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Ange Mibindzou Mouelet, Moulay Driss Zine Eddine El Idrissi, and Paul Jacob Robyn

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**Gabon Indigents Scheme:
A Social Health Insurance Program for the
Poor**

Ange Mibindzou Mouelet, Moulay Driss Zine Eddine El Idrissi, and
Paul Jacob Robyn

The World Bank, Washington, DC, 2018

Table of Contents

Preface to the second round of the Universal Health Coverage Study Series.....	7
Acknowledgments.....	8
About the Author.....	9
Executive Summary	10
1. Introduction.....	12
2. General Health System Overview of Financing and Delivery.....	13
Health System.....	13
Health Financing.....	15
3. Brief Description of Public Health Care and Key Supply-Side Efforts.....	19
4. GIS Institutional Architecture and Interaction with Rest of the Health System.....	21
5. Identification, Targeting, and Enrolment of Beneficiaries	21
6. Special Topics Related to the Management of Public Funds in GIS	22
7. Management of the GIS Benefits Package	23
8. GIS Information Environment	25
9. Discussion of a Theme Specific to Gabon: GIS Financial Sustainability	26
10. Pending Agenda	28
Notes.....	30

Figures

Figure 1 Descriptive Diagram of the Health Pyramid in Gabon.....	14
Figure 2 Changes in Per Capita Health Expenditure in Gabon, 1995–2014.....	16
Figure 3 Total Health Expenditure Per Capita (US\$) of African Countries, 2013	16
Figure 4 Distribution of Funding Sources of the Health Sector in 2014.....	17
Figure 5 Distribution of Health Expenditure per Provider in 2014.....	18
Figure 6 Distribution of Current Health Expenditure per Disease Group in 2014	19
Figure 7 Evolution of the Number of GISs (GEF) Registered at NHISCF.....	22
Figure 8 Income and Expenditures of CNAMGS, 2011–14	27
Figure 9 CNAMGS, Trend of Annual Per Capita Expenditures, CFAF, 2011–14.....	28

Tables

Table 1 Mortality and Life Expectancy Indicators by Gender.....	12
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Abbreviations

CEMAC	Economic and Monetary Community of Central Africa
CFAF	Gabonese Franc
CNAMGS	National Health Insurance Program (<i>Caisse Nationale d'Assurance Maladie et de Garantie Sociale</i>)
GDP	Gross Domestic Product
GEF	Economically Weak Gabonese (<i>Gabonais Economiquement Faible</i>)
GIS	Gabonese Indigent Scheme
GSPH	General Census of Population and Housing
HIV	Human Immunodeficiency Virus
NCDs	Noncommunicable Diseases
NHISCF	National Health Insurance and Social Coverage Fund
ROAM	Compulsory Health Insurance (<i>Redevance Obligatoire à l'Assurance Maladie</i>)
UNICEF	United Nations Children's Fund
UNICO	Universal Health Coverage Studies Series
US\$	United States dollar
WHO	World Health Organization

Preface to the second round of the Universal Health Coverage Study Series

All over the world countries are implementing pro-poor reforms to advance universal health coverage. The widespread trend to expand coverage resulted in the inclusion of the “achieving universal health coverage by 2030” target in the Sustainable Development Agenda. Progress is monitored through indicators measuring gains in financial risk protection and in access to quality essential health-care services.

The Universal Health Coverage (UHC) Studies Series was launched in 2013 with the objective of sharing knowledge regarding pro-poor reforms advancing UHC in developing countries. The series is aimed at policy-makers and UHC reform implementers in low- and middle-income countries. The Series recognizes that there are many policy paths to achieve UHC and therefore does not endorse a specific path or model.

The Series consists of country case studies and technical papers. The case studies employ a standardized approach aimed at understanding the tools –policies, instruments and institutions– used to expand health coverage across three dimensions: population, health services and affordability. The approach relies on a protocol involving around 300 questions structured to provide a detailed understanding of how countries are implementing UHC reforms in the following areas:

- **Progressive Universalism:** expanding population coverage while ensuring that the poor and vulnerable are not left behind;
- **Strategic Purchasing:** expanding the statutory benefits package and developing incentives for its effective delivery by health-care providers;
- **Raising revenues** to finance health care in fiscally sustainable ways;
- **Improving the availability and quality of health-care providers;** and,
- **Strengthening accountability** to ensure the fulfillment of promises made between citizens, governments and health institutions.

By 2017, the Series had published 24 country case studies and conducted a systematic literature review on the impact of UHC reforms. In 2018 the Series will publish an additional 15 case studies. A book analyzing and comparing the initial 24 country case studies is also available: *Going Universal: How 24 Developing Countries are Implementing UHC Reforms from the Bottom Up*. Links to the Series and the book are included below.

Daniel Cotlear, D. Phil.
Manager and Editor
Universal Health Coverage Study Series

Links:

<http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series>
<http://www.worldbank.org/en/topic/universalhealthcoverage/publication/going-universal-how-24-countries-are-implementing-universal-health-coverage-reforms-from-bottom-up>

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Executive Summary

The reform of Gabon's health financing system, which began in 2007, resulted in implementation of compulsory health insurance schemes through the National Health Insurance and Social Coverage Fund (NHISCF) and the National Health Insurance Program (*Caisse Nationale d'Assurance Maladie et de Garantie Sociale*, CNAMGS). The main innovations of this reform included creation of a fund dedicated exclusively to the poor (Economically Weak Gabonese (*Gabonais Economiquement Faibles*, GEF)), entitled the Gabon Indigents Scheme [GIS]), which represent 33 percent¹ of the total population, and innovative financing of this fund through the Compulsory Health Insurance Tax (*Redevance Obligatoire à l'Assurance Maladie*, ROAM). The ROAM is a tax corresponding to 10 percent of turnover excluding taxes of mobile telephone companies, and 1.5 percent of the amounts excluding taxes of money transfers out of the Economic and Monetary Community of Central Africa (CEMAC) zone.

The population eligible for the GIS are Gabonese of both genders who are at least 16 years of age and whose income is less than the minimum guaranteed interoccupational wage of Gabonese Franc (CFAF) 150,000 per month, or about US\$250, an amount recently increased by the government from CFAF 80,000 per month, or about US\$130 per month. Children under 16 years of age are considered beneficiaries of insured parents.

The GIS enables beneficiaries to benefit from the same benefits package and to have access to the same providers as other insured persons (mainly formal sector workers), without paying membership fees, thereby guaranteeing equity of care. This fund covers 80 percent of common illnesses, 90 percent of chronic diseases, and 100 percent of maternity costs. Although the poor do not pay premiums, they do contribute to the scheme by paying a 20 percent copayment for services.

Implementation of the GIS has had a positive impact on the functioning of the health system. The financial contribution of the NHISCF has enabled many health entities to improve the provision and quality of care by recruiting additional staff and purchasing equipment and other essential service delivery inputs, and has enabled the poor to have better access to better health care.

And even if GIS beneficiaries do pay a copayment (20 percent for common illnesses and 10 percent for chronic illnesses), the program has improved the use of and access to care for this group. In addition, the share of direct household payments in total health expenditure fell significantly after the establishment of the NHISCF.

However, the exponential growth of health expenditure by the GIS between 2010 and 2014, from CFAF 7,673,069,023 to CFAF 20,041,897,053, representing 14.7 percent² of public health expenditure and 55 percent³ of the NHISCF current expenditure in 2014, combined with the stagnation of ROAM's income, raises the question of the sustainability of this program.

