USAID
FROM THE AMERICAN PEOPLE

HEALTH SYSTEMS 2020
better systems, better health

info@HealthSystems2020.org
www.HealthSystems2020.org

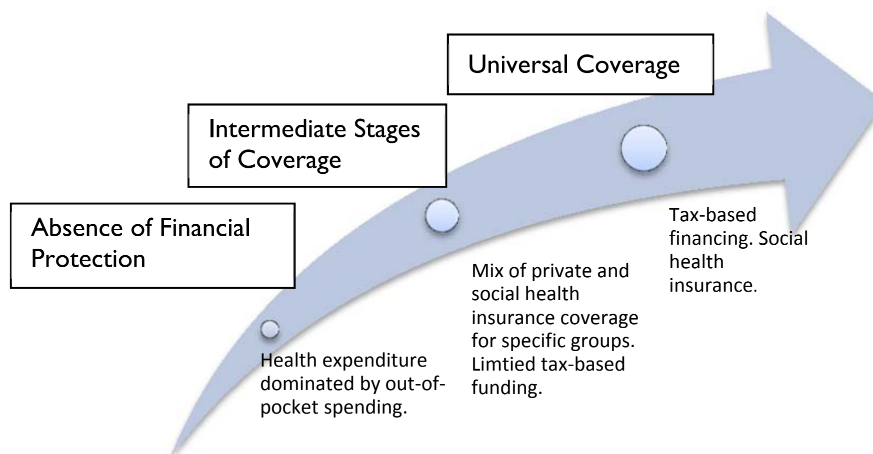
THE PATH TO UNIVERSAL COVERAGE IN AFRICA: FOCUS ON COMMUNITY-BASED HEALTH INSURANCE

Since the 1990s, USAID has supported the development of community-based health insurance schemes (CBHIs) in Africa through a variety of global, regional, and bilateral projects. The purpose of this paper is to analyze experiences moving towards universal coverage in sub-Saharan Africa, with a focus on CBHIs.

OVERVIEW OF UNIVERSAL HEALTH COVERAGE – HOW DO COUNTRIES GET THERE?

Of the 1.3 billion low-income people around the world, many still lack access to effective and affordable health care (Wang and Pielemeier 2012). In 2005, the member states of the World Health Organization committed to moving health systems towards universal health coverage, defined as "developing health financing systems so that all people have access to services and do not suffer financial hardships paying for them" (The World Health Organization 2010). Universal coverage is a goal that countries constantly move towards through a series of gradual reforms and adjustments (see Figure 1). In doing so, governments face key questions – ***How can the system be designed to protect people from the financial burdens of accessing health care, while improving utilization of health services? In moving towards universal health coverage, how can health systems be designed to reach the underserved populations, including rural, extremely poor, or informal sector?*** (The World Health Organization 2010).

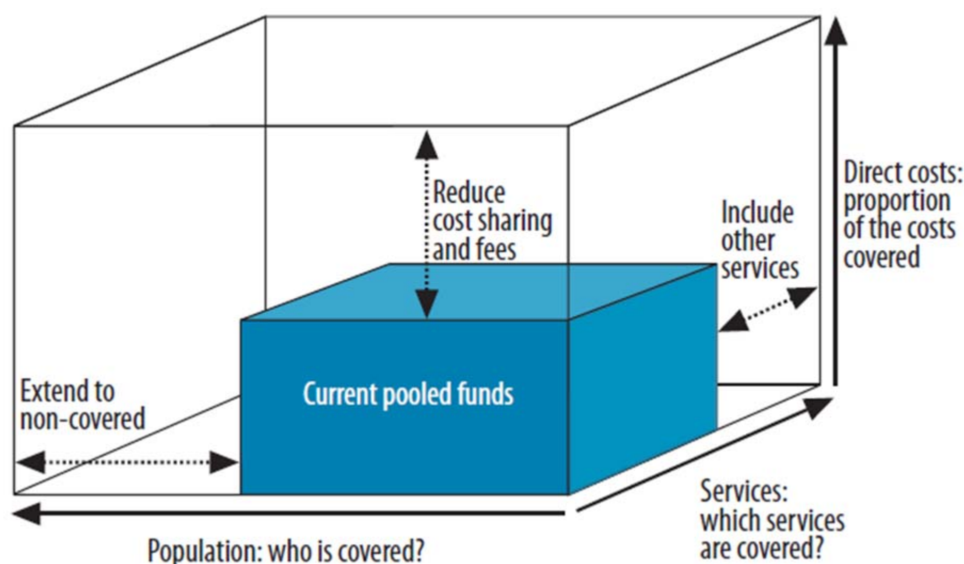
FIGURE 1: THE STEPS TOWARDS UNIVERSAL HEALTH COVERAGE



Challenges in Achieving Universal Coverage

Universal coverage has three dimensions (see Figure 2): direct costs (the proportion of costs covered), population (the proportion of the population covered), and health services (the range of services available) (The World Health Organization 2010). Since universal coverage requires a commitment to cover 100 percent of the population, countries inherently face challenging trade-offs along each of these dimensions as they move towards this goal.

