From Community Health Insurance to National Health Insurance:

Senegal Undertakes Reforms to Increase Financial Protection for Health

The USAID-funded Building a Resilient Health System (BRHS) activity is a five-year cooperative agreement supporting the Government of Senegal (GOS) and its Ministry of Health and Social Action (MSAS – Ministère de la Santé et de l'Action Sociale) to make meaningful and sustainable improvements to its health system. BRHS engages stakeholders from the MSAS, civil society, and the private sector to improve system-wide performance, accountability, access to resources, and resilience. Through targeted technical assistance, the activity strengthens systems in the areas of leadership and governance, human resources for health (HRH), supply chain management, health information systems, public financial management, health insurance, domestic resource mobilization and coordination, and private sector engagement. With a strong focus on collaboration for sustainability, BRHS – led by Chemonics International – emphasizes the co-creation of MSAS-owned solutions and builds on existing political will and initiatives within the Senegalese government. BRHS, through its partner Open Development, works to strengthen the organizational capacity of the National Agency for Universal Health Coverage (ANACMU—Agence Nationale pour la Couverture Maladie Universelle), enabling it to coordinate, plan for, and allocate sufficient resources to fund and improve community health insurance schemes — "mutuelles de santé" — and increase the percentage of the population that is insured. In this context, Open Development has conducted a closer examination of historical insurance structures in Senegal, and the country's progress from community based health insurance to a national-level structure in pursuit of universal health coverage.

Overview

Senegal is a leader in the West African region as it continues to reform and innovate its health system toward the achievement of universal health coverage (UHC). Healthcare is a right guaranteed in the Senegalese constitution[1] and remains a high political priority for the GOS, highlighted in the Plan for an Emerging Senegal, the National Plan for Health System Development, and the National Health Financing Strategy. The government has set a goal to extend financial protection for health through national health insurance from 23 percent of the population in 2022 to 75 percent by 2026. This will be achieved through the country's ANACMU which oversees the operations of over 670 community health insurance bodies or "health mutuals" across the country. Known in French as mutuelles de santé, the health mutuals provide health insurance coverage under the umbrella of the ANACMU for the informal and rural sectors that make up more than 80 percent of the population. This segment of the population (self-employed individuals, day laborers, street vendors, and other workers who do not have a stable source of income) needs different insurance options than the traditional employer-based scheme. Currently, 23 percent of the Senegalese population are covered by health mutuals including approximately 2.5 million classic members – those who receive a 50 percent subsidy on the annual premium (fr. CFA 3,500) – and 2.1 million beneficiaries of the family cash transfer program (PNBSF—Programme National de Bourse de Securité Familiale), and equal opportunities card (CEC—Carte d'Egalité de Chance) which are 100 percent subsidized by the ANACMU (ANACMU 2022).

This brief provides insight into the history of the ANACMU and highlights major reforms that Senegal is embarking upon under its new strategic plan covering the period of 2022-2026. The plan was informed by the results of the external evaluation of the previous strategic plan and guided by the ministerial policy note ordered by the Ministry of Community Development, National Solidarity and Social and Territorial Equity (MDCSNET—Ministère du Developpement Communautaire, de la Solidarité Nationale et de l'Equité Sociale et Territoriale). One of the strategic reforms is to work progressively to make health insurance compulsory, while harmonizing the benefits package across health mutuals and pooling risk at higher levels. The other reform strategies focus on: domestic resource mobilization to ensure the

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[1] Per article 8 and 17 of the Senegalese constitution

financial protection scheme is solvent; improvements in targeting and identifying beneficiary and population selection for free healthcare initiatives; and strategic purchasing to link payment of health services to performance of healthcare structures in providing effective and quality services to beneficiaries. In addition, the new strategic plan will increase access to and utilization of health services by reinforcing the involvement of the private sector in health; strengthen the ANACMU's leadership and governance through revision of the legal framework; and improve the medical audit/control system which builds the capacity of professional services invoiced to the ANACMU.