Additional public resources are needed to cover the remaining population and meet the goal of expanding coverage under the CNAMGS, but additional resources in the current context will likely depend on reprioritizing and a more efficient and effective use and allocation of existing resources. Economic growth is likely to inject additional funds into the health sector. However, since economic growth has recently slowed due to the oil price crisis, significant further increases in public resources for health are unlikely. Prioritization of the budget for health within the current public budget and improved execution of the budget might be possible and

might help inject additional resources for health. Nevertheless, freeing additional resources will likely also require a more efficient and effective use and allocation of existing resources.

The GIS scheme in Gabon is an example of how a political commitment to the poorest, coupled with innovative financing dedicated specifically to medical coverage of the poorest, and management of this scheme by the same public institution that manages the other health insurance schemes, can offer effective financial protection to the poorest population against health risks. However, the absence of cost-effective measures to control the costs of this scheme, coupled with a reduction in fiscal resources in an unfavorable macroeconomic context, constitutes a major risk for the sustainability of this scheme.

1. Introduction

With a surface area of 267,667 square kilometers, the Central African country of Gabon straddles the equator, bounded to the northwest by Equatorial Guinea, to the north by Cameroon, to the east and south by the Republic of Congo, and to the west by the Atlantic Ocean, which borders its 800-kilometer coast. The country has 9 provinces, 48 divisions, 26 districts, 52 municipalities, 35 subdivisions, 164 townships, 969 village clusters, and 2,743 villages.⁴

According to the results of the 2013 General Population and Housing Census of Gabon (GPHS 2013), the country has 1,811,079 inhabitants, compared to 1,014,976 in 1993. Between the two censuses, the average annual population growth rate was 2.9 percent. During the same period, the population density increased from 3.7 to 6.7 inhabitants per square kilometer. Currently, 87 percent of the population lives in urban areas, concentrated in 1.1 percent of the national territory.

According to the 2013 General Census of Population and Housing (GSPH), life expectancy at birth remains relatively low compared to the level of income of the country, that is, 63.6 years (61.2 years for men and 66 years for women), while life expectancy at age 20 is 49.7 years (47.9 years for men and 51.5 years for women) (table 1). The gross birth rate is 34.3 per thousand, and the total fertility rate of 4.2 children per woman remains high.

Table 1 Mortality and Life Expectancy Indicators by Gender

Indicators	Gender		Overall
	Masculine	Feminine	
Life expectancy at age 20	47.9	51.5	49.7
Life expectancy at birth	61.2	66.0	63.6
Gross mortality rate (per thousand)	9	9	9
Total number of annual deaths	—	—	15,782

Source: GSPH 2013, Directorate-General for Statistics, October 2015.

Note: — = not available.

The Gabonese population is relatively young. The average age is 26, and half the population is under 22. The net primary school enrolment rate is 88.2 percent and the literacy rate for people aged 20 to 24 is 87.4 percent.

By 2014, the United Nations Development Programme ranked Gabon 112th out of 187 countries, with a Human Development Index of 0.674 and a GDP of US\$16,977 per capita. Gabon is an upper middle-income country with human development outcomes similar to countries with much lower income levels.

According to the 2013 General Population and Housing Census, one-third (32.7 percent) of Gabonese live in poverty and 3 percent are extremely poor. The Environmental Performance Index (EPI 2010) is 56.4, placing Gabon 96th out of 164 countries surveyed. According to the 2013 GSPH, the employment rate is 55.8 percent and the unemployment rate is 16.8 percent, with more women being unemployed, at 22.9 percent, than men, at 13.1 percent.

The Gabonese economy has long remained a cash economy, based on the richness of its subsoil in raw materials. Although the exploitation of oil reserves remains the main source of income

for the country, the confirmed decline in reserves and the sharp fluctuations in the price of oil have led to diversification and restructuring of the economy. Gabon is now focusing its efforts on the mining sector, the forestry sector, and the processing industries, as part of an extensive program of economic restructuring and tax reform. Unfortunately, the global economic downturn, resulting from the combination of falling oil prices and the international financial crisis, risk impacting these efforts and reducing the expected benefits (even if Gabon and its partners, including the World Bank and the International Monetary Fund, are engaged in implementing measures to ensure investments in the social sectors are protected during the crisis).

The compulsory health insurance program is part of the reform of the Gabonese social protection system. Indeed, it was noted in 2002 that of all the risks covered by this system (Convention No. 102 of the International Labor Organization), diseases were identified as one of the greatest concerns. This was confirmed by a World Health Organization (WHO) study, which showed that private household expenditure in Gabon, consisting mainly of out-of-pocket payments to hospitals, had increased sharply, from 34 percent in 1997 to 52 percent in 2001. Of concern to the public authorities, the government set up, first, the National Social Security Fund, to provide medical care to public officials and the poor. This fund, which was largely financed by the state budget, soon experienced enormous difficulties, which led to its closure as a result of the economic crisis in the country in the early 2000s, insufficient budgets, and mismanagement.

In 2007, in response to the difficulties encountered by the Gabonese population in accessing quality health care, the CNAMGS was established. Under this health insurance scheme, a fund for GEF was established.

This paper briefly describes primary health care and accessibility to health care provision in Gabon, and the social health insurance architecture of the GIS. The paper is not intended to provide an analytical and detailed study on health insurance in Gabon. It simply aims to provide a description the GIS in terms of eligibility criteria, targeting, and registration of beneficiaries; special topics related to the management of public funds of the social insurance of the GIS; management of the services offered; and financial sustainability of the GIS. It contributes to the Universal Health Coverage Studies Series on sharing experiences in the field of universal health coverage.

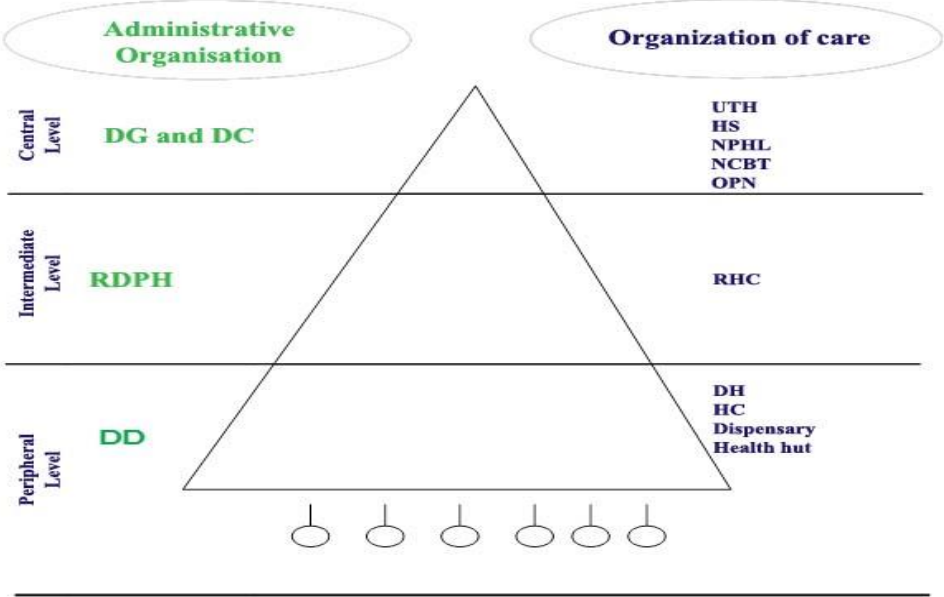
2. General Health System Overview of Financing and Delivery

Health System

The Gabonese health system is comprised of three sectors: public (civilian and military), parapublic (network of providers of the National Social Security Fund, and private (for-profit, nonprofit, and traditional medicine). The civil public sector is pyramidal with three levels (peripheral, intermediate, and central) modeled on that of the general administration. According to Decree No. 0142 / Pr / SPSM of March 2, 2015, reorganizing the health regions and divisions, Gabon has 6 regions and 36 health divisions (similar to health districts). This regulatory provision has not yet been implemented, and the system continues to rely on the old division, which has 10 regions and 50 health divisions (Decree No. 488 / Pr / MSPP of May 30, 1995, to create and organize regions and health divisions).

