BRIEFING NOTE:

HEALTH CARE FINANCING IN WEST AFRICA:

Focus on financial risk protection in Francophone countries

ACRONYMS

ARV	Antiretroviral treatments
CBHI	Community Based Health Insurance schemes
CHE	CHE
CIPRES	Conférence Interafricaine de la Prévoyance Sociale
CTP	Capacity to Pay
EIP	Extended Immunization Programs
GDP	Gross Domestic Product
IMF	International Monetary Fund
LMIC	Low and Middle Income Countries
MHI	Mutual Health Insurance
MoH	Ministry of Health
MSA	Medical savings accounts
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
OOP	Out-Of-Pocket
RAMU	Régime d'Assurance Maladie Universelle
SAP	Structural Adjustment Programs
SHI	Social health insurance
SP	Seguro Popular (Popular Security)
TB	Taxed Based Financing
THE	Total Health Expenditure

UHC	Universal Health Care
VAT	Value-Added Tax
WHO	World Health Organization

INTRODUCTION

Background

In West Africa, among the sixteen (16) countries[1], only six (6) are classified as low-middle income countries: Cape Verde, Cote d'Ivoire, Ghana, Mauritania, Nigeria and Senegal. The others are low income countries. Regardless of the income level, health is one of the most important challenges of West African countries as morbidity indicators show a double burden with resurgent communicable diseases and emergent non-communicable diseases. Malaria, lower respiratory infections, diarrheal diseases and HIV/AIDS are the top 4 killers[2], despite governments' efforts to provide for mosquito nets and Antiretroviral (ARV) treatments.

After independence, almost French West African colonies inherited and continued the colonial health systems. In many of these countries, disparities (in terms of infrastructure, access to care and health outcomes) between regions and between urban/rural settings were acute. Changes began when health financing priorities were guided by a focus on primary health care (following the Alma Ata conference in 1978) and decentralization and targeted cost recovery reforms[3] (subsequent to the Bamako initiative in 1987). Following the economic crisis and the devaluation of the FCFA in 1993, most of the countries which were highly indebted implemented the International Monetary Fund (IMF)'s Structural adjustment Programs (SAPs). The health component generalized cost recovery and introduced user fees. As a result, health financing is generally the responsibility of the private sector, and given the fact that there was a very low degree of coverage of risk pooling mechanisms, health expenditures are mainly out-of-pocket (OOP). Households bore on average 50.125 % in 2009 and 47.375% in 2010 of the burden of Total Health Expenditures (THE).

Hence, Community Based Health Insurance schemes (CBHI) or Micro-Health Insurance (MHI) schemes have mushroomed in many countries (Lahkar and Sundaram-Stukel, 2010) as an alternative to market-based insurance for poor people. However, this led to extreme

[1] According to the UN Population, West Africa comprises: Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone and Togo.
[2] Lozano et al (2012).
[3] Idem

fragmentation of the health system with multiple small pools (of resources and risks) and which has not been completely successful in protecting the very poor[4].

In 2001, the Abuja Declaration showed the awareness of the African Head of States that governments have to be more involved in health sector financing. More recent conferences and key organizations now urge for a more dynamic move towards universal coverage as a solution to impoverishment and financial risk born by the population[5]. In the *Stratégie pour la Santé en Afrique de l'Union africaine* of 2007, the African Union (AU) affirmed that it is important to look at the possibility of instituting social protection for vulnerable people to avoid long-term indebtedness due to health shocks[6]. Later in 2010 and 2012, the organization reaffirmed her commitment for universal coverage[7].

Since the 2005 World Health Assembly, the 2010 World Health Report, and the 2011 World Health Assembly, several declarations and donors also exhort countries to move towards universal coverage to protect their population from health shocks and impoverishment. In 2012, the Bangkok (28th January), Mexico (2nd April) and Tunis (July) declarations culminated in a December resolution of the United Nations reflecting these calls[8].

According to the World Health Ogranization (WHO)[9], Universal coverage means that everyone has access to quality health services that they need without risking financial hardship from paying for them. "On paper", universal coverage can be achieved by raising sufficient funds, reduce the reliance on direct payments to finance services, and improve efficiency and equity[10]. It emphasizes that: "*Simply choosing from a menu of options, or importing what has worked in other settings, will not be sufficient. Health financing strategy needs to be home-grown, pushing towards universal coverage out of existing terrain. It is imperative, therefore, that countries develop their capacities to analyse and understand the strengths and weaknesses of the system in place so that they can adapt health financing policies accordingly, implement them, and monitor and modify them over time. "*

[4] Gilson et al., 2000; Jutting, 2004; Lahkar and Sundaram-Stukel, 2010.
[5] WHO (2010)
[6] African Union (2007)
[7] Union Africaine (2010 et 2012)
[8] Ministère de la santé et de la lutte contre le Sida (2012)
[9] WHO (2013); http://www.who.int/whr/2013/main_messages/en/index.html
[10] WHO, 2010

It is then worth reflecting on the prospect, challenges and opportunities of instituting such systems in francophone West African settings and to assess the contribution of research in this quest for answers.

Objectives

The objective of this briefing note is to analyze the current health financing systems in francophone West African countries. Specifically, the note will:

1. Describe the current health financing systems in francophone West African countries;
2. Highlight potential future orientations and challenges;
3. Derive Highlight lessons from health financing in other settings that could inform reform in francophone West African countries, and
4. Point out knowledge gaps and future research paths.

Justification

In most of the countries of the study, there is a high incidence of OOP spending on health while they are in majority (7 out of 10) low income countries. It is recognized that there is a need to reform the current health system financing mechanisms to achieve universal health coverage for health care. However, little is known about the challenges and opportunities for health system financing in francophone West Africa. This briefing note is intended for policy-makers and all stakeholders involved in preparing and implementing reforms to reach universal health coverage. It will point out challenges at the technical level as well as the policy and research levels. Special attention will be given to equity, governance and sustainability issues during the analysis. It can be used to direct future research and orientation for health financing reforms in West Africa.

The remainder of the note is structured as follows. Section I presents a brief review of literature of the different modalities to finance the health system. Section II overviews the situation in francophone West African countries and compiles lessons on health financing in Asia and Latin America Section III presents IDRC-funded research results, highlighting existing gaps and future research paths. Finally, Section IV concludes.

Section I: REVIEW OF LITERATURE ON FINANCING SCHEMES FOR HEALTH CARE[11]

Financing schemes in health care have been extensively studied in the economic literature. This section presents an overview of private and public financing schemes analyzed through the lenses of their advantages and drawbacks and highlight implications for universal coverage.

A. Private initiatives

Private initiatives are market-based health insurance and Community based-health insurance schemes (CBHI). In these features, membership is voluntary (except in some job-based insurance schemes).

1. Marked-based insurance schemes

Individual health insurance and job-based health insurance are the market-based health insurance schemes. The individual private health insurance scheme is funded by OOP payment (for premiums and health care costs). In some cases, these outlays include a deductible amount that is born by the client and some other features. Entry into the scheme is usually based on experience-rating[12] and ends up by cherry-picking[13]. Generally, contributing members benefit from the services with their dependents (Hsiao, 2007). Job-based health insurance generally works with group ratings and includes almost all the other features of individual private insurance but limits cherry-picking though it only captures people working in the formal private sector.

In reality, market-based schemes can be unaffordable for the majority of the population. In fact, the private insurance markets fail because of adverse selection and moral hazard. The poor may not have access to health care, while wealthy individuals subscribe to insurance (Cutler and Zeckhauser, 2000; Diamond, 1992). As a result, income-related cross-subsidies between groups of different socioeconomic status are impossible and health-care needs may be unmet (McIntyre et al., 2008). It is not surprising that these schemes cover a very small share of the population in Low and Middle Income Countries (LMIC).

[11] This section is from Gnamon PhD Thesis (forthcoming)
[12] See glossary
[13] Idem

2. *Community Based Health Insurance (CBHI) or Mutual Health Insurance (MHI)*

CBHI schemes appear to reduce the financial burden and the loss due to sickness episodes (Dror & Jacquier, 1999) in LMICs. Still, the poorest of the poor may continue to be excluded (Gilson et al., 2000; Jutting, 2004) while moral hazard and adverse selection can arise. MHI schemes can only achieve a minimal pooling of risks due to their small size and the fact that membership is voluntary (GTZ, 2005). Besides, financial and managerial difficulties may arise, such that the overall sustainability of CBHI is not always assured (Atim, 1998; Bennett, Creese, & Monash, 1998; Criel, 1998). Finally, they sometimes strongly rely on subsidies and absolutely need the partnership of quality health care providers to be attractive and credible.

3. *Medical saving accounts:*

According to the WHO (2012), Medical savings accounts (MSA) can be defined as savings accounts designated for out-of-pocket medical expenses. Both employers and individuals contribute to an MSA on a pre-tax basis. Kanchan et al. (2012) highlighted that these earmarked saving accounts usually have an attached high deductible and low premium catastrophic insurance plan (Backup financial mechanism). They have been introduced in response to private health insurance market drawbacks in order to:

- Encourage savings for the expected high costs of medical care[14];
- Enlist health care consumers in controlling costs and then reduce both the spending born by a third-party (private or public health insurer);
- Mobilize additional funds for health systems (Thomson and Mossialos, 2008 and Hanvoravongchai, 2012), and
- Increase cost effectiveness of provided health care services.

MSAs however display also some drawbacks. They indeed are sensitive to the business cycle as they represent an asset of the portfolio[15]. In addition, their existence may reinforce cream

[14] MSAs present the advantage that unused balances and earnings are allowed to be accumulated for use in a future year, unlike with Flexible Spending Account (FSA) and lower the financial burden on the youth and the employed. In fact, MSAs are tax-sheltered and are believed to reduce the amount of OOP from the individual (or household) at the moment the health shock occurs

skimming by the private health insurers[16]. Besides, this system is not affordable or useful for very low income or very sick individuals (Hanvoravongchai, 2002). Finally, MSAs do not allow for risk pooling across individuals; they favor eviction from the health insurance markets and they still require OOP payments through a high deductible. It is important to note that MSAs are not widely used in Africa.