History of Health Mutuals in Senegal

Health Mutual Initiation Phase (1980s-1990s)

Community health mutuals started to develop independently and organically across Senegal in the 1980s, as a form of mutual aid. The level of benefits provided by health mutuals varied according to the type of mutual insurance and the agreements negotiated at the mutual level – a decentralized approach to benefit design that persists in health mutuals even today. Towards the end of the 1990s, the MSAS recognized the importance of health mutuals in facilitating access to care and established a Support Unit (Cellule d'Appui aux Mutuelles de Santé) to accelerate the government's technical support and promotion of health mutuals (Cellule d'Appui au Financement de la Santé et au Partenariat 2008). Between 2000 and 2003 the number of functional health mutuals multiplied by three in the space of three years (from 28 to 79) (MSAS 2010).

Formalization of the Role of Health Mutual as a Financial Protection Strategy Phase (2000s)

In 2003, the law N°2003-14 of 4 June 2003 (and its enforcement order in 2009) established a legal framework for health mutuals by codifying the modalities for their creation, organization, and operations. In 2010, the MSAS developed a national strategy for the expansion of health coverage for the Senegalese (Stratégie Nationale d'Extension de la Couverture du Risque Maladie des Sénégalais) with the goal to improve the affordability of healthcare and the financial protection of households through the expansion of health mutuals (MSAS 2010).

A main component of the strategy was the decentralization and extension of health insurance coverage (DECAM—Décentralisation de l'Assurance Maladie) which targeted the establishment of at least one health mutual in each commune to cover residents who did not have health insurance. Community-based health mutuals were intended to serve the large majority of the Senegalese population who earned their living in the informal sector and/or lived in a rural area. At the time, only 0.22 percent of the population subscribed to private insurance. By 2008, Senegal had about 200 community health mutuals covering 3.79 percent of the population (Cellule d'Appui au Financement de la Santé et au Partenariat 2010).

In addition to the structural changes made by the GOS to standardize and strengthen universal health coverage, to accelerate enrollment in the health mutuals and improve access to healthcare for the most vulnerable populations, the GOS began to subsidize the annual premiums to enroll in health mutuals for select beneficiary groups. Over the course of a decade, several beneficiary groups were provided with subsidies which resulted in expanded coverage but also concerns over the financial solvency of the protection scheme (see Figure 2). The coverage rate of the Senegalese population enrolled in the health mutuals expanded from 4 percent in 2013 to 19 percent in 2018 (see Figure 1), but many of those enrolled were not required to contribute financially to the scheme.

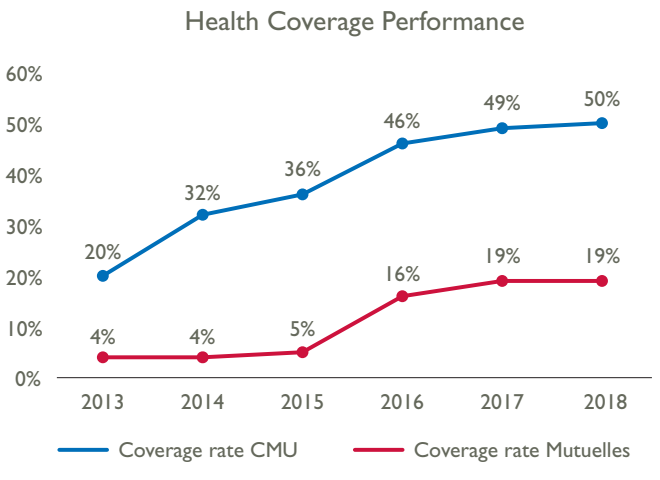

Figure 1: Health Coverage Performance

Additional Beneficiary Expansions 2006 – 2017	
2006	Government introduced Plan Sésame, a free health coverage initiative open to all people aged 60 and older.
2010	Government begins to subsidize dialysis care.
2012	Dialysis care made free of charge.
	Equal Opportunities Card (CEC—Carte d'Egalité de Chance) program launched for people living with disabilities including subsidies for the annual health premiums.
2013	Government offers free health care program for children under five.
	Government subsidizes 50 percent of annual premium (fr.CFA 3,500) per individual per year for "classic beneficiaries."
	Government introduces the national family grant program (PNBSF—*Programme National de Bourse de Securité Familiale*) for poor and vulnerable populations and pays full annual premium for beneficiaries.
2017	Government introduces CMU-*élèves* providing free coverage for primary, elementary, and secondary school children from public and private institutions.
	Government provides free deliveries and cesarean sections for women.