The central or tertiary level includes all the central directorates, including programs, institutes, and referral diagnostic and care facilities, notably four newly built university teaching hospitals. The intermediate or secondary level consists of 10 regional health directorates and 9 hospitals or regional hospital centers located in the provincial capitals. These institutions serve as a reference for structures at the first level of the health pyramid. The peripheral or primary level, known administratively as the health department, is composed of 47 departmental hospitals, 34 health centers, 413 dispensaries, and 157 health huts. The departmental hospital, located in the capital of the administrative department, serves as a reference institution at this level (figure 1).

Figure 1 Descriptive Diagram of the Health Pyramid in Gabon



Source: National Health Development Plan (NHDP) Gabon 2017–2021.
 Note: DC = Director of Cabinet; DD = Department Director (Directeur de Département Sanitaire); DG = Director General; DH = Health Department (Département Sanitaire); HC = health center (centre de santé); HS = hôpital spécialisé (specialized hospital); NCBT= National Center for Blood Transfusion (Centre National de Transfusion Sanguine); NPHL = National Public Health Laboratory; OPN = National Pharmaceutical Office; RDPH = Regional Director of Public Health; RHC = Regional Health Center; UTH = University Tertiary Hospital.

The military public sector depends directly on the Ministry of Defense. It consists of a large hospital, an extensive network of infirmaries, and a training institution, the School of Application of the Military Health Service of Libreville (*École d'Application du Service de Santé Militaire de Libreville*). The private for-profit and nonprofit sectors include private health facilities (119), pharmaceutical institutions (44), and medical laboratories (4), as well as research centers (2) and NGO health facilities (19).⁵ Health care providers across all sectors have contracts with health insurance schemes managed by the CNAMGS once they are accredited by the Directorate of Medical Control and the Fight against Fraud, through predefined criteria.

The maternal mortality ratio and the infant and child mortality rates have significantly declined, but have not met the 2015 Millennium Development Goal 5 targets. Hence, the maternal mortality ratio remains relatively high at 277 per 100,000 live births, while the target for 2015 was 129 per 100,000 live births, although the percentage of births attended by qualified staff is 90 percent. The mortality rate of children under five, at 40.5 per thousand (43 per thousand for

boys and 38 per thousand for girls) is better than the target for 2015, which was 42.6 per thousand.

With regard to communicable diseases, Gabon has experienced an upsurge in malaria cases since 2011, and a significant increase in tuberculosis cases, including multidrug-resistant tuberculosis cases. The prevalence of HIV/AIDS is 4.1 percent, and the incidence rate of tuberculosis is estimated at 444 per 100,000 population. Malaria remains the leading cause of morbidity and mortality, especially among children under five due to the low level of implementation of control measures (use of long-lasting treated bed nets was only 27 percent, the proportion of pregnant women receiving two doses of intermittent preventive treatment of malaria only 12 percent). In the general population, the malaria mortality rate, estimated at 68.4 per 100,000 population, is also still high (PNDS 2017–2021).

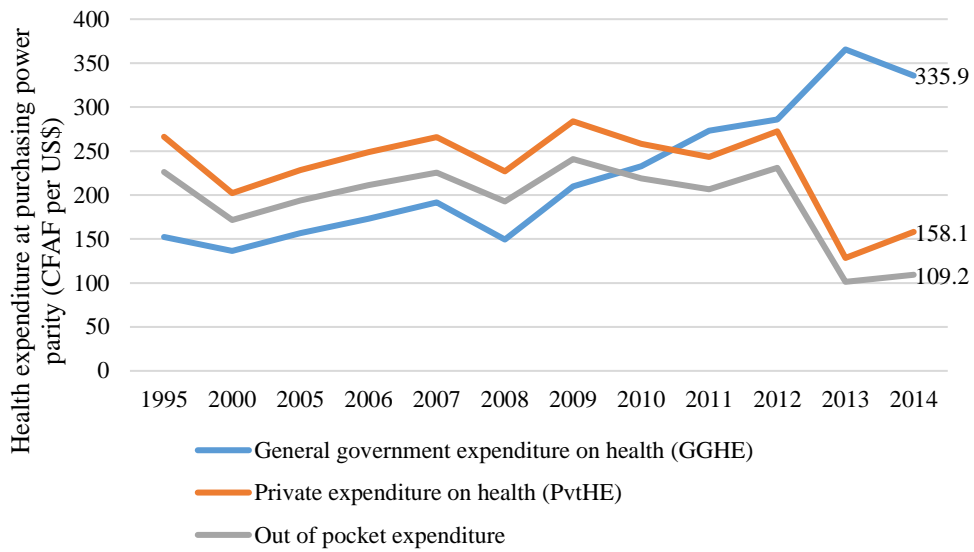
Given the increase in life expectancy, increasing urbanization, and the adoption of a sedentary lifestyle that multiplies risk factors, noncommunicable diseases (NCDs) are a growing concern in Gabon. According to the National Health Development Plan (*Plan National de Développement de la Santé*, PNDS) 2017–2021, since 2004, mortality due to NCDs (716 per 100,000 inhabitants) has exceeded that attributed to communicable diseases (615 per 100,000 inhabitants). The growing burden of NCDs presents an additional challenge for the health system. The results of the latest national health accounts showed that expenditure on NCDs is equivalent to expenditure on infectious and parasitic diseases. With the exception of mental health, which has a policy and a weakly implemented strategic plan, the country does not have normative documents for the management of major NCDs or a system for surveillance and follow-up of these conditions.

Health Financing

Gabon does not fare well when its health spending patterns are compared to other countries of similar income. As a share of GDP, Gabon spent about 3.8 percent in 2013. That was well below the Sub-Saharan Africa regional average (6.2 percent) and below the average of countries with similar income (6.1 percent). In contrast, in 2012 Gabon's health spending per capita was about US\$441 (or US\$735 purchasing power parity), which was significantly higher than neighboring countries (US\$153 purchasing power parity). However, Gabon spends slightly below average compared to other countries of similar income. In Sub-Saharan Africa, Gabon stands as an outlier for many indicators related to health financing. Whether it be the percentage of health expenditures coming from government sources or total health expenditures, Gabon is consistently ranked among the highest in the region.

Funding of the Gabonese health system comes from three main sources: the government budget; health insurance contributions by employers and employees (including the CNAMGS), and some private insurers; and out-of-pocket expenditures by households and other private expenditures such as institutional spending. Because of the public sector's commitment to health during this time, the share of public spending grew from 36 percent of total health spending in 1995 to 68 percent of total health spending in 2014 (figure 2). Government health spending became the largest contributor to Gabon's total health expenditure in 2014. The establishment of CNAMGS has contributed to this significant increase in public spending for health. We review below facts and issues on public spending and health insurance.