Hence, market-based health insurance schemes and MSAs do not promote equity and access to health care. Sustainability is generally not a major issue in the sense that scheme administrator fix the price of their services accordingly. CBHIs reduce inequities but can have governance and sustainability issues.

B. Public initiatives

Social health insurance (SHI) and National insurance which is funded by a tax-based (TB) system are public initiatives[17].

1. Social health insurance (SHI)

Social health insurance schemes are generally understood as health insurance schemes provided by governments to its citizens, especially to low and middle income populations (Acharya et al., YEAR). In social health insurance, contributions from workers, self-employed, enterprises and government are pooled into a single fund or multiple funds on a compulsory basis (Hsiao, 2007). Preventive and public health care may be provided by these funds or responsibility kept solely by the Ministry of Health (WHO 2012).

It is a scheme with mandatory participation and that allows a high level of risk pooling. It is believed to improve access to health care by reducing the OOP costs of health care (Monheit and Cunningham, 1992), especially because contributions are made on the pay as you earn principle. Free riding[18] is limited under this scheme since contributions are taken at source. It however presents the disadvantage to target workers of the formal sector.

2. Tax-based financing (TB) scheme

[15] See glossary for definition
[16] MSAs may not be affordable for medium and lower income individuals. However, they can be presented as condition to obtain a health insurance policy
[17] Bennett, S., & Gilson, L. (2000), Savedoff, W. D. (2004) and Wagstaff, A. (2009).
[18] See glossary for definition

The government has another alternative to provide for health insurance to its citizens: a national insurance scheme funded by a tax-based financed system. In this scheme, individuals contribute to the provision of health services through taxes on income, purchases, property, capital gains, and a variety of other items and activities. Health care costs are paid on the budget of the state and are typically pooled across the whole population, unless local governments raise and retain tax revenues. Health services are purchased by government, usually from a mix of public and private providers (WHO, 2012). In this sense, access to health care is increased, risk is more easily pooled and OOP considerably reduced. However, it is difficult to assess the extent to which contribution are equitable since they come from various taxation sources. A free rider problem can be noticed with some individuals not paying their taxes and yet beneficiating from public supply of health care.

Public health insurance schemes (SHI or TB) can also be limited by over-insurance[19] and moral hazard problems (Castano and Zambrano, 2006). This can then lead to waste and to a sustainability problem. In addition, co-payment requirements can raise concern about fairness, as in the case of the National Health Insurance plan in Taiwan (Ho, 2007). The economic literature has besides shown the existence of a crowding out effect, that is, the introduction of public health insurance, draws people who were previously covered by private health insurance, instead of the targeted population which is the poor. Inequities may be difficult to erase if this situation occurs.

3. Innovative mechanisms (WHO, 2012)

Besides those classic financing schemes, it is important to find innovative mechanisms, in a context of a rising demand for health care services, escalating costs of care, rapid increases in technology and a small fiscal space. Some of these methods are nationally based, such as hypothecated taxes, e.g. 'sin taxes' for tobacco and alcohol as well as national and state lotteries dedicated to health public-private partnerships to co-fund health care. Other mechanisms are internationally focused[20]. There are also other options that may be used to

[19] Idem

[20] Some of the internationally focused mechanisms are:

complement health financing mechanisms, e.g. conditional cash transfers, micro-banking or health vouchers. Such mechanisms can provide supplementary funds and potentially improve equity. By improving also the financial sustainability of the scheme, they can allow to broaden the benefit package or the population covered.

Health vouchers

Health vouchers are used in some countries as a way to provide in-kind transfer for health service utilization. A voucher is a subsidized card that entitles a pregnant woman to antenatal visits, assisted baby delivery including any complications, and a postnatal visit at her choice of qualified facility. They are currently used in Bangladesh, Cambodia, Kenya, Tanzania and Uganda especially for reproductive health (RHVouchers, 2013)[21]. Since it is a recent initiative, documented and quantitative studies on their use are few. However, it is possible to say that vouchers improve equity and access because are priced for and marketed to poor people in urban slums and rural areas (while social health insurance schemes cannot guarantee easy access for those who do not have transportation or who lack knowledge of how to utilize available services, vouchers.).

All the alternatives to fund health systems present drawbacks and advantages. Most of them may end up with under-coverage because of the existence of exclusion (Cf. Table I.). Only public health insurance schemes have high risk pooling and low OOP for individuals, so that exclusion is low. According to Schremmer et al. (2009), compulsory social security schemes, compared to CBHIs, have the advantage of offering a comprehensive and relatively standardized benefit package, to increase redistribution (while in CBHIs, there is minimal redistributions), to have sophisticated computerized management processes and good administrative procedures and to offer a strong purchasing power for health services.

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1) The International Finance Facility (IFF). It consists in selling government bonds secured by future aids flows debt for health swaps, in which external government debt is converted into domestic debt;
2) A debt-for-health swap and,
3) The use of public-private partnerships to develop new products using capital markets.

[21] Filling the Health Equity Gap: How voucher programs deliver where social health insurance schemes may not Research Findings | February 27th, 2012. http://www.rhvouchers.org/research/2012/filling-the-health-equity-gap-how-voucher-programs-deliver-where-social-health-insurance-schemes-may-not Accessed on July 07th, 2013

Therefore, equity is better addressed by public health insurance schemes, while governance and sustainability needs to be optimized to increase adhesion to the schemes.

It is worth noting that there is the possibility of creating hybrid schemes. Within the framework of Public-Private Partnership (PPP), both private interests and the public sector may intervene in funding and running a public health insurance scheme. Health care systems reform in industrialized countries has resulted in a shift from publicly financed systems to mixed ones. They also display significant patient co-payments for services (Besley and Gouveia, 1994; Zweifel and Breyer, 1997). In Ghana, the National Health Insurance scheme is a mix of tax-based (VAT) system and CBHI (at a district level).

Section II: SITUATION OF HEALTH FINANCING IN WEST AFRICA

This section undergoes a critical analysis of the current situation in West Africa, by pointing out challenges and opportunities.

A. Situation in francophone West Africa

As mentioned earlier, the current health care financing systems in West Africa, except for a few countries (with implemented universal coverage schemes) do not promote risk pooling and they consequently expose the poor to financial risk.

In most of the francophone West African countries, health financing is a taxed-based system whereby the government (supported by donors and NGOs) allocates funds to the Ministry of Health (MoH) with a very low degree of coverage of private health insurance. Initially, only Cote d'Ivoire had an operational health insurance scheme for civil servant. In Benin, Niger and Togo, they are prepared as part of the universal health insurance scheme (See Table 1)[22]. Most of the countries have a social security schemes for formal private sector employees. However, in most of the countries (except Cote d'Ivoire but especially in Senegal), there are a high number of mutual health insurance organizations. Table 1 presents a summary of the schemes in the countries.

[22] Projects of establishing a Mutual for Civil Servants exist, but are not implemented in Senegal (2013).. The other countries don't have such a scheme and have not planned it yet (Faye, 2010).

1. *Strategies to reduce the financial burden of health care for poor populations*

In the absence of a national framework for risk pooling, the MoHs and some NGOs have developed strategies to reduce the financial burden of illness for the population, especially the poor, in such a way that the incidence of some diseases and mortality factors may be reduced.

Governments have progressively organized fee exemption or subsidization for certain diseases and conditions such as Leprosy, Buruli Ulcer, Tuberculosis, Malaria, , even harelip, Guinea Worm and snake bites (See Annex 1 &2 for details on each country). In addition, voluntary HIV tests and ARVs are free. Some countries have instituted free/subsidized maternal and under 5 health care, caesarian sections and other obstetrical conditions requiring surgery such as fistula. Extended Programs on Immunization (EPI) are also used to provide free or subsidized immunization to children under 5 and mothers. Finally, in some public hospitals, there is free/subsidized care for some groups of the population such as the poor and students, subject to claim and administrative acceptance of exemption criteria. Senegal in particular, has a policy of reimbursement of care and drugs for people over 60 through the *Sesame Program*. Subsidized/ free care is also used by NGOs to support the population. This will be discussed further in the section on main players in health financing.

Besides all these strategies, and as a result of pressure from donors, *Performance-based financing* is a growing concept that is included in National Health Plan of some countries. It is a reward or incentive based approach (Canavan, Toonen and Elovainio, 2008) whose basic principle is “the money follows the patient”. If health facilities attract more patients and provide quality services they will receive more subsidies and incentive payments on a scheduled basis (monthly, quarterly or bi-annually). It is believed to be particularly relevant in fragile post-conflict contexts. Objectives of payment schemes include cost containment to rationalize the utilization of inputs (sustainability) and transformation of clinical practice towards improved quality of healthcare. PBF is therefore deployed as a modality to incentivize public and private providers, using different contract arrangements as informed by lessons learned from global and local context.

It however raises concerns relative to[23]: distortion of priorities of national health systems due to the targeting of services (Ireland et al. 2011; Scheffler, 2010); 'gaming' or false reporting of results and 'cherry-picking' of patients by health care workers (Ireland et al. 2011; Kalk, 2011); rise of 'perverse incentives' (Fryatt et al. 2010); focus on quantity over quality of service (Ireland et al. 2011; Langenbrunner and Liu, 2005); perpetuation of inequity as areas where health systems are particularly underdeveloped (and thus unlikely to reach outcome targets) might be overlooked for funding (Ireland et al. 2011); and carry debilitating hidden costs due to the resources needed to establish PBF systems and monitoring mechanisms (Kalk, 2011). One specific concern raised by multiple studies is the impact that PBF might have on the intrinsic motivation of health care workers (Eijkenaar et al. 2013; Ireland et al. 2011; Kalk, 2011; Langenbrunner and Liu, 2005). Thin fact, financial incentives might crowd out the high levels of idealism in the health sector, thus leading to de-motivation of health-care workers. (Brown et al., 2013). Finally, it doesn't directly address equity in access to health care by targeting specific population groups with special attention to the poor and vulnerable (Canavan, Toonen and Elovainio, 2008). In a study in 2012, Fretheim et al. concluded that no general conclusion can be drawn regarding the likely impact of performance-based financing in low-and middle-income countries.