FIGURE 2: THREE DIMENSIONS OF UNIVERSAL COVERAGE



Source: World Health Report 2010

Population – Population coverage is a function of the other two dimensions. Direct costs such as premiums, copayments, and user fees are not affordable for the impoverished and limit coverage of this segment of the population (Carrin, Waelkens and Criel 2005). Service coverage is physical access. If rural populations face long distances to reach the nearest provider then they are not truly covered. Service coverage also refers to which services are covered by insurance (or available for free). Exclusion of a service can exclude a segment of the population. Exclusion of ARV treatment means people living with HIV/AIDS are not effectively covered. Population coverage is achieved when copayments are determined by ability to pay and use of services is determined by need. (Wang and Pielemeier 2012).

Direct Costs – The goal is to reduce the direct costs paid by individual patients. Low-income countries still rely heavily on households' out-of-pocket spending to finance health care. Direct payment for health services increases the risk of catastrophic payments, pushing poor households into even deeper poverty (Mills, et al. 2012). Empirical evidence shows that, when proportion of direct costs borne by households falls below 15-20 percent, the incidence of catastrophic health expenditure falls to negligible levels (The World Health Organization 2010). To move towards universal coverage, countries must increase the levels of prepayment (Chankova, Sulzbach and Diop 2008).

A member of a local CBHI scheme in Mali displays her insurance card. Credit: Colby Gottert.

Health Services – As cited earlier, the lack of physical access to health care is a barrier to universal coverage. Many households must travel long distances to health facilities. Transportation may not be available or affordable. Insufficiently skilled staff or unavailability of necessary drugs or supplies is another obstacle to effective coverage. Moreover, many poor households are unaware of the benefits of the health care system, or lack confidence in the system, and do not access the care even when a provider is nearby and they need care. Thus, to successfully provide universal coverage, a reorganization of the health financing system must be accompanied by attention to physical infrastructures, service quality, community-based services, and demand-side factors in order to expand this dimension of universal coverage.

Types of Health Financing

Countries face a variety of options to finance universal coverage, as outlined in **Table 1** (Wang, Switlick, et al. June 2010).

> **"Universal health coverage is the single most powerful concept that public health has to offer."**

Dr. Margaret Chan, Director-General, World Health Organization

TABLE 1: TYPES OF HEALTH FINANCING SYSTEMS[1]

Types of Insurance	Financing Source	Management	Advantages	Challenges	Countries
National health insurance	General taxes	Public sector	• Comprehensive coverage of the population • Progressive revenue collection • Large scope for raising resources • Simple mode of governance • Potential for administrative efficiency	• Funding subject to political pressures and available tax revenues • Potential inefficiency in health care delivery because of lack of competition and provider choice	Canada, Costa Rica, France, Great Britain
Social health insurance	Payroll taxes from employers and employees	Social security agency, health fund, sickness fund(s)	• Mobilizes resources from employers for health • Funding typically earmarked for health • Can be progressive • Strong support from the covered population	• Coverage limited to those employed in the formal sector • Less progressive if tax is capped • Burden of payroll contributions may increase unemployment • More complex to manage • Workers may leave the formal sector to avoid payroll taxes	Colombia, Germany, Japan, Korea, USA (Medicare)
Private voluntary insurance – commercial	Premium payments from individuals or employers/ employees	Commercial insurance company, for-profit or not-for-profit	• Available to low-income groups and informal sector workers • Useful complement to other financing mechanisms, such as user fees or SHI • Facilitates government or donor funding to subsidize premiums to target populations	• Limited financial protection for members • Small risk pools difficult to sustain (bankruptcy common) • Exclusion of the poorest without subsidies • Limited effect on the delivery of care • Requires national-level political and financial support to achieve breadth and depth	South Africa, USA
Community-based health insurance	Premium payments from individuals and/or community	Community or association	• Financial protection for higher-income population • Can supplement state or social insurance coverage • Can build local capacity in professional insurance management	• Typically limited to higher-income populations • Plans compete for healthy/wealthy members • Increases differentials in access based on income • Has high administrative costs	China, India, Philippines, Rwanda, Senegal

[1] Adapted from Wang, Hong, Kimberly Switlick, Christine Oritz, Catherine Connor, and Beatriz Zurita. "Africa Health Insurance Handbook—How To Make It Work." Health Systems 20/20 Project, Abt Associates Inc., Bethesda, MD, June 2010

In particular, financing national health insurance through general taxation or implementing social health insurance through payroll taxes are difficult in low-income countries because the large informal and rural sectors are often outside of the tax base, making the formal sector contributions via taxes too small to cover the entire population. (Carrin, Waelkens and Criel 2005). CBHI was recognized a decade ago as a viable approach to extend coverage to these hard-to-reach populations (Preker 2002).

Community-based Health Insurance

In sub-Saharan Africa, out-of-pocket expenditures still constitute roughly 40 percent of total health expenditures, imposing financial burdens and limiting access to care in some of the poorest countries in the world (Mbengue 2011). Over the last two decades, sub-Saharan Africa has experimented with a grassroots approach to CBHI with schemes emerging at the community level. Governments can support the development of CBHIs as a way to reach underserved populations, including rural areas, informal sector workers, and the poorest segments (Chankova, Sulzbach and Diop 2008).