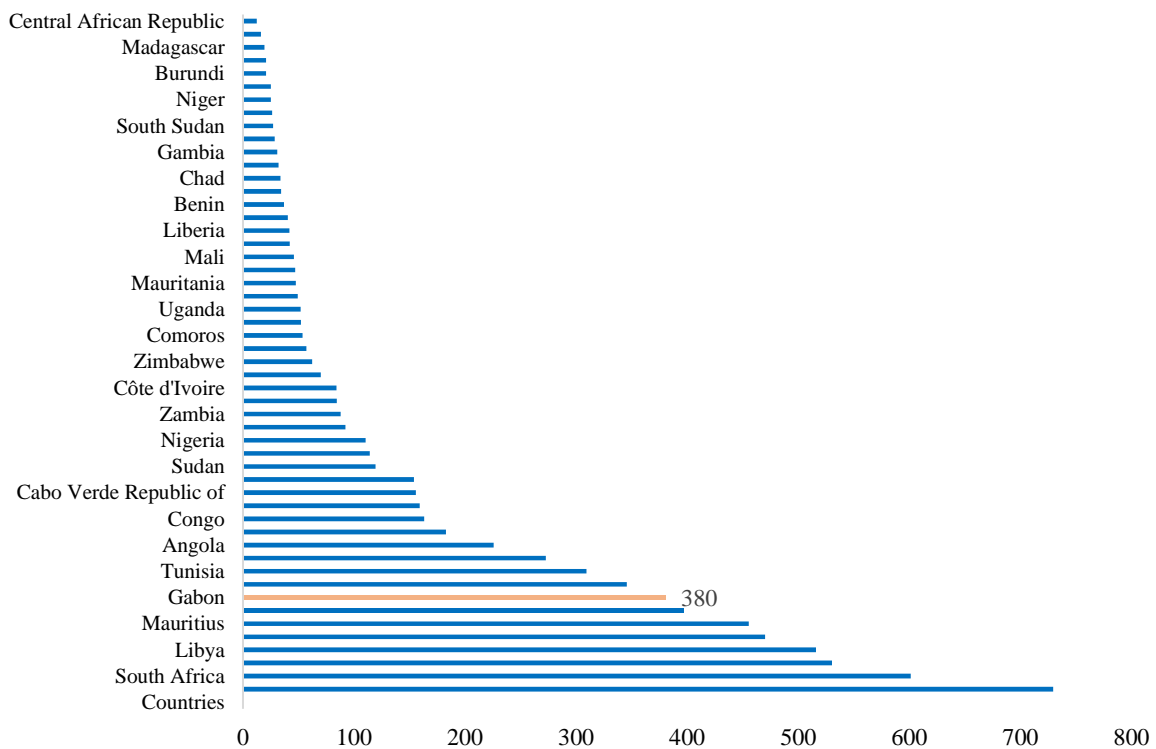
Figure 2 Changes in Per Capita Health Expenditure in Gabon, 1995–2014



Source: WHO Health Accounts Database; <http://apps.who.int/nha/database/Home/Index/fr>.

Gabon spends three times more (US\$380) on health per capita than the regional average of US\$109. However, health expenditure in relation to GDP remains below the African average, including middle-income countries.

Figure 3 Total Health Expenditure Per Capita (US\$) of African Countries, 2013



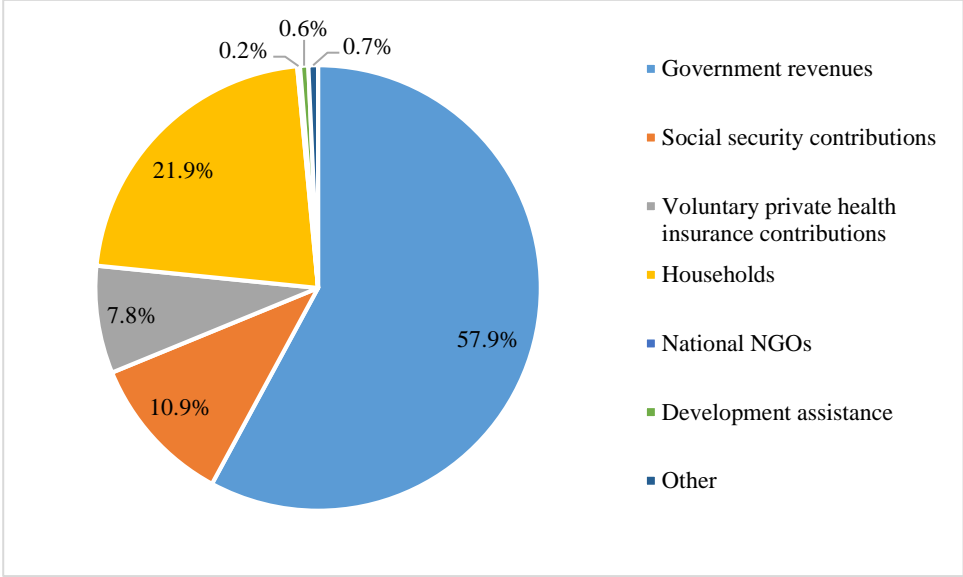
Source: NHA Database, WHO; <http://apps.who.int/nha/database/Home/Index/fr>.

Prior to the establishment of the NHISCF, health spending in Gabon was mainly financed by taxation (state budget), household payments and, secondarily, by employer and employee

contributions to the National Social Security Fund, private insurance, tontine funds (small savings and credit associations), donations, and external financing.

The composition of financing sources has evolved significantly over the past decade due to the rollout of the national insurance program. Indeed, 57.9 percent of health care financing comes from government revenue, 21.9 percent from households, 10.9 percent from social security contributions (NHISCF), 7.8 percent from voluntary private health insurance, 0.7 percent from public development assistance, and 0.1 percent from national NGOs (2014 National Health Accounts). This is a positive development, since it has significantly reduced the share of household direct payments in health financing.

Figure 4 Distribution of Funding Sources of the Health Sector in 2014



Source: 2014 National Health Accounts.

Funding of social health insurance, notably NHISCF, is provided by the state, public sector officials, and employers and employees in the parastatal and private sectors. The NHISCF has three different funds depending on the category of insured persons covered—the private sector fund, the state civil servants fund, and the GIS—covering more than half the Gabonese population (private sector 9 percent, public sector 12 percent, and the GIS 33 percent).

Until 2015, the private sector fund and the state civil servants fund were financed at 4.1 percent and 2.5 percent by employer and employee contributions.⁶ At the end of the social dialogue in 2015, a transitional measure fixing the share of employee contributions at 1 percent was decided. As of January 2017, a draft law envisages a revaluation of the rates of employer and employee contributions for the private sector fund to 4.1 percent and 2 percent, respectively, and for the civil servants’ fund to 5 percent and 2.5 percent. The contribution rate of pensioners is 1 percent.

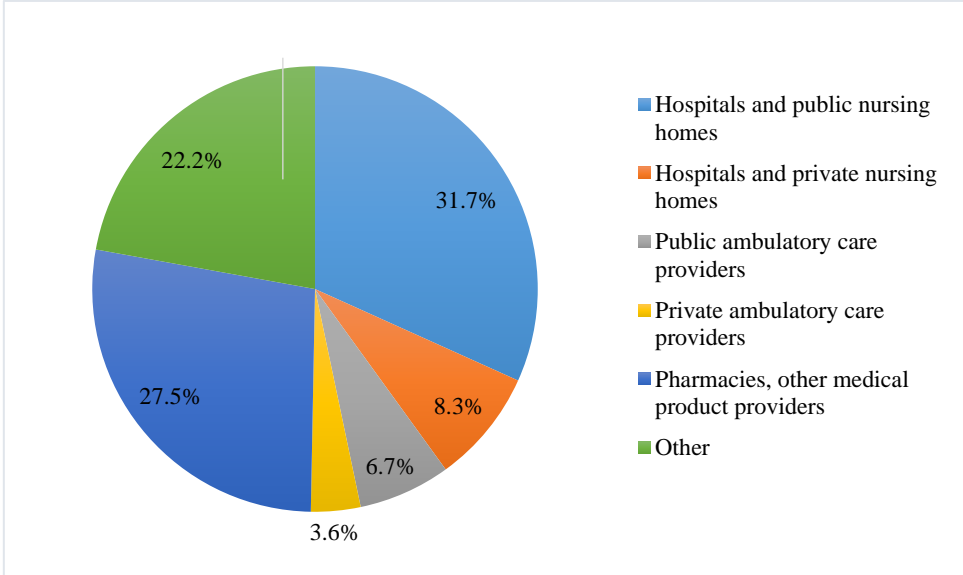
The GIS was financed by an indirect tax called the ROAM. This tax corresponds to 10 percent of the turnover excluding taxes of mobile phone companies, and to 1.5 percent of the amounts excluding taxes of money transfers out of the Economic and Monetary Community of the Central Africa zone.⁷ This tax was abolished on March 1, 2017. As of January 1, 2017, the GIS will be financed by a compulsory levy called the Special Solidarity Contribution. Individuals and legal entities (except those exempted) that conduct, usually or occasionally, taxable transactions the annual turnover of which, excluding taxes, is at least CFAF 30 million, will be liable for the Special Solidarity Contribution.⁸

Universal health coverage through the health insurance and social security scheme in Gabon has been defined as a system enabling economically weak Gabonese to have access to quality care without being obliged to pay contributions.