Figure 2: Additional Beneficiary Expansions

Establishment of the National Agency for Health Coverage – ANACMU—and Health Mutual Unions Phase (2010s)

Even though the GOS had strengthened health mutuals as a form of financial risk protection, the first national universal health coverage (CMU-Couverture Maladie Universelle) program was first launched on September 20th, 2013, and led by a Support Unit attached to the Cabinet of the MSAS. However, after two years of implementation, a decision was made to create an autonomous structure with more financial and human resources. In 2015, under the Decree N°2015-21, the country established the ANACMU under the technical supervision of the MDCSNET with financial supervision from the Ministry of Finance and Budget. The ANACMU mandate is to spearhead the implementation of the national UHC strategy ensuring financial protection of the population against the risk of illness without any form of exclusion. In the same year, the ANACMU developed its first strategic plan for UHC for the period of 2017-2021 (Plan Stratégique de développement de la Couverture Maladie Universelle 2017-2021). This plan called for strategies aimed at developing UHC through the health mutuals, strengthening existing free health policies, and implementing the new free health care initiative for children under five.

To ensure financial sustainability of all the free initiatives, the ANACMU began to reflect on the efficient management of resources particularly with regards to risk management, strong medical control, and negotiation of health services tariffs with health structures.

At the same time, organizations to better coordinate health mutuals were also taking shape, including the establishment of the national union (created in 2014), regional unions, and departmental unions of health mutuals. Their mandate is to ensure functional frameworks that represent the interests of health mutuals in policy making and implementation and coordinate and collaborate with health providers through the signing of agreements related to health services packages.

Key Issues to Inform the New Strategic Plan

In 2020, the MDCSNET commissioned an external evaluation of CMU's 2017-2021 strategic plan. The evaluation highlighted several key issues discussed below that are being taken up for consideration by the GOS to inform the current strategic plan and approach for implementation of UHC.

While established with the intent to improve equity and access to healthcare for the most vulnerable populations, the external evaluation found that the government subsidized health coverage programs are unsustainable and implemented inefficiently. Community health mutuals rely heavily on government contributions. Fifty-two percent of the population registered with health mutuals (i.e., approximately 2.0 million people in 2021) are noncontributory members. In 2021, the ANACMU had fr.CFA 10 billion of debt to health providers and mutuals. The evaluation estimated that only 1.2 percent of mutuals met viability conditions which are based on the minimum number of contributing members (ANACMU 2022).

Another major challenge is the fragmentation of the insurance system with over 670 community health mutuals of limited size across the country. In this fragmented system, the funds available to pay for members' healthcare is limited because resources are scattered across many small mutuals. Therefore, the need to pool both resources and realize operational efficiencies across mutuals is essential to ensure the extension of the protection of the population and for the viability of the scheme.

