



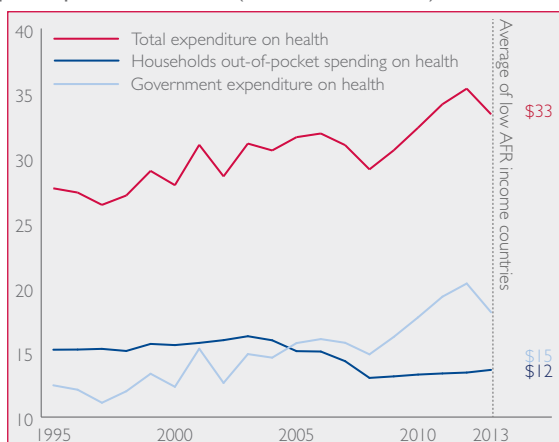
# HEALTH FINANCING PROFILE: BENIN

## Key country indicators

Development indicators*	
Total population	10,323,000
Total fertility rate (births per woman)	4.8
Gross national income per capita (PPP)	1,780
Health care expenditure indicators**	
Expenditure ratio	
Total expenditure on health as % of GDP	4.6% ↓ avg. low-income countries (5%) ↓ global avg. (9.2%)
Level of expenditures	
General government expenditure on health as % of total government expenditure	10.7% ↓ targets set by Abuja Declaration (15%)
Selected per capita indicators	
Per capita total expenditure on health (PPP int.\$)	82
Per capita government expenditure on health at average exchange rate (US\$)	20
Per capita government expenditure on health (PPP int.\$)	44
Sources of funds	
General government expenditure on health as % of total expenditure on health	54.2%
Private expenditure on health as % of total expenditure on health	45.8%
External resources for health as % of total expenditure on health	23.2%
Out-of-pocket expenditures as % of private expenditure on health	89.2%

Note: WHO aggregates are calculated using absolute amounts in national currency units converted to Purchasing Power Parity (PPP) equivalents

## Per capita expenditure in US\$ (constant 2013 US\$)\*\*



\*World Health Organization (WHO) Global Health Observatory, 2015

\*\*WHO Global Health Expenditure Database, 2013

## Contextual Factors

Since the democratic elections of 1991, Benin has been one of the most politically stable countries in West Africa.<sup>1</sup> However, the Beninese population continues to face socioeconomic challenges, including on many health indicators. In particular, the total fertility rate remains high at 4.8 births per woman, and use of family planning methods is low.<sup>2</sup> Benin currently has a population of 10.6 million.<sup>3</sup> The economy is based largely on agriculture, with 56% of the population working or involved in this sector. With an urbanization rate of 1% per year, the population of Benin is currently 43% urban and is expected to reach 50% by 2017. According to the UNDP 2015 Human Development Index, Benin ranks 166 out of 177 countries, with the majority of the population (51.6%) living below the poverty line (PPP int.\$1.25 a day). Life expectancy at birth of the average Beninese is 59.6 years.

The health system in Benin has traditionally focused on the public sector, with a history of strict regulatory measures and centralized decision-making.<sup>4</sup> The country's 12 departments are divided into 34 health zones. These health zones contain one to four communes and are managed by health zone committees and health zone management teams. Each zone has department health centers, commune health centers, and a hospital. A health zone office oversees all public and private health entities within a given zone, including private and public hospitals, clinics, and pharmacies.

The existence of a private health sector in Benin is a relatively new development that is quickly growing as a result of several factors including accelerated urbanization and poor access to and quality of public services. With 50% of the population expected to be urban or peri-urban by the year 2017, the demand for health services is likely to increase significantly. It is expected that the public sector will not be able to respond to the growing demand in the urban and peri-urban areas. This may result in the growth of private health care facilities operated by modern providers as well as traditional healers. With rising urbanization, there is increasing recognition of the private sector as an important player in Benin's health sector. Additionally, the private health sector has significant untapped potential to speed up progress toward expanding the population's access to health care.

In an environment in which the majority of the population has little or no access to healthcare insurance, the existence of mutual health organizations (MHOs) has also increased in Benin since 2001 with the support of bilateral (France, United States, Belgium, Switzerland, and Denmark) and multilateral (ILO) agencies.<sup>5</sup> In 2008, there were approximately 135 MHOs in the country.

Benin's *Plan National de Developpement Sanitaire* (National Health Development Plan) lays out a ten-year strategy (2009-2018) focused on achieving universal health coverage (UHC). The national policy document is translated into Triennial Development Plans. The objectives of the document are: i) to ensure universal access to quality health care and provision of quality health care for the attainment of the MDGs; ii) improve partnerships for health; and iii) improve governance and health resources management.