Gabon has succeeded in mobilizing various sources of funding for different categories of populations (GIS, public employees of the state, employees of the parapublic and private sector, and beneficiaries). To achieve equity, it is recommended, in principle, that the poor should be supported by the most affluent, through cross subsidization of care from the rich to the poor.

Figure 5 shows that most of the funds spent (mainly by the government, social insurance, and households) benefited public hospitals (31.7 percent), pharmacies and other providers of medical goods (27.5 percent), private hospitals (8.3 percent), public ambulatory care providers (6.7 percent), and private ambulatory care providers (3.6 percent).⁹

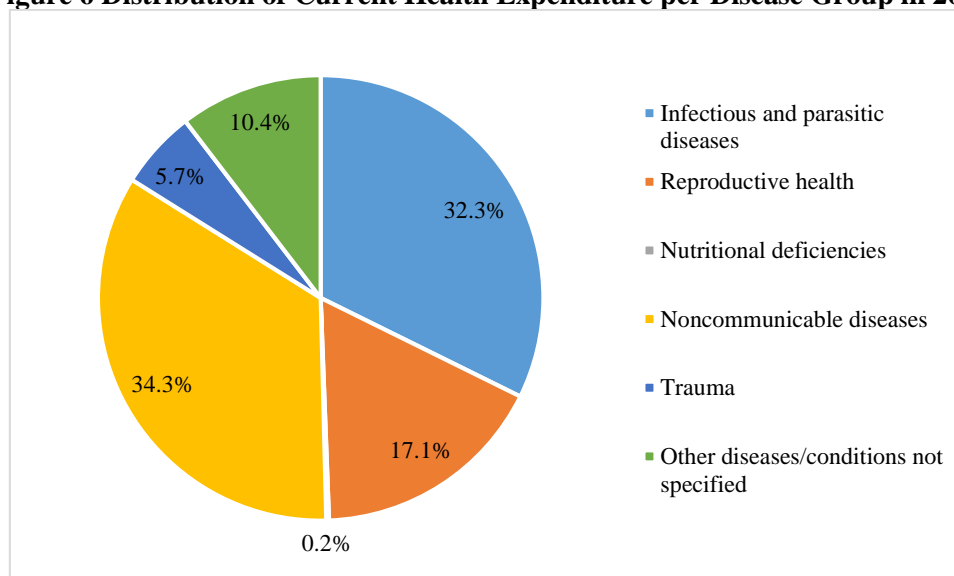
Figure 5 Distribution of Health Expenditure per Provider in 2014



Source: 2014 National Health Accounts.

The 2014 National Health Accounts showed NCDs as the main expenditure item, with 34.3 percent of current health expenditure, followed by communicable diseases with 32.3 percent of current health expenditure, reproductive health 17.1 percent, trauma 5.7 percent, and nutritional deficiencies 0.2 percent (figure 6).

Figure 6 Distribution of Current Health Expenditure per Disease Group in 2014



Source: 2014 National Health Accounts.

3. Brief Description of Public Health Care and Key Supply-Side Efforts

In general, the use of and access to health care by all people has improved, including for the poorest. However, large disparities remain between the most affluent and the poorest, between rural and urban areas, and between educated and illiterate people.¹⁰

In terms of availability of health services, Gabon has nearly 1,000 health facilities (959),¹¹ from health huts to university teaching hospitals, across the public, private, and nonprofit sectors. The geographic coverage of the country in public health facilities is relatively good, with a few exceptions, such as the Northern Health Region, where the population/number of health facilities ratios are unsatisfactory.

The number of beds is estimated at about 4,000 for the entire health system, or 25 beds per 10,000 inhabitants. The bed occupancy rate, at 44.44 percent,¹² is slightly below average for other countries of the subregion such as Cameroon (48.88 percent¹³) and Congo Brazzaville (60 percent¹⁴). However, these figures hide the dysfunctions of the majority of health facilities at the first level of the health pyramid. Indeed, many dispensaries are closed or do not meet any standards.

The health system remains oriented toward hospital-centered health care. This has led to a predominance of curative care, which is reflected in the preferential orientation of investments in hospital structures, to the detriment of primary care facilities. The preventive and promotion component remains insufficiently supported. The ownership and implementation of the primary health care strategy is inadequate, similar to community participation in health service planning and management. The management of NCDs, particularly high blood pressure, diabetes, and cancers, is insufficient, particularly in the interior of the country.

A national pharmaceutical policy was recently adopted regarding drugs. An institutional reform of the National Pharmaceutical Office was done and a national list of essential drugs was drafted

and revised several times with WHO support, notably in 2016. However, in both the regulatory and management plan, the management of drugs is deficient on several levels (for example, the autonomy of administrative and financial management of the National Pharmaceutical Office is ineffective, and the drug needs of health facilities are estimated without systematic consideration of their actual needs).

For several years, the country has been independently financing its vaccination program, and ensures the regular supply of vaccines and consumables for children under one year of age and for pregnant women. However, the lack of equipment for the conservation of vaccines at the level of some peripheral structures compromises the cold chain and limits the continuous supply of vaccination services at the headquarters of some divisions. Efforts have been made to develop a Comprehensive Multi-Year Plan supported by WHO and UNICEF partners, and the capacities of the managers of the Extended Program on Immunization were strengthened. Activities related to routine immunization, polio eradication, and surveillance of acute flaccid paralysis were intensified.

There are an estimated 12,000 health workers across the country, including 11,385 in the public sector. There is one medical doctor per 2,988 inhabitants. In the military, parapublic, and private sectors, there is about one medical doctor per 2,000 inhabitants. If only general practitioners are considered, there is one medical doctor per 7,597 inhabitants for the entire country. This ratio is higher than the WHO standard, which recommends one medical doctor per 5,000 to 10,000 inhabitants.

The national ratio of midwives to women of childbearing age is one midwife per 935 inhabitants. This ratio is well above the WHO standard, which recommends one midwife per 4,000 inhabitants. The population-to-state-nurse ratio is one state nurse per 2,190 inhabitants. Again, the ratio is higher than the WHO standard, which recommends one state nurse per 4,000 inhabitants.

An examination of the geographic distribution of the health workforce per health region reveals that nearly 44 percent of Ministry of Health staff is concentrated in the health region of Libreville-Owendo (its population, at 783,239, comprises 43.2 percent of inhabitants).¹⁵ For the rest, the better-off are in the South-East health regions (Haut-Ogooué, 9.34 percent), South-Central (Ngounié, 8.32 percent), and West (Estuary, 8.16 percent). The other health regions each mobilize less than 7 percent of the workforce. Further analysis of the distribution of staff within the health regions reveals disparities between the health divisions and significant shortages of staff. The new health infrastructures, including university teaching hospitals, have greatly increased the qualitative and quantitative need for human resources.