CBHIs have the potential to:

- Provide financial protection for underserved segments of the population, lowering the equity gap and reducing out-of-pocket spending.
- Raise awareness of the value of insurance, building confidence among participants through community control mechanisms, and increasing utilization of the health care system.
- Increase prepayment from the informal sector and ultimately mobilize more resources for health care.

However, CHBIs also face risks and challenges:

- The grassroots nature of CBHIs means they may lack professional management, political support, or public funding to subsidize enrollment of the poorest segment of the population. This reduces the stability of the scheme as the concentration of risk in smaller, poorer communities increases the likelihood of bankruptcy due catastrophic health expenditures.
- Few schemes have merged together to form larger risk pools or buy re-insurance to protect members from catastrophic health expenditures.
- Many of the existing CBHI schemes have enrolled only a small proportion of the population. Scaling up has been difficult, reducing the schemes' ability to broaden coverage, both in terms of the population covered as well as services provided. Evidence from a study in West Africa suggests that enrollment in CBHIs is skewed towards those with higher education and higher household incomes because they have a better understanding of the benefits of such a system and are able to afford the premium payments (Chankova, Sulzbach and Diop 2008).
- Voluntary participation in the schemes can lead to adverse selection, undermining the sustainability of the scheme. (Wang and Pielemeier 2012).

A few countries such as Ghana, Rwanda, and Mali have used CBHI schemes to move towards universal coverage through specific steps, such as:

- Introducing a legal framework for CBHIs that links or fully integrates them into the larger national health financing system and protects consumers.
- Using government or donor funding to subsidize enrollment of target populations (e.g. very poor or people with an expensive condition such as HIV/AIDS).
- Merging small schemes to form larger regional or national networks to enlarge the risk pool so as to improve financial sustainability and management efficiency (Wang and Pielemeier 2012).

The experience in these countries illustrates opportunities and pitfalls that will benefit other countries.

EVOLUTION OF CBHI IN GHANA, RWANDA, AND MALI

Ghana

CBHIs in Ghana began in the 1990s as a community response to the high user fees charged by public and private providers. Coverage rates ranged from 2 to 25 percent. By 2003, such community schemes covered only 1 percent of the country's population, while civil servants and formal sector employees were covered by social security.

Child in Ghana. Credit: Hirshini von Kalm.

In 2003, Ghana passed the National Health Insurance (NHI) Act into law, which created the mandatory National Health Insurance Scheme (NHIS) that provides a broad minimum package of care (Witter and Garshong 2009). The NHIS built upon existing CBHI schemes at the community level and consolidated them into District Mutual Health Insurance Schemes (DMHIS) that were required to follow national rules on premiums and benefits as well as financing (World Health Organization 2011). The NHI Act established a regulatory body, the National Health Insurance Council (NHIC) to register, license, and regulate public and private health insurance schemes, including the DMHIS. The key responsibility of DMHIS is to enroll members, collect premium payments, and issue identity cards. Despite the development of national guidelines, districts differed in terms of premium payments, registration fees, and waiting periods as of 2008 (Ghana 2009).

Premiums were set at a low rate. Children (up to age 18), the elderly (age 70 and older), and the indigent were to be exempt from premium payment. In fact, in 2008, only 30.6 percent of enrollees in the NHIS paid any premium at all (Durairaj, D'Almeida and Kirigia March, 2010).

An important role of the DMHIS was to determine which individuals were indigent and therefore exempt from premium payments. The methods for determining the indigent status varied widely. In some districts, it was done by the members of health insurance committees in the communities. In other districts, the management committee takes the decision, while in still others special committees are formed. The members of the special committees are usually the chiefs, tax collectors, and other community opinion leaders such as the pastors and traditional priests (Ghana 2009).

The NHIS funds an increasing proportion of health care costs in Ghana, with a steady trend towards fully funding the cost of curative care measures. However, the current payment and reimbursement systems create perverse incentives to provide more curative, rather than preventative health care. Evidence shows that cost savings and better health outcomes can be achieved through emphasis on preventative care (Witter and Garshong 2009).

Coverage

The NHIS covers all 138 districts in Ghana with a predefined benefits package that covers 95 percent of the disease burden in the nation (World Health Organization 2011). NHIS membership grew from 6.6 percent of the population in 2005 to 45.0 percent in 2008, but there is great variation across the different regions (Witter and Garshong 2009). Registration among people in the informal sector and children has also increased.

Funding

Funding for the NHIS comes mainly from taxation and employer contributions (from the formal sector) (Witter and Garshong 2009). A Value-Added-Tax of 2.5 percent specifically apportioned for the NHIS provides 75 percent of the funding. Approximately 20 percent of funding comes from payroll tax of 2.5 percent from the formal sector. The remainder (approximately 5 percent) comes from premium contributions from the informal sector (Witter and Garshong 2009) (World Health Organization 2011). The NHIS faces deficits due to the large percentage of the members that do not pay premiums (almost 70 percent), and the fee-for-service payment for providers that has led to cost escalations.

Impact

The NHIS was created to provide financial protection and improve health outcomes through increased access to health care. While detailed reviews of the NHIS's performance are limited, existing evaluations are promising. Since the inception of NHIS, out-of-pocket spending has decreased from 51 percent of total health expenditures in 2004 to 37 percent in 2009. Meanwhile, government expenditures increased from US$9 per capita to US$28 per capita over the same time (World Health Organization 2011). Another positive result of the CBHIs was an increase in service utilization. However, there is no evidence to show health outcome gains realized by higher utilization (Witter and Garshong 2009).