The constitution of Benin establishes health as a human right. In addition, the right of health for every citizen is emphasized in the Growth and Poverty Reduction Strategic Document, from which the national health policy document originated. In line with the goal of achieving UHC, the National Health Insurance Scheme, commonly known as RAMU (*Régime d'Assurance Maladie Universelle*) was officially launched in December 2011 in a pilot phase. The basic principles of the RAMU are the following:

- Universal health coverage
- Contributory approach
- National solidarity
- Responsibility and involvement of the government
- Equity
- Participatory management
- Efficiency

## Health Financing Functions

■ **Revenue contribution and collection:** Traditional sources of health financing include government contributions, social security contributions from eligible employees, employers and those subject to income tax, development partners, and other donations. Non-traditional sources of health financing have been considered for RAMU as well and examples include VAT tax as well as taxes on tobacco and alcohol purchases.

■ **Pooling:** The Government of Benin is currently in the first phases of implementing RAMU to extend health insurance coverage beyond government employees, individuals with private insurance, and health mutuals. Coverage is mandated for the entire population. RAMU will incorporate existing health insurance schemes, including health mutuals, under an umbrella structure. To help streamline the process the government of Benin intends to work with health mutuals that are already federated and encourage those that are not to become federated, providing participation in RAMU as the incentive.

The proposed implementation plan of the RAMU will first include the formal sector. The informal sector is expected to be integrated through the mutual community health insurance (CHI) schemes that are already in place. The monthly premiums for RAMU members are estimated to range from US\$3 to US\$30 and are expected to be paid in regular installments. The proposed benefit package includes primary care, hospitalization, pharmaceuticals, lab tests, mandatory vaccines, and pre- and postnatal care for expecting mothers.

Community health insurance (CHI) schemes currently cover only 5 percent of the population; there are about 200 schemes active in the country, as opposed to the MOH-projected 2,000 schemes by the year 2012. The involvement of CHIs in the development of RAMU has been slight. The schemes, often implemented with the support of international development partners, do not appear to be working as a united group and are not recognized as a relevant actor in the conceptualization and implementation of universal health insurance.

■ **Purchasing:** At almost 90% of all private expenditure on health, out-of-pocket expenditures are the predominant method of purchasing health services. However, recent efforts to include results-based financing (RBF) through the World Bank and other partners have aimed to strengthen the quality and utilization of

healthcare services. Health facilities receive quarterly payments based on achieved results, especially those regarding maternal and child health. Payments take place after the quality and quantity of care reported are verified both internally and externally. Half of the health facilities have autonomy to decide how to use the RBF payments. An additional incentive to health providers for treating the poor is planned to be provided in the near future to enhance the utilization of these services by the poorest.<sup>6</sup>

## Meeting the Goals of Universal Health Coverage (UHC)

UHC can only be achieved when access to health services and financial risk protection are equitably addressed. Equitable financial protection means that everyone, irrespective of their level of income, is free from financial hardship caused by using needed health services.

### *Financial protection and equity in financing and utilization*

Out of the 34 health zones in Benin, 30 are currently fully functional.<sup>7</sup> Health coverage is relatively high at 77%, although this rate includes inequity in the distribution of health centers, with rural areas having fewer health services than urban areas. The World Health Organization's (WHO) Global Health Observatory estimates that Benin's total health spending was PPP int.\$82 per capita in 2013. Of this figure, 41% was paid by household out-of-pocket spending, placing a significant burden on those living in poverty.<sup>8</sup>

Human resources for health is a major health system problem in Benin, particularly in regards to quantity, quality, and distribution. It adversely affects the quality of health services throughout the country. Benin has embarked on an ambitious initiative for UHC, with strong commitment and involvement of the national authorities at the highest levels; however, the health system faces significant challenges including governance, human resources, infrastructure, management capacity, and adequate information systems that must be addressed in order to scale up implementation.

The RAMU scheme is not likely to reach the entire population, especially those living in rural areas. Existing schemes in Benin cover roughly 20% of the population, putting the vast majority of residents at risk of catastrophic health spending in times of ill health.<sup>9</sup> Therefore there is an urgent need for scale up of RAMU to reach the entire population and to achieve health coverage of rural and poor populations.<sup>10</sup>

### Endnotes

1. [Benin Country Profile](#). Jhpiego. 2012, Johns Hopkins University.
2. [The World Bank World Development Indicators](#), 2013.
3. [Human Development Report 2015](#), UNDP.
4. [SHOPS Project, Benin Private Health Sector Assessment](#), 2013.
5. Anne-Marie Turcotte-Tremblay, Slim Haddad I, Ismaïlou Yacoubou and Pierre Fournier. [Mapping of initiatives to increase membership in mutual health organizations in Benin](#). *International Journal for Equity in Health* 2012, 11:74.
6. [RBF Health: Benin](#). The World Bank Group.
7. [Country Cooperation Strategy](#), 2014. World Health Organization.
8. [World Health Organization Expenditure Database](#), 2013.
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10. Tapscott, Rebecca. [Improving Access to Health for Rural Populations: A Study of CRS' Health Microinsurance Pilot in Benin](#), 2012, Catholic Relief Services.

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