Although the supply of care is quantitatively significant, health indicators, as shown by maternal mortality, remain poor. For example, the number of inhabitants per bed in Gabon is comparable to what is found in Organisation for Economic Co-operation and Development countries, while the health indicators are comparable to countries of Sub-Saharan Africa. This indicates a serious problem of inefficiency coupled with a poor distribution of human and material resources.

4. GIS Institutional Architecture and Interaction with Rest of the Health System

The GIS was created at the same time as the compulsory health insurance scheme by Ordinance 0002/2007/PR of August 21, 2007, establishing a compulsory health and social insurance scheme in the Republic of Gabon. Its aim is to offer medical coverage to the poor or so-called economically weak Gabonese populations.

The NHISCF aims to improve access to health care for vulnerable social groups by reducing health costs, pooling financial resources, and avoiding the use of temporary or informal medicine (such as vendors of street drugs and healers); improve the provision of care by signing contracts for service provisions with health facilities, for example, by contracting with the Military Hospital for hip prosthesis; contribute to the improvement of the health status of the most fragile populations; and contribute to the fight against poverty and social exclusion.

The NHISCF is a third-party-payer social health insurance scheme under the supervision of the Ministry of Labour, Employment, and Social Welfare. It has a Board of Directors that includes representatives of the government, employers, and employees. It is headed by a Director General assisted by three Deputy General Managers (all appointed by the President of the Republic on recommendation of the Board of Directors). The funding sources and accounting of the GIS are different from those of the other two funds (state employee schemes and the private sector employee system). The income of one fund cannot support the expenses of another fund (lack of equalization and cross-subsidies). The NHISCF has decentralized structures in each of the country's nine provinces.

Services are provided by service providers, both public and private, of the three levels of the health pyramid (primary, secondary, and tertiary) for outpatient care and for hospitalizations. Health facilities are accredited by the NHISCF, notably by the Department of Medical Control. Each health facility signs a partnership agreement with NHISCF. At the end of 2014, there were 325 providers, including 99 pharmacies and dispensaries, 99 private clinics and medical centers, 97 public hospitals and medical centers, and 30 military hospitals and medical centers.

The Ministry of Health defines the tools used by the NHISCF, namely, the nomenclature of medical procedures, the list of essential drugs by level of the health facility, and authorizing the opening of private health facilities. The Ministry of Health plays two major roles: provider of health services through all public health facilities, and regulator of the provision of care by defining the standards and other guidelines for patient care.

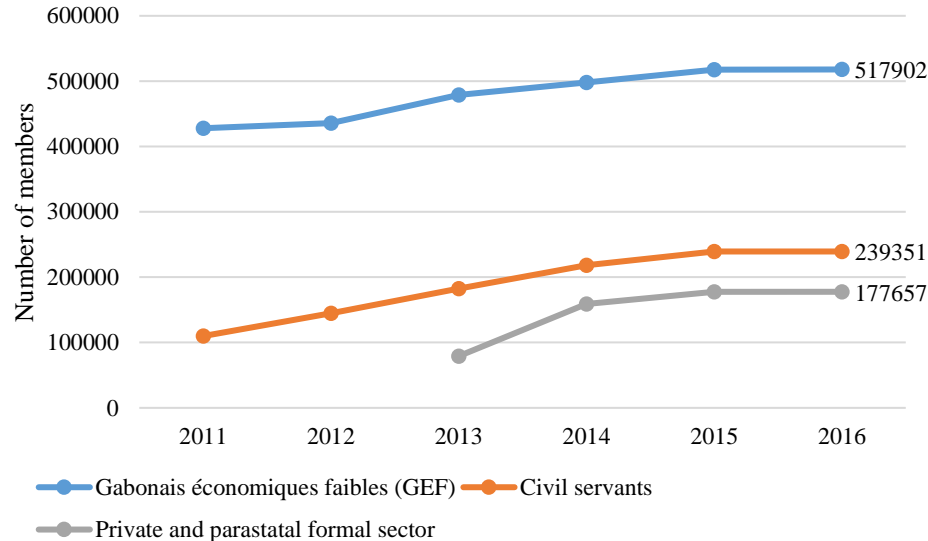
5. Identification, Targeting, and Enrolment of Beneficiaries

The population eligible for the GIS are Gabonese of both genders who are at least 16 years of age and whose income is less than the minimum guaranteed interoccupational wage of CFAF 150,000 per month, or about US\$250,¹⁶ an amount recently increased by the government from CFAF 80,000 per month, or about US\$130 per month. Children under 16 years of age are considered beneficiaries of insured parents. GIS beneficiaries do not pay dues or contributions. There is, however, a copayment for services, called a user fee, which varies according to the type of service provided (see section 6).

To become a member of the NHISCF, beneficiaries must register and receive a biometric insured card before benefiting from the health insurance of the GIS. GIS registration is done after a social survey to ensure that the person meets the enrolment criteria, or during mass registration. The principal insured and his or her beneficiaries (that is, the spouse and dependent children) must register.

The last Gabonese survey on poverty assessment, in 2005, and a 2013 McKinsey report on poverty, estimated the percentage of the Gabonese population living below the poverty line at 33 percent. The number of GIS and their beneficiaries registered with the NHISCF increased from 3,331 at the launch in 2008 to 497,805 in 2014, representing 33.4 percent of the population (figure 7).

Figure 7 Evolution of the Number of GISs (GEF) Registered at NHISCF



Source: CNAM-GS 2016.

6. Special Topics Related to the Management of Public Funds in GIS

The NHISCF is the funding agent for the GIS. It receives funds from the central government through the Ministry of Finance via the tax administration and the public treasury from the taxes paid by mobile phone companies and money transfer companies under the ROAM. This is an aggregate amount and not an amount paid according to the number of insured. The NHISCF, through its regional representations, is responsible for paying the providers who have provided services to insured persons throughout the national territory.

All mobile telephone sector operators pay the state 10 percent of their turnover, excluding taxes, to finance the NHISCF. Tax funding is also derived from all companies that transfer money out of the Economic and Monetary Community of Central Africa (CEMAC) zone and that pay the state 1.5 percent of their turnover, excluding taxes.

During its first years, this funding enabled the NHISCF to provide appropriate services to the covered population. The exponential increase in the GIS-eligible population, from almost 110,000 in 2009 to more than 600,000 in 2014, led to a significant increase in expenditures for the GIS. Because this population is bound to increase due to the economic crisis, funding for

GIS will be inadequate in the next few years, particularly due to escalating costs of care and poor management.

There are no cross-subsidies or an equalization mechanism among the plans administered by the NHISCF, that is, the state public employee fund, the private sector employee fund, and the GIS. Each fund has its own sources of funding and only covers the expenses of its affiliates. However, each fund contributes to the operating costs of the NHISCF.

The classification of medical procedures developed a system for charging hospital stays in public facilities according to the level of the health pyramid and according to the severity of the pathology or trauma (hospitalization days, intensive care, resuscitation).

The fund uses fee-for-service and hospitalization days as a payment method for providers. To benefit from a payment, the health facility must present a health card containing the information on the insured patient, the diagnosis, the service performed, the name of the attending physician, the physician's code (general practitioner or specialist), the name of the health facility, and the disease code.