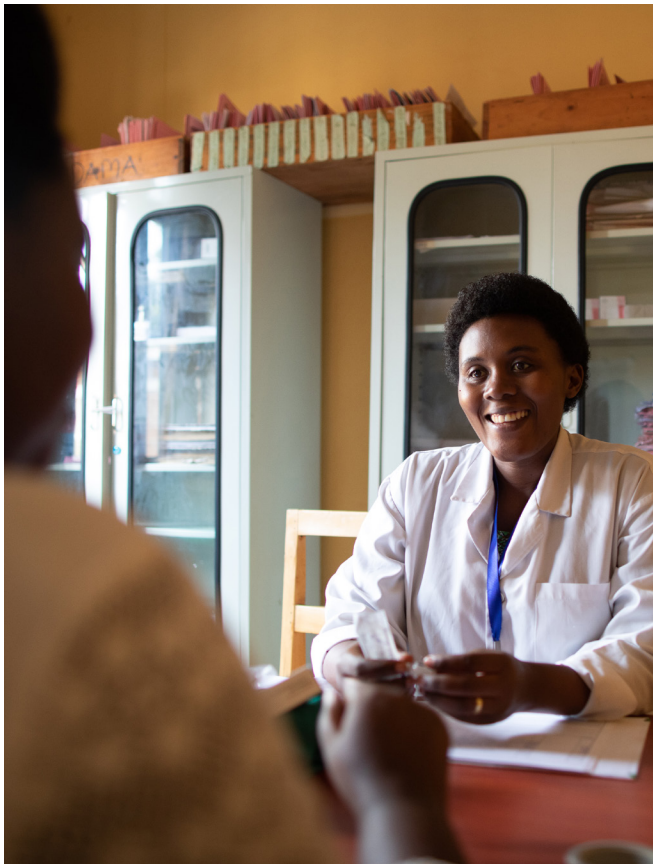

Photo Credit: USAID | Bobby Neptune

The evaluation also revealed an equity challenge as the minimum package of health services provided is not harmonized and depends on the type of affiliation and ability of the scheme to pay for services. PNBSF beneficiaries and CEC holders experienced recurrent shutdowns of services intended for them due to the delay in the payment of contribution subsidies by the government. As a result, even though classic beneficiaries (50% subsidization) and PNBS beneficiaries / CEC holders (100% subsidization) are similar in the number of beneficiaries enrolled, the classic beneficiaries consume about 80 percent of the health services expenditure of health mutuals whereas PNBS beneficiaries and CEC holders' present only 19 percent of the expenses (ANACMU 2022). And these delays in reimbursements discourage mutual health insurance companies from providing coverage for new beneficiaries (Céline Deville et al., 2018).

Ultimately, this situation affects the functioning of health care structures and leads to ineffective services for beneficiaries of medical assistance. From 2017 to 2019, members who stayed more than two years without renewing their membership have increased by 189 percent, a sign that the benefits of enrollment are not being valued by members (Consortium pour la Recherche Economique et Social 2022).

Institutional Reform to Support Mandatory Insurance Coverage

The most significant reform is to make the currently voluntary scheme mandatory. Senegal plans to make health insurance compulsory as part of the development of the new single social security code. As a first step, the ANACMU will manage the health insurance of public servants as well as populations in the informal economy and the rural area through the "compulsory health insurance scheme for the self-employed." To support this new mandate, the ANACMU will transform into a public insurance fund, called the Senegalese Agency for Universal Health Coverage (SEN-CSU— Agence Sénégalaise pour la Couverture de Santé Universelle). The SEN-CMU will support complex functions such as management of financial resources, payment of benefits through a strategic purchasing method, and medical audit.

Integrate Pooling and Management of Non-Contributory Schemes

Currently, the ANACMU pools funds and pays health facilities for services provided under the four free schemes

level for classic members and noncontributors. At the same time, the note recommends increasing the functions of the national agency with financial management of all government-supported free or subsidized health coverage programs, as well as restructuring and professionalizing mutual organizations.

Emerging Health Insurance Reforms

The country is currently implementing the new UHC strategic plan covering the period of 2022-2026, which was informed by the results of the external evaluation of the previous plan and guided by the ministerial policy note ordered by the MDCSNET. In line with the current strategic plan and to address the interlinked financial, efficiency, and equity challenges found in the evaluation, the GOS is undertaking several major reforms. This involves reorganizing the institutional framework of the ANACMU and changing the (children under 5 years old, caesarean, Plan Sésame, and dialysis). However, the financial contributions for PNBSF and CEC members are managed by the health mutuals. The proposed reform will integrate all government subsidized health coverage programs (non-contributory schemes) into one basket, including the PNBSF and CEC, under the SEN-CSU. This means consolidating the PNBSF and CEC pools of funding across mutuals (over 670 separate pools) into a single pool of funding that is combined with the other non-contributory schemes at the national level. This reform would help to significantly reduce fragmentation, simplify financial flows, and increase efficiency. It will also reduce the burden on the health mutuals to pay providers for PNBSF and CEC services.