Wealth is strongly associated with enrollment in NHIS. In a 2007 household survey, about half of the individuals in the richest wealth quintile were insured under NHIS, compared to less than one-fifth of individuals in the poorest quintile. Membership remains skewed against underserved areas who do not receive the benefits of enrolling in the NHIS because they do not have access to health care facilities or cannot afford the costs (Witter and Garshong 2009). For example, wealthier households have greater access to hospital services by virtue of being located in urban centers (World Health Organization 2011). Regional biases also exist. In Ghana, the wealthier southern region received more health resources than the poorer northern region, which also suffers from lack of infrastructure (Gyapong, et al. April, 2007). Thus, poorer groups receive smaller share of health service benefits relative to their needs (Akazili, et al. 2012)

While the NHIS has taken steps to improve access to health care in Ghana, significant challenges remain. Financial sustainability will remain a key concern as Ghana moves towards expanding coverage and simultaneously attempts to rationalize provider payments. Unfortunately, user fees for drugs and service co-payments still constitute a significant portion of the health care costs and continue to be a barrier to entry for many. Inefficiencies in the system, particularly the lack of resources at the primary care level that result in frequent referrals to secondary care facilities, also threaten financial sustainability (Durairaj, D'Almeida and Kirigia March, 2010).

Rwanda

CBHI began as a pilot funded by USAID from 1999-2001 with 54 CBHIs (known as *mutuelles*) with each *mutuelle* linked to a health center and managed by its members (World Health Organization 2011). Members received coverage for a minimum package of health services (Lu, et al. 2012). Encouraged by an evaluation of the results of the pilot program (Schneider, Diop and Leighton March, 2001), the *mutuelle* model was rolled out nation-wide in 2003, covering many in the agriculture and other sectors. In 2008, the system gained legal traction as the structure and organization of *mutuelles* were formally codified. This law also imposed a mandate requiring all citizens to have some form of health insurance. However, enrollment in the *mutuelles* is still voluntary (Kayonga 2007).

Coverage

The *mutuelles* model has scaled up rapidly. As of 2009, *mutuelles* covered approximately 83 percent of the population in Rwanda and other types of insurance covered 8 percent for an impressive total of 91 percent coverage. Membership is on a household basis, with premiums costing roughly US$2 per person annually and copayments of US$0.40 per visit to a primary care facility or 10 percent of hospital care costs (Saksena, et al. March, 2010). Despite economic growth in the last two decades, over 75 percent of the population in Rwanda still lives on less than US$1.25 per day (World Health Organization 2011). Consequently, even minimal premium and copayment charges represent a financial barrier for some segments of the population. Thus, richer households

are more likely to be enrolled in a *mutuelle* (Saksena, et al. March, 2010).

The successful growth of *mutuelles* lies in the ability of individual schemes to operate autonomously at the local level but be governed by national policies (e.g. the definition of a minimum package of services, premium and copayment rates that all *mutuelles* are required to follow). Complementing the *mutuelle* schemes, which mobilize and pool funding, the district health offices operate as autonomous entities, providing services to well-defined populations in either urban or rural zones.

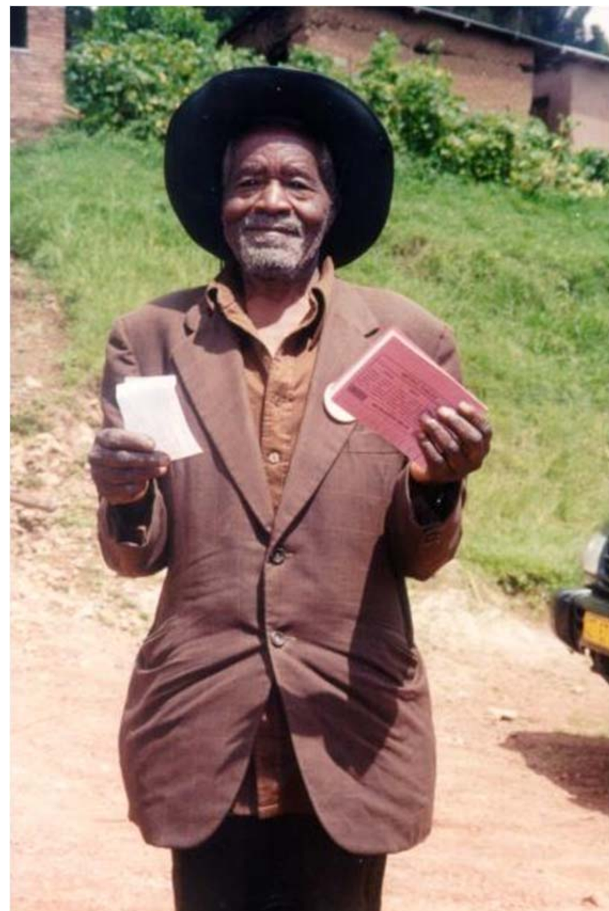
Funding

The *mutuelles* are primarily funded by premiums paid by members, with significant subsidies provided for the very poor. However, it is worth noting that nearly 50 percent of Rwanda's total health expenditures are funded by external sources. Thus Rwanda's health sector overall is still highly dependent on foreign aid.