The GIS, like all the other NHISCF funds, is a system for financing demand for health care according to the principles of a third-party payer. The GIS pays the health facilities only for the services provided to its members and their beneficiaries. The GIS directly pays providers 80 percent of the cost of the services, and the insured pays the remaining 20 percent. For chronic diseases, the GIS pays 90 percent of the cost to the providers and the insured pays the remaining 10 percent. The GIS pays 100 percent of the costs for maternity, dialysis, and cancer treatments. Even if there is a copayment for GIS beneficiaries (20 percent for common diseases and 10 percent for chronic illnesses), the use of and access to care for this group has improved. The trend is also positive for the share of direct household payments in total health expenditure, which fell significantly after the establishment of the CNAMGS.

The NHISCF has a Directorate of Medical Control and the Fight against Fraud, which verifies the validity of the service and controls all provider invoices through review by medical doctors and pharmacist controllers before invoices are paid. The NHISCF also has an internal audit system.

7. Management of the GIS Benefits Package

Decree 0021/MTEPS/MSHP of December 12, 2008, a joint decree of the Minister of Health and the Minister of Social Welfare, defines the compulsory health insurance basket of care for all NHISCF insured persons, including the poor. A December 19, 2008, note from the General Directorate of the NHISCF clarifies the services contained in the basket of care. The NHISCF periodically prepares a list of drugs reimbursable by the NHISCF.

The definition of the basket of care is a political decision based on the input of experts from different technical ministries. Experts from the Ministry of Health develop the epidemiological profile of the country with lists of the main causes of consultations, hospitalizations, and deaths by age group. These experts also provide the National List of Essential Drugs and Medical Devices of the Ministry of Health. A joint committee including experts from the Ministry of Health, the Ministry of Social Welfare, and NHISCF determines the benefit package covered

by the scheme. The experts' conclusions are translated into a joint decree of the Minister of Health and the Minister of Social Welfare.

All beneficiaries of all schemes under the CNAMGS have the same benefits package, which compliments the package of services and commodities financed under the Ministry of Health and other external financiers. The CNAMGS package of services is biased toward clinical care, while the Ministry of Health package is biased toward preventive programs. For example, family planning is not included in the benefits package. Among medicines, CNAMGS promotes the use of generics (or branded if generic is not available), and the use of medicines from the national essential medicines list. There is, however, an inclusion and exclusion list. In addition, the beneficiaries of the GEF Scheme are also eligible for some nontraditional health benefits, such as a childbirth bonus and education costs for children under 18 years of age.

Services covered by the program include ambulatory services (medical consultations, nursing services, dental services, diagnostic tests, small surgeries, prenatal care, and postnatal care), hospitalizations (professional fees, room and board, drugs, and every medical service necessary, referrals, deliveries, diagnostic tests), drugs and devices, and foreign referrals (for cases curable but with no care available in-country). Among those services and commodities in the exclusion list are antiretroviral therapy, aesthetic surgery, traditional medicine, family planning commodities, and screening (for example, pap smear, mammogram, and others). Health promotion, prevention, and most public health services are excluded, as are diseases funded directly by the Ministry of Health (through vertical programs), and traditional medicine.

Some services require prior approval from the NHISCF. These are the completion of any additional examinations in a private institution contracted in the event of non-availability in the public sector; medical devices and implants required for the various medical and surgical procedures, taking into account the nature of the disease or the accident; corrective or substitute equipment; medical eyewear; nonurgent oral care; medical evacuations out of the country for appropriate care that cannot be provided locally; the performance of specific paramedical procedures (speech therapy, psychomotricity); and medical visits at home.

The list of drugs reimbursable by the NHISCF is drawn up by pharmacists, medical doctors, and midwives according to the most common pathologies and the effectiveness of the drugs in question. Experts at the NHISCF discuss the cost-effectiveness of retaining different molecules according to the evidence base. Development partners, such as WHO, are often involved in this process.

The revision of the benefits package is defined by official texts, notably by Decree 0021/MTEPS/MSHP of December 12, 2008, defining the compulsory health care insurance package of benefits. This revision is made at the initiative of the NHISCF. The review of the benefits package explicitly takes into account the budgetary impact. The NHISCF assesses the cost of new services before including them in the package. The institutions that participated in the development of the benefits package are also involved in its review.

The list of drugs reimbursable by the NHISCF is drawn up and periodically revised by the NHISCF with the support of pharmacists, prescribing physicians, the Ministry of Health, and WHO. The last revision of the list of reimbursable drugs included new molecules, notably in generic form, and allowed the withdrawal of drugs whose benefits had not been demonstrated.

Poor households belonging to the GIS receive the same services, the same health care benefits package, the same list of reimbursable drugs, and have access to the same public or private

providers as the other NHISCF insured persons (state agents and employees of the private sector).

Implementation of the NHISCF had a positive impact on the functioning of the health system. The financial contribution of the NHISCF enabled several health facilities to improve supply and quality of care by recruiting additional staff, and purchasing equipment and reagents. Hospital revenues doubled or even tripled. Regular payment of bills allows managers to increase hospitals resources and thus to invest in improving the quality of care and increasing premiums for medical doctors and other health care workers. That is, for each insured patient consulted, hospitals pay a premium to the physicians who conducted the consultation. Similarly, since the establishment of the NHISCF, the prices of consultations and medical procedures have all been revised upward, sometimes tripling in price.

The establishment of the NHISCF and the GIS enabled managers of private health facilities to attract a new clientele (the poor) who could not afford services in these facilities because of the tariffs charged. This also made it possible in large urban centers, in particular, to promote competition among providers because patients now have more choices. However, in rural areas, due to insufficient health facilities, there has been little impact on competition and quality of care.

8. GIS Information Environment

The NHISCF has a Directorate of Medical Control and the Fight against Fraud, which carries out regular and permanent checks on the quality and effectiveness of services and the regularity of invoices. Through medical doctor inspectors, it conducts regular visits to hospitalized patients to ensure the effectiveness of the hospitalization and the diagnosis made for the patient. The mission of medical doctor inspectors is to validate the hospitalization of the insured person. The NHISCF has established an information system that enables it to have as much information as possible about providers, insured persons, prescriptions, and medical procedures.

In this context, the NHISCF has an effective communication unit which, through its website, posters, radio and television reports, and participation in the management of mainstream programs, regularly communicates the operational aspects of the institution, as well as the rights and obligations of the insured. Similarly, in addition to the communication service, the NHISCF has set up a short and free telephone number to allow public access to information about the insurance. Finally, the Directorate in charge of Medical Control acts as an interface between the insured and providers to deal with complaints from the insured about services received.

However, the services relating to the collection of complaints are not properly codified or formalized. For example, there is no form available for collecting complaints, no clear system for resolving complaints or compensation (letter of apology, compensatory medical treatment, reimbursement, and so forth), and no dedicated service for the reception and settlement of these complaints or an independent mediator.

9. Discussion of a Theme Specific to Gabon: GIS Financial Sustainability

The GIS is financed by a dedicated fee system for the health of the poor called the ROAM. These are taxes on mobile telephones and on money transfers abroad. For the mobile telephone sector, all operators (Libertis, Moov, Airtel, and Azur) pay the state 10 percent of their turnover, excluding taxes, to finance the NHISCF. The other source of financing for taxes is that of money transfers abroad, out of the CEMAC zone (Western Union, MoneyGram, and others), which also pay the state 1.5 percent of their turnover, excluding taxes, to finance the NHISCF. This is an innovative financing method Gabon has implemented to finance health services for the poor and is a first in Africa. This funding brings CFAF 20 billion (US\$34 million) a year to the GIS.