2. Movement towards universal coverage

Almost all the francophone West African countries have demonstrated the will and desire to move towards universal health insurance schemes. Over the past three years, some countries have already launched the process of establishing such a scheme while in others, the project is still at an embryonic level. This sub-section provides an overview of the challenges and the opportunities for each group of countries.

Most of the countries have passed it in law and/or officially launched the scheme, or well advanced in preparations after receiving the support of the WHO (P4H Social Protection Network) in the designing of the scheme[24]. It is only in Guinea that there is no deliberate

[23] This section is from Brown et al.. (2013).

[24] Source: http://www.who.int/providingforhealth/countries/en/. The scheme is planned for 2015 in Burkina Faso http://fr.starafrica.com/actualites/le-burkina-faso-va-adopter-lassurance-maladie-universelle-en-2015.html

political will to introduce such a scheme. Table 1 depicts the status of National health insurance scheme in francophone West Africa.

In Burkina Faso, Mauritania and Niger the universal health insurance is still under study with ongoing consultations to prepare for it.

In Senegal, a scheme is operational since 2009 and is currently tested in five health districts (out of twelve) with the support of the Agence Belge de Developpment (CTB)[25]. The *Régime d'Assurance Maladie Universelle* (RAMU) was launched in Benin in December 2011 by President Boni Yayi, but has not been fully implemented. In Togo, the *Institut National d'Assurance Maladie (INAM)* is operational since 2012 but only covers civil servants up to now. Finally, in Mali, the *Régime d'Assurance Maladie Obligatoire (RAMO)* is also operational since 2011 Several challenges have been emphasized by studies, including governance, clarification of the role of each actor, identification of the poor and benefit package design.

Cote d'Ivoire is a particular case where the scheme was passed into law in 2001 and the Conférence Interafricaine de la Prévoyance Sociale (CIPRES) in a 2010 study classified the country as being in the final phase of designing the project. However, there was no implementation due to a decade of political crisis with three major shocks (2002, 2004 and 2010-2011). Presently, free health care is only available for mothers and children under six. Very recently, the Minister of Employment and Social Affairs announced [26] a new universal health coverage scheme called *Couverture Maladie Universelle* to be launched by the end of 2013 or in 2014. Consultations will soon begin to design the whole scheme.

The challenges for such systems will undoubtedly be the responsiveness of the health care supply to an increased demand subsequent to the reduction (or elimination) of financial barriers. In the Ivorian case, lack of infrastructure, equipment, drugs and personnel was pointed out during the free health care program initiated by the Ivorian government from May 2011 to January 2012. In addition, doctors were overwhelmed by a tremendous rise in consultations (Ouattara, Houngbedji and Koudou, 2013). However in Niger, Ridde, Queuille

[25] Source: http://www.btcctb.org/fr/casestudy/nouveau-mod%C3%A8le-d%E2%80%99assurance-maladie-universelle-test%C3%A9-cinq-districts-sanitaires-s%C3%A9n%C3%A9gal

[26] Source : http://www.guineeeconomie.com/news_fiche.php?id=636

and Kafando (2012) noted that free care didn't worsen the workload of health professionnals.

Most of the existing plans on universal health coverage in West Africa (except in Cote d'Ivoire) have been built by combining strengthened mutual health insurance schemes and a compulsory health insurance for formal workers (Togo, Mali, Benin). In Benin, Cote d'Ivoire and Mali a sub-component of the scheme covers the needy (See Table 1).

Table 1 : Social security schemes in francophone West Africa and Ghana

COUNTRY	National health insurance	NHI for exempted	Status of NHI	Social security	Mutual for civil servants	Other formal workers' mutuals	CBHIs
Benin	Réseau d'Assurance Maladie Universelle (RAMU)	Fonds National pour les Indigents (As a part of RAMU)	Pilot phase launched in 2011	MUTUELLE DE SECURITE SOCIALE; Caisse Nationale de Sécurité Sociale (CNSS),Fonds National des Retraités du Bénin (FNRB)	MSAE : Mutuelle de Santé des Agents de l'Etat (as a component of RAMU) FSPA, FNRB	Mutuelle de Sécurité Sociale (MSS)	Union Communales des Mutuelles de Santé Réseau de Mutuelles de Santé « ALLIANCE SANTE » Maison de la Mutualité
Burkina Faso	Système National d'Assurance Maladie (SNAM)	NONE	UNDER STUDY-To be launched in 2015	Caisse Nationale de Sécurité Sociale - CNSS		La fédération des mutuelles professionnelles	Union des mutuelles de santé du Centre (UMUSAC); 200 les mutuelles de santé communautaires (MUSA) en 2007
Cote d'Ivoire	Assurance Maladie Universelle (AMU) not implemented	Caisse Nationale d'Assurance Maladie, as part of AMU	TERMINAL PHASE OF STUDY- PILOT PHASES TO BE LAUNCHED IN LATE 2013 OR 2014	Caisse Nationale de Prevoyance Sociale (CNPS-for formal private sector) Caisse Generale de Retraite des Agents de l'Etat (CGRAE-public servants)	Mutuelle Generale des Fonctionnaires de Cote d'Ivoire (MUGEFCI)	la **MA-CNPS** (Mutuelle des Agents de la CNPS), LE **FPPN** (Fonds de Prévoyance de la Police Nationale), le **FPM** (Fonds de Prévoyance Militaire), la **MUMADGI** (Mutuelle des Agents de la Direction Générale des Impôts), la **MUSA-ANADER** (Mutuelle des Agents de l'ANADER), la **Mutuelle des Agents du CNRA**, la **Mutuelle des Agents de Palamfrique, CAMES/CIP, LA MUTREP-CI** (Mutuelle des Travailleurs et Retraités du Secteur Privé de Côte d'Ivoire)	Low
Guinea	NONE	NONE	NONE	CNSS			(MURIGA; Union des Mutuelles de Santé de Guinée Forestière EMUFOUD (Réseau des Mutuelles du Fouta Djallon) and 110 mutual health organizations in 2004
Ghana	National Health Insurance scheme (NHIS)		OPERATIONAL SINCE 2005	Social Security and National Insurance Trust (SSNIT)- 1972 ; Global Social Trust, a pilot project for social protection for informal sector adnd vulnerable population	Civil Servants Health Care Scheme affiliated to the NHIS after 2005		
Mali	Régime d'Assurance Maladie Obligatoire-(2011)	Régime d'Assistance Médicale (RAMED) Poor (2011)	OPERATIONAL SINCE 2010	INPS l'INPS, la Caisse Malienne de Sécurité Sociale (CMSS) et de l'Union Technique de la Mutualité (UTM)			Assurance Maladies Mutualiste (For each sector and each estate)
Mauritania	A supplementary health insurance scheme (couverture maladie supplémentaire) run by CNAM and opened to all citizens is in preparation	?	UNDER STUDY	Caisse Nationale de Sécurité Sociale (CNSSS);Caisse des Retraites de l'Etat;	Caisse Nationale d'Assurance Maladies (CNAM)		Mutuelle Communautaire de Sante de Dar Naim Nuackchott; Mutuelle de Santé KAEDI
Niger	Extension del'Assurance Maladie volontaire et des Mutuelles de Santé dans le cadre du projet	?	UNDER STUDY	Caisse nationale de sécurité sociale (CNSS); Caisse Autonome de Retraite du Niger (CARENI)	In creation but 80% of health spending from civil servants are paid by the government	Mutuelles (entreprises et milieu rural)	MUTUELLE ALFURMA Mutuelle de Santé "Tounda- Hiney"
Senegal	Universal Health Insurance		OPERATIONAL SINCE 2009, PILOT STUDY IN 2013	Social Security Fund	Mutuelle de Sante des Agents de l'Etat (MSAE)	Mutuelle des Volontaires et Contractuels de l'Education (MVCE); Union des Mutuelles du Partenariat pour la Mobilisation de l'Epargne et le Crédit (UM-PAMECAS) UMS (Union des Mutuelles du Senegal); Mutuelle Sociale Transvie	
Togo	Institut National d'Assurance Maladie - INAM (2012)	?	UNDER STUDY	la Caisse de Retraite du Togo (CRT) pour les agents du secteur public et la Caisse Nationale de Sécurité Sociale (CNSS)			

Source : Author using multiple sources.

3. Challenges

Several studies have demonstrated that the existence of a third-party payer (hence subsidized or free health care) shifts the demand for health care curve and results in higher use of health care services. The implementation of exemptions policies in various Francophone WA countries has shown that in these settings, some challenges exist to scale up quality and quantity of health care provided[27]. They are related to the current organization of the health care system. Some of them are:

- Lack of personnel, drugs (and other medical goods) and infrastructure (hospital, health centers) to satisfy the demand;
- Worsened working conditions for healthcare providers;
- Low financial incentives for health care professionals to work more or better and to ensure the success of the policies;
- Policy relies heavily on external and not internal funding;
- Rigidity and centralization in reimbursement procedures from the government's side with in delays of payments from the government, raising issues around the financial sustainability at the local level site of service delivery ;
- Lack of transparency in the amount to be paid by the government;
- Some of the policies are too general and fail to effectively target and identity the needy;
- Isolated policy that doesn't take into account other determinants of health care utilization;
- Low capacity of evaluation of the functioning and impact of the policies, and
- Poor integration into the health system hindered implementation of the policies, and
- Dysfunctions in governance of funds and management of personnel.