Impact

Between 2000 and 2006, out-of-pocket expenditures fell by more than 50 percent, and there was an even further reduction for households enrolled in *mutuelles*. Over the same period, the percentage of households incurring catastrophic health spending (defined as payments in excess of 40 percent of a household's capacity to pay[2]) also decreased significantly, from 11.9 percent to 7.7 percent overall. The percentage of households suffering catastrophic payments was even less for households enrolled in *mutuelles*, at 5.1 percent (Lu, et al. 2012). Finally, government spending on health has increased from 8.2 percent in 2005 to 10.2 percent in 2010.

As a result of the *mutuelles* as well as the introduction of a performance-based financing policy in 2005, the overall utilization of the system has also increased (Saksena, et al. March, 2010). As an example, consultation rates increased from 0.25 visits per person per year in 2001 to 0.86 visits per person per year in 2008, and the modern contraceptive prevalence rate[3] increased from 10 percent to 45 percent over the same period (World Health Organization 2011). Furthermore, medical care utilization for children under five with fever or diarrhea increased from 13 percent in 2000 to 33 percent in 2008, while women treated by skilled birth attendants also increased from 39 percent to 67 percent during the same period (Lu, et al. 2012). As a result, health outcomes have improved as well – under-five mortality decreased by nearly 50 percent between 2005 and 2010, and incidences of communicable diseases such as tuberculosis and malaria have also decreased (World Health Organization 2011).



A *mutuelle* member in Rwanda displays his insurance card. Credit: Health Systems 20/20.

[2] As defined by Xu et al., a household's capacity to pay is the effective income remaining after basic subsistence needs have been met. Effective income means the total consumption expenditure of the household (Xu, Evans, et al. 2003)

[3] The modern contraceptive prevalence rate (CPR) is defined by Sharan et al. as the proportion of women of reproductive age who are using a modern contraceptive method. (Sharan, et al. 2011)

With more than 90 percent of the population covered by *mutuelles* and other health insurance schemes, Rwanda appears close to achieving universal coverage. The challenges that remain include ensuring long-term sustainability of the system (given that 50 percent of total health funding comes from external sources) and improving equity of coverage by reducing the different enrollment rates based on household income.

Mali[4]

Although Mali has made progress toward improved health indicators, utilization of health services remains low and health outcomes leave much room for improvement. In 1996, the government of Mali adopted a legal framework to support CBHIs but little progress was made due to lack of strong, coordinated political commitment to a standardized national approach. In 1998, the Union Technique de la Mutualité (UTM) was created as an independent association that provides technical assistance to CBHIs. By 2006, there were an estimated 102 CBHIs in Mali. However, these CBHI schemes were small and isolated, resulting in a small risk pool that exposed each scheme to the risk of catastrophic expenditures and bankruptcy.

In 2009, the UTM played a central role in the development of a new policy to invigorate CBHIs by organizing a workshop that brought together the major stakeholders to agree on a consensus-based national CBHI strategy. Through a collaborative effort among government leaders, USAID, the World Bank, and the Ministerial Leadership Initiative, the government of Mali adopted a national risk protection policy in 2010. The policy established a legal framework of three mechanisms to improve financial protection of households against the cost of health services: 1) mandatory health insurance, (*Assurance Maladie Obligatoire*, or AMO), 2) a non-contributory assistance scheme for the poorest population (*Regime d'Assistance Medicale*, or RAMED), and 3) CBHIs. The AMO is funded by salary contributions from the formal sector and is expected to cover 17 percent of the population. RAMED, funded by national and local governments, is expected to fund coverage of the poorest 5 percent of the population.

"I am a community member, and I know that joining a CBHI scheme makes it easier to access care."

Member, Kolikoro Community Health Mutuelle, Mali

Photo credit: Colby Gottert.

The remaining 78 percent of the population is expected to enroll into CBHIs. AMO, RAMED, and the *mutuelles* now fall under the responsibility of the *Direction Nationale de la Protection Sociale et de l'Economie Solidaire* (DNPSES), a directorate of the Ministry of Social Development, Solidarity and the Elderly.

UTM will provide technical support to the CBHI schemes to implement the national policy. As of the release of this brief, Mali had formed a new unity government as a step towards recovery from a military coup that overthrew the country's elected government in March 2012.

ADDITIONAL RESOURCES ON UNIVERSAL COVERAGE AND COMMUNITY-BASED HEALTH INSURANCE

UHC Forward - A comprehensive platform that aggregates and consolidates information about universal health coverage to accelerate the successful implementation of reforms globally. The publications section is particularly useful in

[4] This section was adapted from Senauer, Katie, and Cheikh Mbengue. 2012. *Scaling Up Community-Based Health Insurance in Mali: A Case Study.* Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

providing other resources and documents with more in-depth discussions. (Results for Development Institute 2011)

Health Systems Financing: The path to universal coverage - *World Health Report 2010* offers a comprehensive guide to universal health coverage and options to raise resources and remove financial barriers, especially for the poor. (The World Health Organization 2010)

SHIELD - A six year multi-country research project led by African universities and funded by CIDA is finally bearing fruit (http://heu-uct.org.za/research/projects/shield-project/):