Expand Pooling Across Mutuals for Contributory ("Classic") Members

To further increase efficiency of the use of government resources, the independent evaluation recommended that the SEN-CMU also manage the funds for the classic beneficiaries (fr.CFA 3,500 per person per year) and directly pay health service providers instead of transferring the funds to the mutuals. As mentioned above, since 2013, the GOS pays fr.CFA 3,500 to the mutuals as a subsidy (50 percent of the annual premium for classic members). However, this proposed reform was not accepted by the mutual organizations. Mutuals will continue to receive the subsidies from the Government for classic members, but the use of that contribution will be detailed in a delegation agreement between mutual organizations and the SEN-CMU.

One change is that the classic members' direct contribution will now be pooled at the departmental level by grouping all health mutuals within each department into one mutuelle departementale. Currently, there are over 670 community-based health mutuals in Senegal which will be reduced into 46 mutuelles departementales[2]. This will allow for more risk sharing across mutuals, taking the burden off of small mutuals to cover high-cost services alone, and reduce the administrative burden for each mutual as well (Diane McIntyre et al. 2008). This reform comes with a redistribution of roles and responsibilities. The mutuelle departementale will manage health insurance at the department level for classic members, covering all facility levels. The former community-based mutual will remain and become branches in charge of population awareness for mass enrollment, distribution of beneficiaries' cards, and collection of enrollment fees and premiums. The roles of each party will be specified in management delegation agreements that will be signed with the mutual health insurance organizations. This reform also comes with the effort to professionalize mutuals by having paid and trained staff/employees instead of volunteer members running key functions which was found as an issue during external evaluation of the UHC strategic plan; 69 percent of the staff currently working at the mutuals are volunteers (Consortium pour la Recherche Economique et Social 2022).

Implementation of Strategic Purchasing Reforms

Claims will be paid directly to the health providers by the ANACMU for the free healthcare initiatives, while the mutuals will use a third-party payer and co-payment system. Health providers will prepare claims and send them to the mutual department which will verify the claims (beneficiary ID numbers, enrollment and membership status, health services provided, and costs according to the applicable fee structure). After verification, the mutual department will submit the claims to the ANACMU which will also have a medical control unit to verify as well before proceeding to pay the health providers. It is the ANACMU who will negotiate tariffs with health providers. Regarding fee structure, the country will apply a ministerial decree fee-for-service at the hospitals and a fixed amount system at health post and health center levels. Regarding strategic purchasing,

[2] Entretien avec M. Serigne Diouf le Directeur des opérations à l'Agence de la CMU - YouTube

Photo Credit: USAID | Alain Ngann

in the context of performance-based payment to public health providers, the health services will be provided on the basis of fixed tariffs, despite the government resources already financing health workers, drugs, and operating costs.

Improve Record Keeping Through Unique Identifiers and Digitalization

To date, the majority of enrollment has been done on paper using country-issued identification cards. When health insurance is mandatory, SEN-CMU will need a mechanism for systematically enrolling individuals and families and making sure there is no double counting in the system. With the reform, everyone will be issued a national insurance card (carte nationale d'assuré) connected to their unique social security code (code unique de securité sociale). This will ensure that the agency has accurate records of who each member is and what program they are enrolled in. The information system—Integrated Management Information System for Universal Health Coverage (SIGICMU – Système d'Information de Gestion Intégré de la Couverture Maladie Universelle)—is already in process. SIGICMU will be a national digital system that allows for real time management and decision making with the aim to combat fraud, optimize the invoice/claim processing, allow for monitoring of resources and performance indicators, and provide the information necessary for evidence-based decision-making. The system will include a biometric identification module (SIBIO - Système d'Identification Biometrique) which will help to target beneficiaries for the subsidized programs. The country plans to develop it over a two-year period (20232025) to cover 3,500 service points, including health posts, health centers, public health establishments, pharmacies, approved private practices, and mutuals[3].

