%	$ 1,319.15	>38.5%
Burkina Faso	23,571,485	185/193	$ 19.74	70.10%	$ 893.08	>40%
Togo	9,053,799	163/193	$ 8.41	90.70%	$ 973.21	>49.2%

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

Secondly, the three countries have low gross domestic product (GDP), estimated at $17.14 billion, $19.74 billion, and $8.41 billion USD, respectively. Notably, Burkina Faso had a significantly higher proportion of health expenditure against the total government budget and spending on health as a 9.84 % of GDP relative to the other two countries (Table 2). All three countries allocate much less than the recommended per capita health expenditure of $ 86.3, % of government health expenditure to the GDP (recommended 5%) and less than 15% allocation of the total budget to the health sector (4). This limits the ability to mobilize adequate resources for the health sector.

Table 2: **Country health expenditure profiles**

Country	Spent on health per capita	Spent on health as % of GDP	Spent on health as a % of government budget
Benin	**$ 4.33**	**0.32**	**1.60**
Burkina Faso	**$ 24.38**	**2.73**	**9.84**
Togo	**$ 5.38**	**0.55**	**2.5**

Source: Africa Union, 2021

Thirdly, in all three countries, the workforce is predominantly informal, estimated at 97%, 70%, and 90.7% of workers, respectively. Informal workers typically lack structured mechanisms for premium collection. It is further characterized by the absence of formal payroll systems, and significant administrative investment is required to enforce collections (5). Policymakers in these countries concurred that voluntary contributions to health insurance have been ineffective and often plagued by adverse selection.

'' Many of the voluntary contributions that we have witnessed are made when the family is facing a health emergency or hospitalization'' Benin policymaker

Forthly, the three countries collect a relatively low proportion of tax revenue in relation to GDP, with rates of 14.31 (6), 17.7% and 14.2% (7) in 2022 compared to an OECD average of 33.3% to GDP (8). Tax collection is particularly challenging in Africa, where reliable tax revenues primarily come from formal employees while a large informal workforce remains largely untaxed (9). Compounding the narrow tax base are challenges such as tax revenue leakages, corruption, high debt levels, and low taxpayer compliance (10). The limitations in tax collections strain national treasuries as they attempt to allocate and distribute resources across various government priorities.

'' Although tax is a reliable source of domestic financing, our countries have not managed to effectively optimize tax collections. This limited resource has then to be shared with many competing priorities, including those of the health sector'' Togo policymaker

ii) Fragmented pooling arrangements limit the capacity to accumulate adequate resources for health strategic purchasing of health services

The pooling arrangements in the 3 countries are fragmented, limiting the ability to redistribute financial risks across the population and address their health needs. Although there has been progress in reaching the poor through subsidies in each of the three countries, these schemes are not effectively integrated with the overall national health priority of UHC. For instance, different pools are managed by various agencies with varying purchasing arrangements. Burkina Faso has been implementing the "gratuité" program, which exempts user fees for maternal, child, and newborn health (MNCH) services, since 2006 (11). In Benin, while there is an attempt to consolidate pool management under the main AM-ARCH program, the schemes have different rules and coverage and require multiple administrative efforts. Table 3 shows the various sources of funds in the 3 countries, resulting in multiple pools.

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 2024

iii) Several technical and political limitations have impeded the implementation of mandatory health insurance policiesin these countries.

These included political changes in governmental, such as a coup in Burkina Faso, capacity gaps among policymakers, and insufficient government funding for premium payments through national budgets. For example, while the Universal Health Insurance Scheme (RAMU) in Burkina Faso was initiated in 2008 with a framework established in 2011, challenges such as capacity issues within the Ministry of Health, the Ministry of Finance, and RAMU, along with inadequate incentives, have affected implementation fidelity of the scheme. These issues have led to low subscription rates, limited utilization, and concerns about sustainability (11). Despite its launch in 2015, RAMU mainly covers formal employees, such as select civil servants who have premiums deducted from their salaries, whileinterim measures by the government have provided coverage to the poor and vulnerable through selected mutuelles. In Benin, the pilot phase having ended, it was noted that the AM-ARCH project encountered challenges such as administrative complexity and the necessity for robust mechanisms to enforce compliance and collect premiums.

"The project's effectiveness is compromised by ongoing administrative hurdles and the lack of strong enforcement mechanisms for premium collection." (Policymaker, Benin).

Discussion and Policy Recommendations

Despite the bold efforts in the 3 countries, coverage through mandatory health insurance has remained low, covering less than 10% of the population, as highlighted in Table 4. Although the mandatory health insurance policies envisioned health coverage for all, they have predominantly targeted formal employees, leaving informal workers reliant on voluntary contributions and OOP. In Benin, the AM-ARCH program aims to expand service provision and progress toward UHC, requiring all employers (both public and private) to provide coverage for their employees. Self-employed workers are expected to secure their own coverage, but enforcement mechanisms are lacking, resulting in informal workers being invited to contribute voluntarily. In Burkina Faso, the RAMU scheme still has a low coverage at 6%, primarily those in formal employment. In Togo, although mandatory health insurance has been in place since 2011, coverage remains low at 3.71% after more than a decade (12). This is indicative that the premiums are still unaffordable for many, particulary the informal sector workers and poor populations.