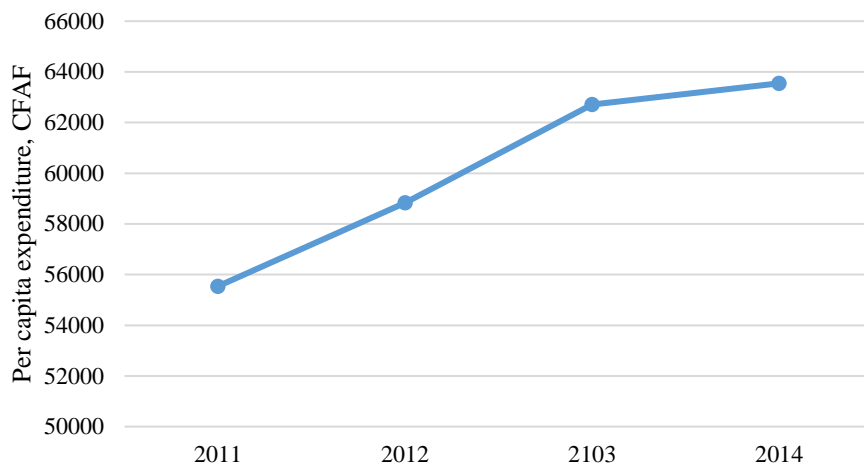
The sustainability of financing sources for subsidizing GEF beneficiaries has been questioned due to recent trends in revenue and expenditures. Between 2008 and 2011, revenue from earmarked taxes doubled; revenue from general taxes stayed the same in 2011 and made up about 12 percent of total revenue of the GEF fund that year. Releases from the treasury and tax departments are reportedly delayed. These delays affect the credibility of the funds, particularly for the poor and for civil servants. GEF's financing has been criticized for being narrow, unsustainable, and vulnerable to economic shocks, while the definition applied to identify GEF population groups has recently been noted as being too broad and imprecise. To improve targeting for improving coverage among the poor, the definition of GEF itself may need to be more precise. In contrast, the schemes for civil servants and formal private sector workers have built-in contributions and are self-sufficient.

The CNAMGS consumes a significant amount of resources, and questions about sustainability over the medium to long term have arisen. While income continues to surpass expenditures, the gap has shrunk over time (figure 8), and is expected to continue to do so in the future. In 2011, per capita spending of the CNAMGS program was CFAF 55,000 (US\$96). Per capita expenditures have increased over time to CFAF 64,000 (US\$111) in 2014 (figure 9). In 2012, claims made up 60 percent of CNAMGS's total expenditures for all schemes. That figure doubled from the previous year. On a per capita basis, annual claims spending has increased significantly over the years. Given the fee-for-service payment mechanism, moving forward, claims could increase at a far greater pace than revenue is generated. The considerable increase in GIS health expenditure between 2010 and 2014, which almost tripled from CFAF 7.7 billion to CFAF 20 billion,¹⁷ combined with the stagnation of ROAM revenues, raises the question of the sustainability of this important financing instrument of health services for the poor.

Figure 8 Income and Expenditures of CNAMGS, 2011–14



Figure 9 CNAMGS, Trend of Annual Per Capita Expenditures, CFAF, 2011–14



Source: CNAMGS audit, 2016.

Additional public resources are needed to cover the remaining population and meet the goal of expanding coverage under the CNAMGS, but additional resources in the current context will likely depend on reprioritizing, and a more efficient and effective use and allocation of existing resources. Economic growth is likely to inject additional funds into the health sector. However, since economic growth has recently slowed due to the oil price crisis, significant further increases in public resources for health are unlikely. Prioritization of the budget for health within the current public budget and an improved execution of the budget may be possible and would help inject additional resources for health. Nevertheless, freeing additional resources will likely also require a more efficient and effective use and allocation of existing resources.

In addition to prioritizing health in the government budget, fiscal space can indeed be generated through several mechanisms. First, space can be generated by raising revenues through taxes, mandatory contributions, and borrowing. Improving the collection of tax revenue is the first option for generating additional resources for the government. The introduction of new earmarked taxes, such as a sin (tobacco and/or alcohol) tax, is another way to generate resources for the health sector. Fiscal space can also be realized by gains in efficiency. In most settings, improvements in allocative and technical efficiency have the potential to free up substantial resources for health. Though hard to quantify, the focus should be on reforming expenditure management, implementing effective cost-control strategies, and upgrading quality of service.

10. Pending Agenda

The GIS scheme in Gabon shows that the lack of effective cost control measures entails a major risk for the sustainability of the health coverage of the poorest people, which is financed almost exclusively by public funds. Given the financial sustainability situation, and to ensure the optimal functioning of the GIS, it is important to consider the following:

- New inclusion criteria need to be redefined for the status of economically weak Gabonese in the GIS
- New resources need to be found to fund the GIS (excise duties on tobacco and alcohol, which are under consideration)
- A study is needed on innovative financing to identify sectors other than tax levels to contribute to ROAM

- Strategies need to be developed for controlling GIS costs and optimizing resource utilization by the CNAMGS by:
 - Promoting the prescription and use of generic drugs
 - The systematic use of standardized flowcharts and/or treatment regimens, particularly in primary health care facilities, which will make it possible to harmonize the management of common pathologies and control the use of irregular nonpathological drugs while limiting and/or avoiding over-prescription
 - The level of reimbursement of drugs needs to be revised. Over-the-counter, convenient, or nonessential drugs should not have the same reimbursement rates as essential or life-saving drugs. For example, antibiotics could be reimbursed at 30 percent while an antimalarial drug could be reimbursed at 90 percent. The same could be true for insulin or antihypertensive drugs
 - A ceiling system needs to be established for the care of members and beneficiaries, particularly for certain specific care (dentistry, optics, and others)
 - There needs to be a precise definition of the content of certain procedures (days of hospitalization, consultation in some specialties, ophthalmology, dental surgery).
 - A payment system needs to be established for mixed providers: a fee-for-service payment associated with payment for a disease episode for well-coded pathologies, a package or full budget for chronic diseases
 - The level of remuneration of providers needs to be reviewed
 - A strategic purchasing policy needs to be established for CNAMGS (such as performance-based financing).
- An efficient information system that is in harmony with the national health information system needs to be implemented by the NHISCF, which would enable efficient management of the flow of information among the insured, the insurer, and care providers. This measure would be useful for monitoring, evaluating, and controlling the use of health services by insured persons and the future estimation of related expenditures.

Notes

¹ 2013 GSPH of Gabon.

² 2014 Health accounts.

³ 2014 Health accounts.

⁴ Summary table in *Circonscriptions administratives du Gabon, Ministère de l'Intérieur, de la Sécurité Publique, de l'Immigration et de la Décentralisation*, January 30, 2015.

⁵ *Gabon Statistical Yearbook* 2011.

⁶ Musango and Inoua 2010.

⁷ www.NHISCF.ga.

⁸ 2017 Finance Law; <https://www.droit-afrique.com/uploads/Gabon-LF-2017.pdf>.

⁹ 2014 Health Accounts; <http://csgabon.info/>.

¹⁰ Saleh, Couttolenc, and Barroy 2014.

¹¹ *Gabon Statistical Yearbook* 2011.

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¹³ http://www.memoireonline.com/01/14/8492/m_Contribution-du-contrle-de-gestion--la-performance-des-hpitaux-publics-au-Cameroun33.html.

¹⁴ http://www.aho.afro.who.int/profiles_information/index.php/Congo:Secondary_and_tertiary_care_services/fr.

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¹⁶ Per Decree No. 12 / PR / MTEPS of April 23, 2010.

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The Series consists of country case studies and technical papers. The case studies employ a standardized approach aimed at understanding the tools –policies, instruments and institutions-used to expand health coverage across three dimensions: population, health services and affordability. The approach relies on a protocol involving around 300 questions structured to portray how countries are implementing UHC reforms in the following areas:

- **Progressive Universalism:** expanding coverage while ensuring that the poor and vulnerable are not left behind
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- **Raising revenues** to finance health care in fiscally sustainable ways
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