These challenges must be considered in effectively establishing Universal Health Care (UHC). Both supply (quality) and demand-side (financial protection) issues must be addressed by UHC schemes. Besides, the choice of combining mutual health insurance schemes and mandatory formal sector insurance can be explained by the fact that poverty and informalization of the economies are prominent in these countries. It could be difficult to collect contributions from the informal sector. It is seldom to find relevant and updated

[27] Ridde, Queuille. et Kafando (2012) ; All other things on personnel in Cote d'Ivoire et al!!!!; Project Results 105309 (IDRC document).

information on income levels in this sector. Using a proportional tax can be difficult to implement and can generate free riding or prevent individuals to enter or remain in the system. For this reason, most plans are built in such a way that contributions of the informal sector (including a great share of agriculture) are lump sum payments but direct taxes are used to collect contributions for formal sector employees and pensioners. In the case of developing countries, it appears however a second best solution because of free-riding and opting out. In Benin however, the RAMU suggests a lump sum contribution for the entire population. Levying a lump sum can raise equity issues in term of tax incidence. Most of the time, this practice is regressive. It can put a heavier burden on the poorer and reduced the ability of the system to collect as much resource as available[28].

4. Main players in health financing

Apart from the governments, some NGOs and international donors' actions are crucial in financing the current strategies to reduce the burden of health care for the populations. The Global Fund against Malaria, HIV/AIDS and tuberculosis finances subsidization or exemption of fees for treatment including ARVs. The GAVI alliance is also a strong partner in providing immunization especially for the EPIs, while the Bill and Melinda Gates Foundation is highly involved in immunization and mosquito nets distribution. NGOs are also active in subsidization or exemption of fees; for example, the Raoul Follereaux Foundation in the case of leprosy. A study on capitalization on user fees policies in West Africa (Ridde, Queuille et Kafando, 2012) has noted the following NGOS and actors in health financing:

- ONG HELP, (hilfe zur selbsthilfe e.v.)
- Médecins du Monde (MDM-Physicians of the world)
- Médecins Sans Frontières (MSF -Physicians without borders)
- Terre des Hommes (TDH)

[28] In most of the case the lump sum is low enough to be "bearable for poor households" and encourage taking up. In the case of Benin, it is 1,000 FCFA (approximately 2.07 $, as of the November 29, 2013) per person and per month. In so doing, the scheme collects less than what the tax base of wealthier individuals can allow to collect. On the other side, increasing the lump sum can crowd out the poor who will not be able to afford contributions.

B. Health financing in other settings

This section presents health financing in African countries with an almost universal system (Ghana and Rwanda), as well as the case of South Africa. Some selected cases of successful reforms in Latin America and Asia are also reviewed in order to inform reform in francophone West Africa.

1. Successful African countries

This subsection presents the facts on three (3) African countries: Ghana, Rwanda and South Africa. Ghana represents the case of establishment of universal health coverage, Rwanda a successful implementation of Mutual health insurance scheme and South Africa a system dominated by private health insurance schemes.

Ghana

According to the WHO Global Health Expenditure Atlas, Ghana was the third country in West Africa with the lowest OOP share (29%) in health care financing in 2009 and 2010.The Ghanaian National Health Insurance Scheme (NHIS) is well-known in the Economic Community of West African States region. Starting from the early 1990s, Ghana began to seek other ways of financing health care, including NGO and initiated community-based health insurance schemes (CBHIs). While popular among members and international donors at the time, the schemes only targeted specific areas and were not supported by general government revenue to allow them to cater for the poor. The NHIS was established under Act 650 of 2003 by the Government to provide a broad range of health care services to Ghanaians through district mutual and private health insurance schemes (Blanchet, Fink and Osei-Akoto, 2012). The insurance became operational in 2005 and registration of the Ghanaian population increased from 18% in 2006 to 62% in 2009 and to 66.2% in 2010. As of 2010, 54.5% of the registered population is under 18 years old and 32.6% are those working in the formal sector.

The NHIS is funded through Value-Added Tax (VAT), social security deductions for formal sector workers and voluntary membership contributions by those outside the formal sector, with members obtaining care from accredited public or private health services. The indigent,

children under 18 years whose parents are enrolled and the aged (70 and +) are exempted from payment (Goudge et al., 2012).

The effect of the NHIS on access to health care has been studied extensively. Witter and Garshong noted that the number of outpatient visits per capita in Ghana increased sharply after 2005, the same year NHIS operations began. Mensah et al found that pregnant women enrolled in the NHIS are more likely to receive prenatal care, give birth in a hospital, and have skilled attendants present at birth. Similar results were found in a recent study tracking health seeking behavior in two districts before and after NHIS rollout[29]. Finally, Blanchet et al (2012) found that on average, individuals enrolled in the insurance scheme are significantly more likely to obtain prescriptions, visit clinics and seek formal health care when sick.

However, there exist some equity concerns about the new funding source (a VAT-based tax) which may be more regressive. In addition, membership of the NHIS at present is pro-rich and pro-urban biased concerning renewals. Some other challenges remain in relation to its accountability (Witter and Garshong, 2009).

Rwanda [30]

Rwanda's case is largely considered as a "success story" on extending health coverage especially because the country emerged from a very violent political crisis. After an unsuccessful attempt, the Government launched in 2001 a program to organize universal coverage through community health insurance (Musango, Doetinchem et Carrin, 2009) to cover those in informal and rural economies. Health system funding is then based on risk pooling organized through formal sector insurance and CBHIs as follows:

(1) *La Rwandaise d'assurance maladie (RAMA)* which covers civil servants and their dependants instituted in 2001 and reformed in 2002; it covers a large range of medical services including ARVs[31];

[29]Blanchet et al, 2012.

[30]This section heavily draws on http://www.issa.int/News-Events/News2/Rwanda-innovates-to-sustain-universal-health-care-coverage

[31]The contribution is 15% of the salary with 7.5% paid par the employer and 7.5% by the employee. The coinsurance rate is 85%.

(2) The *Fonds d'appui aux rescapés du genocide (FARG)* covers the victims of the genocide for a certain range of services, including health insurance[32];

(3) The *« Medical Military Insurance » (MMI*) is a compulsory scheme that covers all the soldiers[33];

(4) Private health insurance schemes which have existed since 2006 in Rwanda. They essentially target firms. In 2009, there were only three such schemes providing coverage to around 0.1 % of the Rwandese population. Premiums range between 100 and 700 $ US per individual per year;

(5) The Community Based Health insurance organized by the government;

(6) A 100% coverage (sponsored by the government) for the *inyangamugayo*, individuals working in traditional courts on the genocide;

(7) Free health care for prisoners , and

(8) *The Caisse sociale du Rwanda* which is the national social security fund covering occupational health[34] care and services.

As a result, there was a rapid expansion of CBHI coverage and utilization of services by the population for the period 2003-2010 (See Annex 3), from 7% to 91% of the population, with a utilization rate rising from 31% to 95% in the same period of time.

Nevertheless, there exist challenges concerning absence of data and accurate identification of poor households. In addition, low premiums can jeopardize the sustainability of the scheme which already has an increasing debt. A reform of CBHI management and monitoring is ongoing to correct these drawbacks.

South Africa

In South Africa, health care is financed through a combination of mechanisms but the most prominent is through private health insurance schemes. In 2005 for instance, allocations from general tax accounted for about 40%, private medical schemes about 45%, and OOP

[32]Each civil servant contributes to 1% of his salary and 5% of the budget is given by the state and other voluntary gifts are used to finance the scheme. This scheme also covers for education costs and other social needs.

[33]They pay 5% of their salary and the government contributes to 17% of their salary

[34]Contribution are collected from the employer who pays 5% of the salary (3% for pensions and 2% for occupational risks) and from the employee (3%).

payments for about 14% of total health care financing (Ataguba and Akazili 2010). Ataguba and McIntyre in 2012 found that inequities exist in the South African health system. In 2005, for instance, general tax revenue (public finance), was used to cater for about 68% of the population dependent entirely on underfunded public facilities, and to subsidize care for the insured minority. Private insurance contributions only covered about 16% of the privately insured population who are the richest group (McIntyre et al. 2007)[35] and from private health providers. 21% of the total population uses private primary care services on an OOP basis (McIntyre et al. 2007[36] and Mills et al, 2012). Besides, the public health system is overburdened by the volume of users and there are ongoing debates about the fairness of the distribution of resources between the public and private sectors relative to the population served by each (McIntyre et al. 2007[37]; Ataguba and Akazili 2010). National and social health insurance has been hotly debated for many years as a possible mechanism to reduce inequity (Goudge et al, 2012). McIntyre and Ataguba 2012 using a simulation technique showed that extended private insurance schemes is the least progressive option[38], would impose a very high payment burden on households and the option with the highest pro-rich distribution for public health care .

It appears from the South African case that private health insurance expansion is not a solution in low-income settings from the demand-side. From the supply side, there is a need to scale-up capacities in the public health system.

2. The Case of Latin American countries

In Latin American countries, there are different schemes, but it is worth noting innovative schemes such as Colombia's regulated competition model that provides universal coverage and has encouraged reforms in countries[39]. In Chile, the Acceso Universal de Garantías Explícitas AUGE Plan seeks universal coverage with a limited package and guaranteed waiting times, and Mexico's Seguro Popular offers tax-financed coverage through social

[35]Cited by Ataguba and McIntyre, 2012
[36] Cited by Goudge et al, 2012.
[37] Idem
[38] The paper investigates option to reach universal care in the country. The other options were universal coverage and status quo(keeping the current health system financing feature with 16% of private health insurance).
[39] Dominican Republic and Peru

insurance covering the previously uninsured. While several countries contract private providers for their public schemes, all permit the private sector to sell services with limited regulation to those able to pay (Knaul et al, 2012). In this section, the Colombian and Mexican cases are presented.