- GILSON, L., ERASMUS, E., BORGHI, J., MACHA, J., KAMUZORA, P. & MTEI, G. (2012) Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project. *Health Policy & Planning,* 27(suppl 1), i64-i76

- GOUDGE, J., AKAZILI, J., ATAGUBA, J., KUWAWENARUWA, A., BORGHI, J., HARRIS, B. & 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 & Planning,* 27(suppl 1), i55-i63

- MACHA, J., HARRIS, B., GARSHONG, B., ATAGUBA, J. E., AKAZILI, J., KUWAWENARUWA, A. & J., B. (2012) Factors influencing the burden of health care financing and the distribution of health care benefits in Ghana, Tanzania and South Africa. *Health Policy & Planning,* 27(suppl 1),i46-i54

CBHI member visits doctor. Credit: Colby Gottert.

- MCINTYRE, D. & ATAGUBA, J. E. (2012) Modelling the affordability and distributional implications of future health care financing options in South Africa Health. *Health Policy & Planning,* 27(suppl 1), i101-i112

- MCINTYRE, D. & BORGHI, J. (2012) Inside the black box: modelling health care financing reform in data-poor contexts. *Health Policy & Planning,* 27(suppl 1), i77-i87

- MCINTYRE, D. & MILLS, A. (2012) Research to support universal coverage reforms in Africa: the SHIELD project (editorial). *Health Policy & Planning,* 27(suppl 1), i1-i3.

- MILLS, A., ATAGUBA, J. E., AKAZILI, J., BORGHI, J., GARSHONG, B., MAKAWIA, S., MTEI, G., HARRIS, B., MACHA, J., MEHEUS, F. & MCINTYRE, D. (2012) Equity in financing and use of health care in Ghana, South Africa, and Tanzania: implications for paths to universal coverage. The Lancet. DOI:10.1016/S0140-6736(12)60357-2

Bibliography

Akazili, James, Bertha Garshong, Moses Aikins, John Gyapong, and Di McIntyre. "Progressivity of health care financing and incidence of service benefits in Ghana." *Health Policy and Planning* 27, no. 2 (March 2012).

Atun, R., and N. Menabde. "Health systems and systems thinking." In *Health Systems and the Challenges of Communicable Diseases*, by R. Coker, R. Atun and M. McKee. 2008.

Balabanova, D., M. McKee, A. Mills, G. Walt, and A. Haines. "What can global health institutions do to help strengthen health systems in low income countries?" *Health Research Policy and Systems* 8, no. 22 (2010): http://www.health-policy-systems.com/content/8/1/22.

Balabanova, Dina, and Mills A (eds). McKee M. *'Good health at low cost' 25 years on: What makes a successful health system?* London: London School of Hygiene & Tropica Medicine, 2011.

Barros, P. "The slow and unnoticed changes in the funding mix." *Health Economics* 16 (2007): 437-440.

Basu, S., Jason Andrews, Sandeep Kishore, Rajesh Panjabi, and David Stuckler. "Comparative performance of private and public health care systems in low- and middle-income countries: a systematic review." *PLoS Medicine* 9, no. 6 (2012): e1001244.

Bennett, S. "The role of community-based insurance within the health care financing system: a framework for analysis." *Health Policy and Planning* 19, no. 3 (2004): 147-158.

Bennett, S., Kara Hanson, Patrick Kadama, and Dominic Montagu. *Working with the non-state sector to achieve public health goals.* Making Health Systems Work: Working paper No. 2, Geneva: World Health Organizaiton, 2005.

book, Kutzin health financing. n.d.

Bowen, S., and A. Zwi. "Pathways to "evidence-informed" policy and practice: a framework for action." *PLOS Medicine* 2, no. 7 (2005): e166.

Busse, R., and S. Stock. "The German health care system, 2009." In *International profiles of health care systems: Australia, Canada, Denmark, England, France, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States*, by The Commonwealth Fund, 28-31. 2010.

Bustreo, F., April Harding, and H. Axelsson. "Can developing countries achieve adequate improvements in child health outcomes without engaging the private sector?" *Bulletin of the World Health Organization* 81 (2003): 886-895.

Carrin, Guy, Inke Mathauer, Ke Xu, and David B Evans. "Universal coverage of health services: tailoring its implementation." (World Health Organization) 86, no. 11 (November 2008): 857-863.

Carrin, Guy, Maria-Pia Waelkens, and Bart Criel. "Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems." *Tropical Medicine and International Health* 10, no. 8 (August 2005): 799-811.

Cashin, C, and Y Chi. *New Zealand's Performance Management Program for Primary Health Organizations.* Washington, D.c.: World Bank, 2011.

Cashin, Cheryl, Angela Micah, and George Schieber. *Assessing the prospects for additional fiscal space for health in Ghana.* Background Paper to the Ghana Country Status Report, Washington, D.C.: World Bank, 2011.

Chankova, Slavea, Sara Sulzbach, and François Diop. "Impact of mutual health organizations: evidence from West Africa." *Health Policy and Planning* 23, no. 4 (May 2008): 264-276.

Christianson, Jon, Sheila Leatherman, and Kim Sutherland. *Paying for quality: understanding and assessing physician pay-for-performance initiatives.* Research Synthesis Report No. 13, Princeton, NJ: Robert Wood Johnson Foundation, 2007.