'' The informal workers and the poor population have not been effectively covered in the mandatory health insurance schemes. They have use out-of-pocket payments when they seek for health services'' (Policy maker, Burkina Faso)

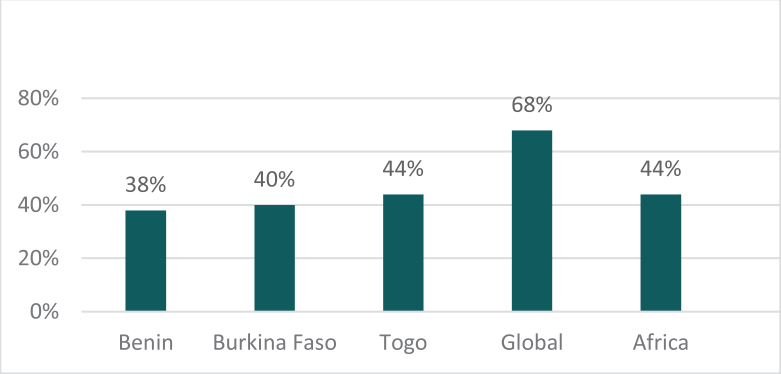
Table 4: **Country's social health insurance coverage rates**

Country	2001	2006	2011	2016	2021
Benin	0.00%	0.00%	0.00%	1.79%	2.06%
Burkina Faso	0.20%	1.20%	0.12%	0.20%	6.00%
Togo	0.00%	0.00%	0.01%	2.76%	3.71%

Sources: WHO Global Health Expenditure 2024

It is worth noting that the service coverage index for each of the three countries remains lower than the global, African and regional averages signifying opportunities for further strengthening of health systems. Table 5 presents country profiles by UHC service coverage index (SCI).

Table 5: **Countries' service coverage indices against global and Africa averages**



Source: UHC Progress Monitoring Report (2023)

We offer the following policy recommendations;

i) Adaptation to country context in health financing reform

The findings in this brief suggest that, in addition to enacting mandatory health insurance laws, policymakers must recognize and address the contextual barriers to effective implementation. An examination of various models of mandatory health insurance applied by some high-income countries (HICs) is highlighted in Table 5. While it is important to learn from applications of SHI in other countries, policymakers must recognize the fundamental cultural, political, and governance differences at play. The Bismarck model, while successful in Germany and other European countries, has been favored by the unique cultural context, high tax collections, political responsiveness and socialization over time. However, no health system is perfect and the path to universal coverage requires ongoing adaptation to each country's unique context. SSA countries can begin with the law but need to ensure that contextual issues are considered in the design and implementation of mandatory health insurance policies.

Table 6: **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

ii) Aligning technical competence by political interests to achieve UHC

While all three countries aim to provide health insurance coverage for everyone, political and technical obstacles may impede this goal. Therefore, it is crucial to ensure that health remains a central focus in both political and technical discussions. A call for system-wide reforms that address the high poverty rates, low tax base and the inclusion of the informal workers - who are the majority - require that technical competence is closely aligned with political interests.

iii) Leveraging Government budgets to reduce reliance on contributory health insurance

Evidence indicates that the introduction of contributory health insurance schemes has not significantly increased revenues for the health sector or advanced LMICs towards UHC (13). While there is consensus that health systems objectives could be achieved by replacing out-of-pocket expenses with pre-paid pooling mechanisms, this is more effectively achieved through budget transfers rather than contributory insurance, which links payments to specific sub-population entitlements (13). The findings of this brief correspond to the evidence on the limitations of contributory health insurance in mobilizing sufficient resources to enhance coverage in SSA. Similarly, the administrative burden associated with mandatory health insurance implementation in the region often exceeds what governments in these countries anticipate.

iiv) Multiple approaches with central co-ordination

Although country contexts may differ, multiple pooling arrangements with a central co-ordination point can prove valuable. 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 (14) (12).

v) Continuous assessment to ensure alignment with health financing best practices

Countries would benefit from regularly assessing their national health systems using established frameworks to ensure that health financing functions adhere to best practices. This approach facilitates continuous improvement and alignment with crucial reforms in resource mobilization, pooling, and purchasing. It helps strengthen overall health system performance, improves the utilization of health services relative to needs, enhances financial protection, and increases access to higher-quality health services.

Conclusion

The topic of mandatory health insurance has become increasingly prominent, with many LMICs adopting it as a policy to advance towards Universal Health Coverage (UHC). Despite this, multiple studies indicate that reforms intended to enhance access to health insurance have not consistently led to increased coverage, with numerous SSA countries struggling to expand voluntary health insurance schemes to secure funding for UHC (10)(11). This situation calls for a deeper reflection from stakeholders on the factors that limit or impact the growth of health insurance coverage in their specific contexts. What remains clear is that to make significant progress towards UHC, governments in LMICs need to do more than enact mandatory health insurance policies by adapting health financing reforms to country context, aligning technical competence with political interest, system-wide reforms that address the high poverty rates, low tax base and inclusion of informal workers, leveraging government budgets to reduce reliance on contributory health insurance mechanisms, central-co-ordination of multiple pools and continuous assessment to ensure alignment with health financing best practices in resource mobilization, pooling, and purchasing for the health sector.

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