The Colombian case[40]:

In 1993, Colombia initiated a process of health sector reform with the aim of achieving coverage for all Colombian citizens through a process of universal insurance. The new health system grants all Colombian citizens the benefits of a basic health service package along with the right to choose a private or public insurance provider. People with capacity to pay (CTP) are affiliated to the Contributory Health Insurance Scheme (Régimen Contributivo), and are registered with one of 40 Health Promoting Entities (Entidades Promotoras de Salud, EPS). Affiliation with an EPS requires payment of a monthly contribution equivalent to 12.5% of the worker's income[41], which confers access to an explicit benefits package covering the affiliate and his or her first-degree relatives. In exchange for their contribution, affiliates and their relatives receive an integral health service package known as the Compulsory Health Plan (Plan Obligatorio de Salud). If they wish, affiliates can purchase additional health insurance. Poor people[42] are covered by the Subsidized Health Insurance Scheme (Régimen Subsidiado), and may register freely with any of the 49 EPS that operate under the subsidized scheme. The government covers the cost of the basic benefits package offered under this scheme. As of 2008, 49% of these costs were financed by transfers from the central government treasury, 24% by the solidarity fund financed mostly through a solidarity payroll tax contribution (1.5% of payroll), and the rest mainly by territorial (departmental and municipal) health sources (Ministry of Social Protection, 2009). According to the National Health Survey (Encuesta Nacional de Salud), in the year 2007, 78% of the population was covered by an insurance scheme, 46% of whom were covered by the subsidized scheme. By 2011, coverage reached 95% as noted above; 53% of whom were

[40] This section is from Knaul et al, 2012, Chapter 7.

[41] In the case of formal workers, 4 percent is contributed by the employee and 8 percent by the employer. Independent workers contribute the full 12 percent of their salary, starting from a floor of two minimum wages (around US$355 in 2006) (Pablo Gottret, George J. Schieber, and Hugh R. Waters, 2008).

[42] Defined as those who lack the CTP as identified by a proxy means test known as the System of Identification of Social Subsidies Beneficiaries (Sistema de Identificación de Beneficiarios, SISBEN)

covered under the subsidized scheme. The country recorded OOP of 22% in 2009 as a share of THE (WHO, 2011). Besides, insurance appears to be a fundamental variable for financial protection.

However, it is only recently that benefits packages offered through the contributory and subsidized insurance schemes were equalized. In the past, only contributory scheme affiliates had a very complete package. There was then inequitable access to health care and some populations are still isolated from health care[43]. Deficiencies persist in capacity and quality of primary care and preventive medicine. Sustainability issues have been raised, along with quality of health outcomes, due to use of emergency care instead of primary health care[44].

A current health care system reform is in preparation with the support of the InterAmerican Development Bank to correct these drawbacks and assure more equitable access to quality services and greater efficiency in resource management.

The Mexican case

In Mexico, the government enforced in 2003 a law to create the *Sistema de Protección Social en Salud (SPSS)*[45] and the "*Seguro Popular*" (SP) (Aracena-Genao et al, 2011) to ensure financial protection for the population out of the scope of existing social security institutions. This new system included the Fund for Protection against Catastrophic Expenses (FPGC). The social security schemes cover the Mexican Institute for Social Security (IMSS) and the Institute for Security and Social Services for Civil Servants (ISSSTE) cover only formal workers of the private and public sectors (Knaul et al, 2012-chapter 9). The creation of the SSPS and the launch of SP in 2004 involved a major legislative reform focused on financial reorganization and the commitment to increase funding for health by 1% of GDP, primarily through public resources. The mobilization of additional public resources for SP created the financial conditions necessary to expand the coverage of public health insurance in Mexico. The most recent data from the Ministry of Health (MOH) indicate that the number of SP

[43] InterAmerican Develpoment Bank (2013)
[44] Idem
[45] System for Social health Protection

affiliates reached 52.5 million in February 2012. The majority of SP affiliates belong to the poorest four income deciles and 35% live in rural communities (Knaul et al, 2012-chapter 9).

In a study in 2011, Sosa-Rubí, Salinas-Rodríguez and Galárraga found that SP had no effect on catastrophic health expenditures at the local level. However, at the household level, they found a protective effect of SP on catastrophic health expenditures and the OOP health payments in outpatient and hospitalization in rural areas; and a significant effect on the reduction of OOP health payments in outpatient services in urban zones.

From 2004-2009 the FPGC increased its coverage from 6 to 49 interventions, that means a spending increase of 2,306.4% in nominal terms and 1,659.3% in real terms. The HIV/AIDS was the intervention prioritized with 39.3% and Mexico City had the highest proportion of expenditure (25.1%). A few diseases included in the health profile are covered by the FPGC (Aracena-Genao et al., 2011).

An Organisation for Economic Co-operation and Development study shows that some challenges remain because of a narrow benefit package, low efficiency and quality of public providers, along with low governance. This study emphasizes the need to find additional funding sources to ensure sustainability of the system.

3. The Case of Asian countries

In Asia, specifically in South-East Asian countries, a certain number of countries implemented reforms to move towards universal health coverage. The cases of Thailand and Sri Lanka are presented.

Thailand[46]

Thailand has three organized schemes for universal health coverage running with private health insurance schemes:

(1) The Civil Servant Medical Benefit Scheme (CSBMS): It covers civil servants, public employees and their dependents. The scheme is paid totally from general tax

[46] This section is from Pablo Gottret, George J. Schieber, and Hugh R. Waters, (2008).

revenue, based on a fee-for-service retrospective reimbursement system. Public facilities are the main providers under this scheme.

(2) The Social Security Scheme (SSS): The SSS is a tripartite system, funded by equal-share contributions by employers, employees, and the government. It covers private employees and temporary public employees. The insurees are about equally distributed between public and private facilities. This scheme pays the providers under a contract capitation system.

(3) Universal Coverage Scheme (UCS or the "30 Baht Scheme"): Universal health insurance coverage, since October 2001, has combined the previous Medical Welfare Scheme and the Voluntary Health Card Scheme, further expanding coverage to 18 million more people. This scheme covers 74.6 percent of the population with a comprehensive package of care, including both curative and preventive care. It is financed solely from general tax revenue. Public hospitals are the main providers, covering more than 95 percent of the insured. About 60 private hospitals joined the system and register around 4 percent of the beneficiaries. After the new government assumed office in October 2006, the B 30 copayment was abolished, and the system is now totally free of charge. In addition, since October 2003, the government has also embarked on universal access of ARV.

The country recorded that the number of outpatient visits in all public hospitals in 2003 increased between 40 and 50 percent (Pachanee and Wibulpolprasert 2006). However, some people buy specific health insurance. Their coverage is quite low usually less than 2 percent of the population.

Some challenges regarding an increase in workload and dissatisfaction of health personnel, adverse effects of resource allocation reform and financial sustainability exist. It is however believed that this universal health care access is a success, because of the near-disappearance of uninsured[47], the significant reduction of the catastrophic illnesses and out-of-pocket health expense as well as poverty reduction, consumer satisfaction, the expansion

[47]The number of uninsured has dramatically decreased from 20 percent of the total population in 1998 to 2 percent in 2007 (table 12.8) (NHSO 2007a). Coverage is then assumed to be universal

of the benefit package, the strengthening of the capacity for knowledge generation and management, and the strong public involvement and support.

Sri Lanka[48]

In Sri Lanka, public sector health spending is financed exclusively from general tax revenue, with a small contribution from international development assistance (less than 5 percent). There is no social insurance. A fifth of private financing is from employer spending on medical benefit schemes for their employees and on group medical insurance schemes, plus a smaller amount from individually purchased medical insurance.

However, all government health services, with few exceptions, are available free to all citizens, including all inpatient, outpatient, and community health services. Free services range from ARVs for HIV/AIDS patients to coronary bypass surgery. Access to all services is reinforced by a policy of permitting patients to visit any hospital in the country without restriction, and with no enforcement of a referral system. The government is able to do this because of a high level of technical efficiency in its delivery system, which keeps costs low, and the implicit strategy of encouraging the richer patients not to burden the government health system by voluntarily opting to use private providers.

Section III: HEALTH CARE FINANCING AND RESEARCH

This section presents some results of IDRC-funded projects on health financing and the gaps identified in the literature.

A. Health financing system research in IDRC projects: key lessons

Health financing and extension of coverage to poor and / or people in the informal sector have been the focus of recent projects financed by the GEHS program.

Three projects were run in the context of public policy and protection from exclusion. The first one found that reducing the gap between subscriber and promoter expectations may

[48]This section is from Pablo Gottret, George. Schieber, Hugh and Waters (2008).

help increase enrolment in, and performance of CBHIs[49]. The second one evaluated the criteria for selection of indigents in public hospitals. It was found that in Cote d'Ivoire, selection of indigents by health practitioners was subjective and not done on the basis of a set of defined criteria. In Burkina Faso, exemption for obstetrical emergencies was found not to be well designed, meaning that poor women couldn't have access to designated services. Following the research, the Hospital management reformulated the exemption policy. Finally, in Senegal, barriers on participation in mutual health insurance schemes and access to health care were identified for a better coverage of people in the informal sector.

Another study in Burkina Faso suggested an alternative to fuzzy identification of indigents. It particularly focused on the selection process and the viability of community exemption from payment, comparing three interventions (one state-led and two communities led). It concluded that community-based targeting was better accepted by the stakeholders than was the State-led intervention. The strengths of the community-based approach were a clear definition of selection criteria, information of the waiver beneficiaries and use of a participative process and endogenous funding. However, the weakness was the fact endogenous funding led to restrictive selection by the community. The system needs to be improved and retested to generate more knowledge before scaling up.

Another project analyzing user fees exemptions in Burkina Faso, Mali and Niger examined the effect of these policies implemented by the governments. Generally, it has been found that they led to improvement in diagnoses and treatment of morbidity. However, several caveats were highlighted, related to financial and organizational dysfunctions which negatively impacted healthcare quality, along with lack of technical and budgetary preparation. It is worth noting that except in Burkina Faso, working condition of health workers were worsened by the policy.