Damberg, C., K. Raube, S. Teleki, and E. de la Cruz. "Taking stock of pay-for-performance: a candid assessment from the front lines." *Health Affairs* 28, no. 2 (2009): 517-525.

Deshpande K, RaviShankar, Diwan V, Lönnroth K, Mahadik VK, Chandorkar RK. "Spatial pattern of private health care provision in Ujjain, India: a provider survey processed and analysed with a Geographical Information System." *Health Polkicy and Planning* 68, no. 2 (2004): 211-222.

Durairaj, Varatharajan, Selassi D'Almeida, and Joses Kirigia. "Technical Brief for Policy Makers- Obstacles in the process of establishing a sustainable National Health Insurance Scheme: Insights from Ghana." World Health Organization, March, 2010.

Durand-Zaleski, Isabelle. "The French health care system, 2009." In *International profiles of health care systems: Australia, Canada, Denmark, England, France, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States*, by The Commonwealth Fund, 23-27. Washington, D.C., 2010.

Frolich, A., J. Talavera, P. Broadhead, and R. A. Dudley. "A behavioral model of clinician responses to incentives to improve quality." *Health Policy* 80, no. 1 (2007): 179-193.

Ghana, Health Systems 20/20 Project and Research and Development Division of the. *An Evaluation of the Effects of the National Health Insurance Scheme in Ghana.* Technical Report, Bethesda: Health Systems 20/20 project, Abt Associates Inc., 2009.

Grogan, Bruce. *Rebuilding Basic Health Services Project (RBHS): Year 2 Assessment.* Washington DC: Global Health Technical Assistance Project, 2011.

Guthrie, B., Glenna Auerback, and A. Binman. "Competition for Medicaid enrolles based on performance does not improve quality of care." *Health Affairs* 29, no. 8 (2010): 1507-1516.

Gyapong, John, Bertha Garshong, James Akazili, Moses Aikins, Irene Agyepong, and Frank Nyonator. "Critical Analysis of Ghana's Health System: Focus on Equity Challenges and the National Health Insurance." University of Cape Town, April, 2007.

Health Systems Action Network. *Website.* 2006. www.hsanet.org (accessed 2006).

Ikegama, N. "Japan - World Bank Partnership Program on Universal Health Coverage: Concept note for the research program in Japan – health finance and human resources for health ." 2011.

Ikegami, N. "All payor rate setting: the Japanese experience." 2011.

Jacob Hughes, Amanda Glassman, and Walter Gwenigale. *Innovative Financing in Early Recovery: The Liberia Health Sector Pool Fund.* Washington DC: The Center for Global Development, 2012.

Kayonga, Caroline (Permanent Secretary, Ministry of Health, Rwanda). "Towrads Universal Health Coverage in Rwanda." *Brookings Glboal Economy and Development.* Brookings Institution, 2007.

Kutzin, Joe. "Sustaining universal coverage: concepts, implications, provocations." *Fiscal dimensions of universal health coverage: a conversation about country experiences.* Washington, D.C.: The World Bank, 2011.

Kutzin, Joseph, Ainura Ibraimova, Melitta Jakab, and Sheila O'Dougherty. "ismarck meets Beveridge on the Silk Road: coordinating funding sources to create a universal health financing system in Kyrgyzstan." *Bulletin of the World Health Organization* 87, no. 7 (2009): 549-554.

Lagomarsino, Gina, Stefan Nachuk, and Sapna Singh Kundra. *Public stewardship of private providers in mixed systems: Synthesis report from the Rockefeller Foundation-sponsored initiative on the role of the private sector in health systems.* Washington, D.C.: Results for Development Institute, 2009.

Langenbrunner, J., and Aparnaa Somanathan. *Financing health care in East Asia and the Pacific: best practices and remaining challenges.* Washington, D.C.: World Bank, 2011.

Langenbrunner, John, Cheryl Cashin, and and Sheila O'Dougherty. "What, how, and who: an introduction to provider payment systems." In *Designing and implementing health care provider payment systems: how-to manuals*, by Langenbrunner J, Cashin C and and O'Dougherty S (eds.), 1-26. Washington, D.C.: The World Bank, 2009.

Liberia, Ministry of Health and Social Welfare of. *Liberia Health Sector Partnersip Forum Report.* Washington DC: USAID, 2007.

Lu, Chunling, et al. "Towards Universal Health Coverage: An Evaluation of Rwanda Mutuelles in its First Eight Years." *PLoS ONE* 7, no. 6 (June 2012).

Matteo, Livio Di, and Rosanna Di Matteo. *The fiscal sustainability of Canadian publicly funded health care systems and the policy response to the fiscal gap.* CHSRF series of reports on financing models: Paper 5, Ottawa: Canadian Health Services Research Foundation, 2012.

Mbengue, Cheikh. "Revitalizing Community-based Health Insurance in Africa Toward Universal Coverage." Health Systems 20/20 Project, Abt Associates Inc., February 28, 2011.

McIntyre, D., et al. "Beyond fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic of Tanzania." *Bulletin of the World Health Organization* 86, no. 11 (2008): 817-908.

McIntyre, Diane, et al. "Beyond fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic of Tanzani." *Bulletin of the World Health Organization* 85, no. 11 (2008): 817-908.