Make Local Government Contribution Compulsory

The evaluation of the UHC program also recommended making the contribution of local and regional governments compulsory and equal to at least 10 percent of the municipal budget. Local government contribution to the UHC is stated in Act 3 of Decentralization. Although it has not yet been fully implemented, some local authorities have supported the UHC by subsidizing the enrolment of residents who do not receive free health care into community mutuals. As primary health care is transferred to local authorities, each local government has the obligation to contribute to the financing of the UHC in its territorial division. The modalities for how the local government contribution will be assessed is under discussion.

Considerations

In brief, the planned reforms have several advantages including improving the operational efficiency and financial management of both the government's and the mutuals' resources. The reforms also focus on the needs of the most vulnerable and maintain a national system to identify in-need

[3] https://www.agencecmu.sn/systeme-dinformation-de-gestion-integre-de-la-couverture-maladie-universelle-sigicmu

individuals. The reforms do, however, come with a significant shift in roles and responsibilities. Historically, the health insurance system was built on the foundation andautonomy of mutuals which have spent years building the system from the ground up. However, to successfully accelerate the country's progression towards UHC, reform that shifts responsibilities to the central-level ANACMU (SEN-CMU) and mutuelles departementales is essential to ensure the durability and sustainability of the system.

As the Government of Senegal enters a period of reform, effective communication and consultation with relevant stakeholders will be essential to securing the political and social support for the implementation of the reforms. While challenging, the government will need to negotiate with the mutuals to ensure that they not only understand the reasons behind the reforms, but take them on as their own, rise to the occasion, and continue to lead the community-based effort to enroll and secure financial protection for the health of the population.

The introduction of mandatory health insurance involves challenges and uncertainties for legal, political, and social reasons. In the medium term, while finding solutions to these challenges, the country has started to find ways to incentivize membership by coupling the benefit of a public service to the subscription to health insurance via a systematic affiliation to the UHC program. It is an alternative or even a transitional phase to compulsory membership. For example, the ANACMU initiated the process when establishing a mutual for the General Delegation for the Rapid Entrepreneurship of Women and Youth (DER /FJ—Délégation générale à l'Entrepreneuriat rapide des femmes et des jeunes). This alone aims to enroll 200,000 people (Rewmi actualité 2022). Through these types of initiatives, Senegal is aiming to accelerate the extension of financial protection through mass enrollment in collaboration with local authorities, government programs, and offices.

Historically, however, boosting enrollment in a voluntary scheme has limits and to more effectively advance towards universal health coverage, mandatory membership has shown to be the most effective tool in both increasing access to and use of health services and decreasing out of-pocket expenditure (Chuma J., et all., 2013). It will take time to develop the necessary laws, regulations, and policies to accompany the reforms and a large investment in not only the health insurance system and management (e.g SIGICMU), but also in the quality of care in public facilities. If members do not have confidence in the health system and are concerned about the quality of care they or their family members will receive, even if mandatory, it will be challenging to collect premium payments from paying members or even enroll PNBSF or CEC-qualifying individuals (Seck I., et all. 2017). Many people in Senegal are still not aware of the UHC and the options available for financial protection for health. Effective community based communication will continue to be essential and is an important role for the mutuals in increasing and sustaining enrollment. Through this reform process, while challenging, Senegal is proving its commitment to the Senegalese people and moving forward with the changes needed to improve access to affordable and quality healthcare for all.

Conclusion

Looking ahead, BHRS will continue supporting ANACMU in fostering policy dialogue and collaboration among key players, including mutual organizations, MSAS, the Coordinating Institution for Compulsory Health Insurance (ICAMO – Institution de Coordination de l'Assurance Maladie Obligatoire), and the Private Health Sector Alliance (ASPS - Alliance du secteur privé de la santé) to jointly implement the reforms. In addition to the efforts to expand insurance coverage via systematic and group enrollment, alongside the enhanced participation of women mutualists, BHRS will also continue to assist ANACMU in engaging private health providers through application of preferential rates for mutuals beneficiaries aiming to increase access and utilization of health services.

This brief was written by Farba Lamine Sall, Mame Abdoulaye Gueye, and Annick Ranirisoa of Open Development, a partner in Chemonics' BRHS consortium. The authors wish to thank Seringue Diouf, ANACMU Director of Operations, for his contributions to this brief.

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