An ongoing project in Niger studies the neglected issues in the health sector and looks at their impact on access to health care. It addresses issues like quality of care by examining the impact of midwife's malpractice on demand for prenatal care.

[49] Ouimet et al, 2007

These IDRC projects have addressed some of the key debates on extending health coverage but some questions remain. Among them, it is possible to cite:

- How can indigents and the poor be effectively identified at a national level?
- How do we effectively and equitably collect contributions from the informal sector?
- Will a levy of (supplementary) taxes have effects on the macroeconomic level (unemployment, consumption, etc.)?
- Is universal health insurance sustainable without donors' involvement?

B. Gaps identified and future research

Very little is known about the existing financing system and the prospect of new alternative systems and several gaps can be identified in the literature concerning health financing systems in West Africa. Some of them are general gaps related to availability of data. Other gaps related to the fact that there is over-insurance, underinsurance and sustainability of insurance schemes. Finally, there also exist gaps on the trade-off between better access to health care (equity) and quality of care (governance and efficiency).

1. Gaps related to data availability and management

There is generally a lack of data and poor management of existing ones. Information on current organisation of health care financing is not available. There is no data repository on existing health care financing schemes in West Africa. In reality, National health accounts are not systematically produced in the countries in such a way that data on health spending is compiled and analysed on a regular basis (Annex 4).

Data need to be built around utilization and expenditure patterns and costs of health care services, especially in the case of existing health insurance schemes. In the case of utilization and expenditure, data exist in private and mutual health insurance scheme but are not available to researchers for use. Data on health care cost and Medical CPI is lacking. It needs to be collected at health center, district and national level. Besides, data on perception of health care quality is lacking.

Hence, there is a need to create research departments in MoHs. With the availability of data, studies will be feasible, and can analyze:

- The existence of moral hazard and physician-induced demand on health care in West African countries;
- The determinants and dynamics of drug consumption (Agence Nationale des Statistiques et de la Démographie WHO (2012, Rapport d'analyse des dépenses catastrophiques de sante et leur impact sur l'appauvrissement et l'utilisation des services au Sénégal 2005 & 2011, Sénégal.)
- Computation and assessment of the Medical CPI in Africa to explain the increase of medical care costs and the major components of this increase because universal coverage systems may be threatened by it;
- Methodological costing of alternative strategies for universal coverage in the countries;

2. Gaps related to over-insurance and underinsurance

Some gaps needs to be filled to investigated the extent of over-insurance (of a low share of the population) in West African countries and how this could affect take up rate, utilization of care and sustainability in a universal health insurance scheme. Studies on over-insurance investigate the existence of physician-induced demand and moral hazard. In addition, underinsurance (of the majority of the population) and determinants of health care have to be more investigating, comparing health care seeking behaviour by insurance status. Studies could examine:

- Criteria for selection of drugs into health insurance schemes;
- Extensive studies on the impact, the benefits of patronizing to existing health insurance schemes;
- The drivers of medical expenses;
- Health insurance holding and health seeking behaviour, and
- Physician-induced demand in private health insurance scheme.

3. Gaps related to access and quality of care

As shown in some other studies[50], current health systems in francophone countries may be overstretched and question may rise concerning the quality of care in a context of increased access to health care. It is then important to analyze the following issues:

- The extent and magnitude of neglected issues in health care such as midwifes' practices[51];
- The perceived quality of care by patients, especially in public facilities
- The determinants of "quality" care, especially in public facilities
- The prerequisite in terms of quantity and quality of (public) health care for universal coverage: what is required supply to satisfy the demand generated from releasing financial barriers to health care?

4. Gaps related to the design of universal health scheme

Planning and organizing universal health coverage needs to be based on studies. There is a need to invest in exploring the following issues:

- Scoping studies, literature reviews and state of knowledge in health care financing in West Africa : such studies exist for east and southern Africa, Nigeria and Ghana, but not for francophone West African countries;
- What are the costs, benefits and feasibility of unifying the public health insurance schemes in one plan? What are the magnitude, causes and costs of health insurance coverage duplication?
- How can we develop cost containment strategies that do not reduce utilization of health care for the needy?
- Setting priorities studies: such studies undertaken by Alliance don't include[52] francophone West Africa countries;
- Functioning and sustainability of existing health care financing schemes in West Africa;

[50]Such as Ridde, Queuille and Kafando (2012).
[51] This question is addressed in the case of Niger in an IDRC funded and ongoing study
[52] Ranson M. K., Law T. J., Bennett S.(2008), Establishing health system financing research priorities in developing countries using a participatory methodology, Alliance for health research, WHO.

- There is no evidence (financial or actuarial projections) that the future planned universal coverage or mutual health insurance systems can draw on? To predict sustainability? , and
- What is the socially desirable benefit package?

Aside from these gaps, there is a need to elicit some other questions such as health financing schemes in the context of a fragile state, since a certain number of countries experienced or are experiencing wars and political crises. Besides, it is worth noting that very few active research groups on health systems research, social and medical sciences, public health or health economics are undertaking regional studies or providing materials and studies in francophone West Africa.

There is a need to fill research gaps, provide data and feed in the debates on equity VS quality of care, equity VS sustainability, governance and equity to promote evidence and context-based decision making for universal health coverage in francophone West Africa countries.

Section IV: CONCLUSION AND LESSONS LEARNED

In francophone West Africa, risk pooling is very low and current health financing systems involve high spending from the population. Although universal coverage is envisioned in almost all the countries, the resulting plans and laws, in most of the cases, are not clear about the way resources will be collected, who will benefit and what is the content of the benefit package. It is true that some studies show that CBHIs have a good potential of working in LMICs, but there is a need to build a national pool to ensure both equity in access and sustainability of the scheme. In Ghana, expanding CBHIs didn't work while it is considered as a success in Rwanda.

These schemes need to be built on the basis of lessons learned from other countries, by paying attention to both the supply-side (by scaling up quality, efficiency and governance especially from public providers) and the demand-side (by building contribution scheme and benefit package that can increase access to care especially for the poorest). The examples from the world suggest that:

(1) There is a possibility of having high technical efficiency in health care supply by the public sector (Sri Lanka) ;
(2) The expansion of private health insurance schemes is not a solution for achieving universal coverage (South Africa) ;
(3) It is possible to find an objective way to identify poor that will beneficiate from exemption (Colombia);
(4) Universal coverage brings the challenge of financial sustainability regardless of the modality used (mutual health insurance or social health insurance scheme), (Colombia, Ghana, Mexico, Rwanda and Thailand) and
(5) Medical staff's working conditions have to be considered in organizing universal coverage for the success of the scheme (Cote d'Ivoire, Mali). The case of Niger shows that there is a possibility to increase access to health care and keep reasonable workload.

Universal coverage will not happen overnight. It also requires a better organization of the health information systems so as to collect and analyze data actively to have a better understanding of the whole system. Governance can also encourage quality of care and

increase population's adhesion and participation to the scheme. Ensuring good quality of care means that equipment, medical goods and infrastructure are available, as well as enough health practitioners. Besides, prerequisites for the success of universal health coverage go beyond the health sector and can concern the organization of the economy. Informalization reduces the chances of having progressive contributions by obliging to collect lump sum taxes because incomes are unobservable.

Finally, each country has a special context that necessitates rigorous investigations to determine the optimal path to universal coverage.

The last WHO report clearly shows that universal coverage has to rely on research, quality research is essential in the rush for universal coverage. There is a need to conduct massive research to inform decision-making in this respect. This is especially important because financial sustainability of the scheme is an important concern to address, plans have to be carefully designed, tested and reformed where necessary to increase access to health care and increase financial protection for poor households. It will also be important to go the extra mile and carefully create platforms and discussions to better convert research findings into effectively made decisions.

Bibliography

Abdelmoumni A. (2011) La mutualité comme acteur clé de développement de l'économie sociale et solidaire *Présentation FIESS -18 OCTOBRE 2011 – QUEBEC*. UNION AFRICAINE DE LA MUTUALITE

Bennett, S., & Gilson, L. (2000). Which Financing Mechanisms are Pro-poor. *International Health Sector Development, London (forthcoming)*. Retrieved from http://xa.yimg.com/kq/groups/23309723/1332742353/name/pro-poor-financing.pdf

African Union (2007) *Projet Stratégie Africaine de la santé : 2007 à 2015, CAMH/MIN/5(III),*.Troisième session ordinaire de la Conférence des Ministres de la Santé de l'Union Africaine, Johannesburg (Afrique du Sud)-9 - 13 Avril 2007.

Aracena-Genao B., González-Robledo M. C., González-Robledo L. M., Palacio-Mejía L. S., Nigenda-López G., (2011), El Fondo de Protección contra Gastos Catastróficos: tendencia, evolución y operación, *Salud Pública de México / vol. 53, Suplemento 4 de 2011*.

Asenso-Boadi F. M. and Agbeibor W.(2010), Scaling up national health insurance scheme: Ghana's experience*, Presentation for the Forum on health financing in Tanzania* , Blue Pearl Hotel, Dar es Salaam, Sept. 2010.

Association Internationale de la Mutualite (AIM) http://aim-mutual.org/index.php?page=12&region=AF

Ataguba J. E and McIntyre D. (2012) Paying for and receiving benefits from health services in South Africa: is the health system equitable? *Health Policy and Planning 2012;27 :i35–i45*. doi:10.1093/heapol/czs005.

Ataguba J.E. and Akazili J. (2010), Health care financing in South Africa: moving towards universal coverage, *CME February 2010 Vol.28 No.2*.

Blanchet N. J., Fink G. and Osei-Akoto I. (2012), The effect of Ghana's national health insurance scheme on health care utilization, *Ghana Medical Journal Volume 46, Number 2, June 2012*.

Brown G. W., Barnes A., Harman S., Gruia M. and Papamichail A. (2013), Annotated literature review: African actors, global health governance and performance-based funding *EQUINET Discussion Paper 98 June 2013*, Regional Network for Equity in Health in East and Southern Africa (EQUINET)

Canavan A., Toonen J. and Elovainio R. (2008), *Performance Based Financing: An international review of the literature*, KIT Development Policy & Practice.