Mills, Anne, et al. "Equity in financing and use of health care in Ghana, South Africa, and Tanzania: implications for paths to universal coverage." *The Lancet* 380, no. 9837 (July 2012): 126-133.

Mossialos, E., A. Dixon, J. Figueras, and J., eds. Kutzin. *Funding Health Care: Options for Europe.* Edited by European Observatory on Health Care Systems. Buckingham: Open University Press, 2002.

Preker, Alexander S., Guy Carrin, David Dror, Melitta Jakab, William Hsiao, & Dyna Arhin-Tenkorang. "Effectiveness of community health financing in meeting the cost of illness." *World Health Organization Bulletin*, 2002: 143.

Results for Development Institute. *UHC Forward: Towards Universal Health Coverage.* 2011. http://uhcforward.org/ (accessed August 2012).

Saksena, Priyanka, Adélio Fernandes Antunes, Ke Xu, Laurent Musango, and Guy Carrin. "Impact of mutual health insurance on access to health care and financial risk protection in Rwanda." World Health Organization, March, 2010.

Schneider, Pia, Francois Diop, and Charlotte Leighton. "Pilot Testing Prepayment for Health Services in Rwanda: Results and Recommendations for Policy Directions and Implementation." March, 2001.

Senauer, Katie, and Cheikh Mbengue. *Scaling Up Community-Based Health Insurance in Mali.* Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc. , 2012.

Sharan, Mona, Saifuddin Ahmed, John May, and Agnes Soucat. "Ch. 25 - Family Planning Trends in Sub-Saharan Africa: Progress, Prospects, and Lessons Learned." In *Yes Africa Can*, 445-464. The World Bank, 2011.

The Commonwealth Fund. "The Australian health Care System, 2009." In *International profiles of health care systems: Australia, Canada, Denmark, England, France, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States*, by J. Hall, D. Squires and (ed.), 8-11. Washington, D.C., 2010.

The World Health Organization. "The World Health Report - Health Systems Financing: The path to universal coverage"." Geneva, Switzerland, 2010.

U.K. Department of Health. "Resource allocation: weighted capitation formula." 7th Edition, London, 2011.

USAID. *USAID website.* 2012. http://www.usaid.gov/our_work/global_health/hs/ (accessed April 2012).

Wang, Hong, and Nancy Pielemeier. "Community-Based Health Insurance: An Evolutionary Approach to Achieving Universal Coverage in Low-Income Countries." *Journal of Life Sciences*, March 2012: 320-329.

Wang, Hong, Kimberly Switlick, Christine Oritz, Catherine Connor, and Beatriz Zurita. "Africa Health Insurance Handbook—How To Make It Work." Health Systems 20/20 Project, Abt Associates Inc., Bethesda, MD, June 2010.

WHO. "Public tensions, private woes in Chile." *Bulletin of the World Health Organization* 86, no. 11 (2008): 825.

WHO. *World Health Statistics 2012*. Geneva: World Health Organization, 2012.

Witter, Sophie, and Bertha Garshong. "Something old or something new? Social health insurance in Ghana." *BMC International Health and Human Rights*, August 2009.

World Bank. *Health partnerships: how governments can engage the private sector to improve health in Africa.* Washington, D.C.: International Bank for Reconstruction and Development /The World Bank, 2011.

World Health Organization. *Success Stories of Health Financing Reforms for Universal Coverage: Ghana.* World Health Organization, 2011.

World Health Organization. *Success Stories: Building from the bottom up, steering and planning from the top - Rwanda.* World Health Organization, 2011.

Xu, Ke, David B Evans, Kel Kawabata, Riadh Zeramdini, Jan Klavus, and Christopher J L Murray. "Household catastrophic health expenditure: a multicountry analysis." *The Lancet* 362 (July 2003): 111-117.

Xu, Ke, Pryanka Saksena, Matthew Jowett, Chandika Indikadahena, Joe Kutzin, and David Evans. *Exploring the thresholds of health expenditure for protection against financial risk.* World Health REport, Geneva: World Health Organization, 2010.

Health Systems 20/20 is USAID's flagship project for strengthening health systems worldwide. By supporting countries to improve their health financing, governance, operations, and institutional capacities, Health Systems 20/20 helps eliminate barriers to the delivery and use of priority health care, such as HIV/AIDS services, tuberculosis treatment, reproductive health services, and maternal and child health care.

Abt Associates Inc. leads a team of partners that includes:

Aga Khan Foundation | Bitrán y Asociados | BRAC Universit | Broad Branch Associates | Deloitte Consulting, LLP | Forum One Communications | RTI International | Training Resources Group | Tulane University School of Public Health

www.healthsystems2020.org | E-mail: info@healthsystems2020.org

Abt Associates Inc. | www.abtassociates.com
4550 Montgomery Avenue, Suite 800 North | Bethesda, MD 20814 USA

Recommended citation: Sharma, Nithya, Sayaka Koseki. 2012. ***The Path to Universal Coverage in Africa: Focus on Community-based health Insurance***. Health Systems 20/20 Brief. Bethesda, MD: Abt Associates Inc.

DISCLAIMER: The author's views expressed here do not necessarily reflect the views of the United States Agency for International Development or the United States Government.