Conférence Interafricaine de la Prévoyance Sociale (2010), Étude du niveau d'instauration de l'Assurance Maladie dans les États membres de la CIPRES.

Culyer, A. J. (2005). *The dictionary of health economics*. Northampton, Mass.: Edward Elgar Pub.

Faye C. (2010) *Revue de la protection sociale dans quelques pays d'Afrique de l'Ouest*, Union Européenne, Pole sur les mutuelles et autres.

Fretheim A., Witter S., Lindahl A. K. and Olsen I. T. (2012) Performance-based financing in low- and middle-income countries: still more questions than answers *Bulletin of the World Health Organization 2012;90:559-559A*. doi: 10.2471/BLT.12.106468. http://www.who.int/bulletin/volumes/90/8/12-106468/en/

Gottret P., Schieber G. J., and Waters H. R., (2008) *Good practice in health financing: lessons from reforms in low and middle-income countries*, Pablo Gottret, George J. Schieber, and Hugh R. Waters, coeditors.

Goudge J., Akazili J., Ataguba J., Kuwawenaruwa A., Borghi J., Harris B. and Mills A. (2012) Social solidarity and willingness to tolerate risk- and income-related cross-subsidies within health insurance: experiences from Ghana, Tanzania and South Africa, *Health Policy and Planning 2012;27:i55–i63*. doi:10.1093/heapol/czs008.

Huber G., Hohmann J., Reinhard K. (2003), Mutuelles de Santé - : 5 Années d'Expérience en Afrique de l'Ouest, Débats, Controverses et Solutions Proposées, Rapport N4300, Santé, Education, Sécurité Sociale, Projet Assurance Maladie Sociale, GTZ.

Huber G., Hohmann J., Reinhard K. (2003), Mutuelles de Santé - : 5 Années d'Expérience en Afrique de l'Ouest, Débats, Controverses et Solutions Proposées, *Rapport N4300*, Santé, Education, Sécurité Sociale, Projet Assurance Maladie Sociale, GTZ.

interAmerican Development Bank Website (2013) http://www.iadb.org/en/news/news-releases/2013-07-08/colombia-to-deepen-reforms-in-its-health-care-system,10500.html Accessed on December 2, 2013.

Jansen C., Lodenstein E., Lodi E. and Toonen J.,(?) *Vers la couverture maladie universelle au Bénin : Réflexions et perspectives*.

Jeune Afrique Website http://www.jeuneafrique.com/Article/DEPAFP20130921112149/. Accessed on 29 November 2013.

Knaul FM, Wong R, Arreola-Ornelas H. *Household Spending and Impoverishment. Volume 1 of Financing Health in Latin America Series*, Cambridge, MA: Harvard Global Equity Initiative, in collaboration with Mexican Health Foundation and International Development Research Centre, 2012; distributed by Harvard University Press.

Lozano R., Naghavi M., Foreman K., Lim S., Shibuya K., Aboyans V. , Abraham J., Adair T., Aggarwal R., Ahn S. Y, AlMazroa M. A, Alvarado M., Anderson H R., Anderson L.M, Andrews K. G, Atkinson C., Baddour L.M, Barker-Collo S., Bartels D. H, Bell M. L, Benjamin E. J, Bennett D., Kavi Bhalla, Bikbov B., Bin Abdulhak A., Birbeck G., Blyth F., Bolliger I., Boufous S., Bucello C., Burch M., Burney P., Carapetis J., Chen H., D. Chou, Chugh S.S, Coff eng L. E, Colan S. D, Colquhoun S., Colson K E., Condon J., Connor M. D, Cooper L. T, Corriere M., Cortinovis M., Courville de Vaccaro K., Couser W., Cowie B. C, Criqui M. H, Cross M., Dabhadkar K. C, Dahodwala N., De Leo D., Degenhardt L., Delossantos A., Denenberg J., Des Jarlais D. C, Dharmaratne S. D, Dorsey E R., Driscoll T., Duber H., B. Ebel, Erwin P. J, Espindola P., Ezzati M., Feigin V., Flaxman A. D, Forouzanfar M. H, Fowkes F. G. R, Franklin R., Fransen M., Freeman M. K, Gabriel S. E, Gakidou E., Flavio Gaspari, Gillum R.F, Gonzalez-Medina D., Halasa Y. A, Haring D., Harrison J.E, Havmoeller R., Hay R. J, Hoen, B. Hotez P. J, Hoy D., Jacobsen K. H, James S. L, Jasrasaria R.,

Jayaraman S., Johns N., Karthikeyan G., Kassebaum N., Keren A. , Khoo J -P, Knowlton L. M., Kobusingye O., Koranteng A., Krishnamurthi R., Lipnick M., Lipshultz S. E, Lockett Ohno S., Mabweijano J., MacIntyre M. F, Mallinger L., March L., Marks G. B, Marks R., Matsumori A., Matzopoulos, R. Mayosi B. M, McAnulty J. H, McDermott M. M, McGrath J., Memish Z. A, Mensah G. A, Merriman T. R, Michaud C., Miller M., Miller T. R, Mock C., Mocumbi A. O., Mokdad A. A, Moran A., Mulholland K., Nair M N., Naldi L., Venkat Narayan K M, Nasseri K., Norman P., O'Donnell M., Omer S. B, Ortblad K., Osborne R., Ozgediz D., Pahari B., Durai Pandian J., Panozo Rivero A., Perez Padilla R., Perez-Ruiz F., Perico N., Phillips D., Pierce K., Pope III C A., Porrini E., Pourmalek F., Raju M., Ranganathan D., Rehm J.T, Rein D. B, Remuzzi G., Rivara F. P, Roberts T., Rodriguez De León F., Rosenfeld L. C, Rushton L., Sacco R. L, Salomon J. A, Sampson U., Sanman E., Schwebel D. C, Segui-Gomez M., Shepard D. S, Singh D., Singleton J., Sliwa K., Smith E., Steer A., Taylor J. A, Thomas B., Tleyjeh I. M, Towbin J. A, Truelsen T., Undurraga E. A, Venketasubramanian N, Lakshmi Vijayakumar, Vos T., Wagner G. R, Wang M., Wang W., Kerrianne Watt, Weinstock M. A, Weintraub R., Wilkinson J. D, Woolf A. D, S. Wulf, Yeh P-H, P.Yip, A. Zabetian, Zheng Z-J, Lopez A D , Murray C. J L (2012) Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010, *Lancet 2012; 380: 2095–128.* *http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673612617280.pdf*

McIntyre and Ataguba (2012)

Mills A., Ally M., Goudge J., Gyapong J. and Mtei G. (2012), Progress towards universal coverage: the health systems of Ghana, South Africa and Tanzania, *Health Policy and Planning 2012; 27: i4–i12*. doi:10.1093/heapol/czs002

Ministère de la santé et de la lutte contre le Sida (2012) *Stratégie nationale de financement de la santé pour tendre vers la couverture universelle,* République de Côte d'Ivoire.

Ministère du Développement Social, Solidarité et des Personnes Agées de la République du Mali MDSSPA (2011) *État des lieux de la couverture maladie universelle au Mali* : Rapport final, Octobre 2011.Bamako, Mali. http://www.who.int/providingforhealth/countries/MDSSPA_Mali-Etat_des_lieux_couverture_universelle_sante_Mali_version_finale.pdf

Musango L., Doetinchem O. et Carrin G. (2009) De la mutualisation du risque maladie à l'assurance maladie universelle : Expérience du Rwanda, *Discussion Paper Numéro 1 - 2009 HSS/HSF/DP.F.09.1*, Department "Health Systems Financing" (HSF), Cluster "Health Systems and Services" (HSS), WHO, Geneva.

Organisation for Economic Co-operation and Development OECD (2010) *OECD Perspectives: Mexico Key Policies for Sustainable Development.* http://www.oecd.org/mexico/45570125.pdf Accessed on December 2, 2013.

Ouattara AF, Houngbedji CA, Koudou BG (2013) Free Health Care in Public Health Establishments of Côte d'Ivoire: Born Dead? *Occup Med Health Aff 1: 114. doi:10.4172/omha.1000114*

Ouimet M.-J, Fournier P., Diop I. and Haddad S., (2007), Solidarity or Financial Sustainability: An Analysis of the Values of Community-based Health Insurance Subscribers and Promoters in Senegal, *Canadian Journal Of Public Health July – August 2007*.

Ridde V, Queuille L, Kafando Y (eds.) (2012) : *Capitalisations de politiques publiques d'exemption du paiement des soins en Afrique de l'Ouest*. Ouagadougou : CRCHUM/HELP/ECHO; 2012.

Savedoff, W. D. (2004). Tax-based financing for health systems: options and experiences/by William Savedoff. Retrieved from http://apps.who.int/iris/handle/10665/69022

Sosa-Rubí S. G, Salinas-Rodríguez A., Galárraga O., (2011), Impacto del Seguro Popular en el gasto catastrófico y de bolsillo en el México rural y urbano, 2005-2008, *Salud Pública de México / vol. 53, Suplemento 4 de 2011*.

Togo L., (Year) Planification du système de couverture du risque maladie au mali : cas des personnes indigentes Mali, *Rapport DNPSES*.

Trosper J. F. (1964) Overinsurance. Its Meaning, *The Journal of Risk and Insurance, Vol. 31, No. 4 (Dec., 1964), pp. 603-611* Published by: American Risk and Insurance Association Stable URL: http://www.jstor.org/stable/250812 .Accessed: 02/12/2013 10:00

Union Africaine (2010), *Décisions, Déclarations et Résolution : Assembly/AU/Dec. 289-331 (XV), Assembly/AU/Decl. 1-2 (XV) and Assembly/AU/Res.1 (XV)*, Conférence de l'Union Africaine, Quinzième Session Ordinaire 25 – 27 Juillet 2010, Kampala (Ouganda).

Union Africaine (2012), *Décisions, Déclarations et Résolution : Assembly/AU/Dec. 391 – 415 (XVIII), Assembly/AU/Res. 1 (XVIII) and Assembly/AU/Decl. 1 - 3 (XVIII)*, Conférence de l'Union, Dix-huitième session ordinaire 29 – 30 janvier 2012, Addis-Abeba (Éthiopie)

Union Africaine de la Mutualité (UAM) http://www.uam.org.ma/members.html

Wagstaff, A. (2009). Social Health Insurance vs. Tax-Financed Health Systems—Evidence from the OECD. Retrieved from https://openknowledge.worldbank.org/handle/10986/4018

WHO (2010) *World Health Report 2010: Health system financing: the Path to Universal Coverage*, Geneva.

WHO (2011) *Global Health Expenditure Atlas.*

WHO (2013) *World Health Report 2013: research for universal health coverage*, Geneva.

WHO website: http://www.who.int/providingforhealth/countries/en/

http://www.who.int/whr/2013/main_messages/en/index.html accessed on 27 November 2013

World Health Assembly Resolution (2011), *On Sustainable health financing structures and universal coverage*, Geneva.

Glossary

Adverse selection Insurers tend to set their premiums in relation to the average experience of a population. If, in fact, members of subsets of the population have different probabilities of illness (or at any rate they believe they have different probabilities) then those with low probabilities (or low perceived ones) may not buy insurance and those with high probabilities (or perceptions) may eagerly seize their opportunity. If this happens, insurers end up with clients who are likely to prove costlier than expected. High-risk individuals tend to 'drive out' low-risk individuals.

Asset Possessions of value, both real and financial. Real assets include land, buildings, or machinery owned. Financial assets include cash, bank deposits, bonds, and stocks.

Cherry-picking Same as *cream skimming*.

Cream skimming A practice in private health insurance markets by which the insurer obtains a higher proportion of good risks (people with a low probability of needing care or who are likely to need only low-cost care, or both) in their portfolio of clients than the insurance premium is calculated on.

Crowding Out In general, a reduction in private expenditure (especially investment) that occurs when a government's expansionary fiscal policy (which may be to the advantage of the health care sector) causes interest rates to rise. In health economics, the term has been used to describe the effect that public health insurance programmes may have on the demand for private health care insurance

Experience-rating The setting of insurance premia where the probabilities used are based on the historical risk, for example as revealed by past claims experience. Cf. Group or Community Rating.

Free rider One who consumes a good (especially a public good) without contributing to the cost of providing it.

Free riding Action of a free rider

Group-rating or **Community rating** Setting health care insurance premia according to the utilization of a broad population (for example, one defined by employer type or geography).

Moral hazard This is of two main types. Ex ante moral hazard refers to the effect that being insured has on behaviour, increasing the probability of the event insured against occurring. Ex post moral hazard derives from the price-elasticity of demand: being insured reduces the patient's price of care and hence leads to an increase in demand by insured persons.

Over insurance The situation in which settlement of loss in health insurance is much more than the loss sustained as to encourage the insured to overutilize medical care facilities, incur unduly expensive insured services or make fake claims through malingering.

Portfolio A collection of different assets owned by an individual or firm.

Risk pooling Insurance pools risks. Since the costs of health care can be extremely high, uninsured individuals face possible large losses. By agreeing to contribute a small premium to a common pool held by an insurer for use to compensate whoever actually suffers the loss, individuals may be able to reduce the net costs of risk bearing in a way that increases their welfare. Premiums will normally include elements beyond the expected cost of insured events and their probabilities of occurring in order to cover the operating costs of the insurer and a return on capital (so-called loading). See Adverse Selection

Definitions in the glossary come from the Dictionary of Health economics and the Oxford dictionary of Economics, except for overinsurance (Trosper, 1964) and Samaritan Dilemma (Wikipedia)

Samaritan dilemma Samaritan's dilemma is a dilemma in the act of charity. It hinges on the idea that when presented with charity, in some location such as a soup kitchen, a person will act in one of two ways: using the charity to improve their situation, or coming to rely on charity as a means of survival.

Definitions in the glossary come from the Dictionary of Health economics and the Oxford dictionary of Economics, except for overinsurance (Trosper, 1964) and Samaritan Dilemma (Wikipedia)

Annex

Annex 1: Free care in West Africa for some countries

	Date	Description de la politique	Type
Bénin	2009	Exemption pour la césarienne (kit + acte opératoire + forfait hospitalisation).	Ciblée
	1997	Exemption pour le traitement de la lèpre, l'ulcère de **Buruli**, la tuberculose.	Universelle
	?	Exemption pour la prise en charge des personnes atteintes du VIH/SIDA.	Ciblée
Burkina Faso	2007	Exemption pour le traitement antipaludéen pour les enfants de moins de **5** ans.	Ciblée
	2007	Subvention des soins obstétricaux et néonataux d'urgence, et gratuité totale pour les femmes enceintes indigentes	Ciblée
	2003	Exemption pour les consultations prénatales.	Ciblée
	?	Exemption pour le traitement de la tuberculose, la lèpre, la fistule obstétricale, le **Noma**, et les soins préventifs (programme élargi de vaccination, planning familial, maladies tropicales négligées).	Universelle
		Exemption pour la prise en charge des personnes atteintes du VIH/SIDA.	Ciblée
Ghana	2008	Exemption pour le traitement antipaludéen pour les femmes enceintes.	Ciblée
	2003-08	Exemption pour l'ensemble des services liés à l'accouchement.	Ciblée
	1997-03	Exemption pour les services pour les enfants de moins de **5** ans.	Ciblée
	1995	Exemption pour la tuberculose, les morsures de serpents et le vers de **Guinée**.	Universelle
Guinée	2007	Exemption pour les césariennes.	Ciblée
	2007	Exemption pour la prise en charge des personnes atteintes du VIH/SIDA.	Ciblée
Mali	2007	Exemption pour le traitement antipaludéen pour les femmes enceintes et les enfants de moins de **5** ans.	Ciblée
	2005	Exemption pour les césariennes dans les services publics.	Ciblée
	2004	Exemption pour la prise en charge des personnes atteintes du VIH/SIDA.	Ciblée
	?	Exemption pour la prise en charge de la tuberculose et de la lèpre.	Universelle
Niger	2007	Exemption pour le dépistage et la prise en charge des cancers féminins.	Ciblée
	2006	Exemption pour les services pour les enfants de moins de **5** ans.	Ciblée
	2006	Exemption pour les préservatifs et contraceptifs (planning familial).	Universelle
	2006	Exemption pour les consultations prénatales (incluant le traitement antipaludéen).	Ciblée
	2005	Exemption pour les césariennes.	Ciblée
	?	Exemption pour les traitements de la tuberculose et de la fistule obstétricale.	Universelle
	?	Exemption pour la prise en charge des personnes atteintes du VIH/SIDA.	Ciblée
Sénégal	2010	Exemption pour le traitement antipaludéen.	Universelle
	200 ?	Exemption pour les soins et les médicaments pour les personnes âgées de plus de **60** ans (plan **Sésame**).	Ciblée
	2005	Exemption pour les soins obstétricaux et néonataux d'urgence, sauf à **Dakar**.	Ciblée
	2003-04	Exemption pour la prise en charge des personnes atteintes du VIH/SIDA.	Ciblée

Source: Ridde, Queuille and Kafando (2012)

Annex 2: Free care in West Africa for other countries

	FREE CARE IN WEST AFRICA COMPLETED		
	Government	**NGOs**	**Year**
Cote d'Ivoire	Free voluntary screening and ARV treatment in public hospitals		2008
	Free treatment against tuberculosis		?
	Free treatment against leprosis		?
	Subsidized		2012
	Subsidized delivery for poor pregnant women		2012
	Free health care (consultation) for all in public hospital		April 2011-January 2012
	Free vaccinations for children under five and for pregnant women Expanded Immunization Program	Free Tetanos vaccinations for pregnant women Expanded Immunization Program	?
	Free treatment against harelip in public hospital		2013
	Subsidization of care for some categories in public hospitals (students and others)		?
			?
Mauritania	Free voluntary screening and ARV treatment in public hospitals	Free treatment against leprosis	?
	Free treatment against tuberculosis		?
Togo	Free surgery for obstetric fistula	Subsidization of care for HIV infected persons	?
	Free ARV treatment in public hospitals		2008
	Free treatment against tuberculosis		?
	Free treatment against leprosis		?
	Free treatment against malaria in a certain period of days (15)		?
	Subsidized of malaria drugs		
	Free malaria care and prophylaxy for pregnant women		
	Free vaccinations for children under five and pregnant women through Expanded Immunization Program		
	Subsidization of caesarian sections in some hospitals		2011
	Subsidization of care for poor and HIV infected in public hospitals		
Senegal	Under 5 free health care		Oct-13

Source: Author's compilation from different sources

Annex 3: CBHI coverage and utilization from 2003 to 2010 in Rwanda

Table 1. CBHI coverage and utilization (percentage of population), 2003-2010

	2003	2004	2005	2006	2007	2008	2009	2010
Enrollment in CBHI	7	27	44.10	73	75	85	86	91
Utilization rate	31	39	47	61	72	83	86	95

Source:http://www.issa.int/News-Events/News2/Rwanda-innovates-to-sustain-universal-health-care-coverage

Annex 4: NHA completion in West Africa countries

	Number of releases	Last release year
Benin	0	
Burkina Faso	5	2003;2004;2005-2006; 2007-2008;2009
Cameroon	1	1995
Cote d'Ivoire	1	2007-2008
Guinea	0	
Ghana	1	2002
Mali	1	1998-2004
Mauritania	0	
Niger	2	2002-2005;2006
Nigeria		
Senegal	2	2002;2005
Togo	1	2002

Source: WHO website