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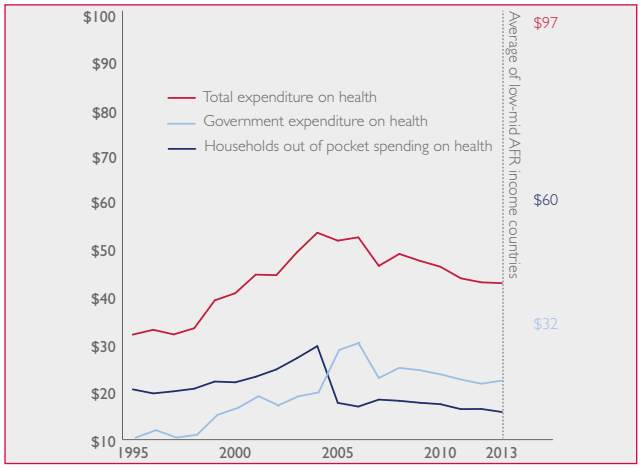
HEALTH FINANCING PROFILE: SENEGAL

Key country indicators

Development indicators*	
Total population**	13,926,253
Total fertility rate (births per woman)	4.9
Gross national income per capita (PPP)	2,240
Health care expenditure indicators* **	
Expenditure ratio	
Total expenditure on health as % of GDP	4.2% ↓ avg. low-income countries (5%) ↓ global avg. (9.2%)
Level of expenditures	
General government expenditure on health as % of total government expenditure	7.6% ↓ targets set by Abuja Declaration (15%)
Selected per capita indicators	
Per capita total expenditure on health (PPP int.$)	96
Per capita government expenditure on health at average exchange rate (US$)	24
Per capita government expenditure on health (PPP int.$)	50
Sources of funds** **	
General government expenditure on health as % of total expenditure on health	39.6%
Private expenditure on health as % of total expenditure on health	48.0%
External resources for health as % of total expenditure on health	17.3%
Out-of-pocket expenditures as % of private expenditure on health	76.0%

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$)**



Contextual Factors

The 2005 National Health Accounts (NHA) estimates that, in Senegal, public health expenditure makes up 52% of total health spending, the private sector accounts for nearly 48% of total health expenditures, and external sources constitute almost 3.1%. Nearly 43% of total health expenditures is via out-of-pocket payments made directly by households. Half of this amount is used for the purchase of drugs, followed by payments for traditional healers.[1]

Decentralization reforms have allowed for the public sector to engage with private for-profit and non-profit sectors, through partnerships between government (central and local authorities) and community-based or nongovernmental organizations. Since the 1990s, reform changes aimed at extending coverage to unreached sectors of the population have primarily targeted seniors above the age of 60 and pregnant women for caesarian care. User-fees were implemented for services delivered at government health facilities, and by the 2000s, financial constraints were recognized as an important barrier to the use of health services.

In 2013, Senegal launched its Universal Health Coverage (UHC) program. Senegal's UHC Strategic Plan for 2013-2017 incorporates elements of coverage expansion and risk pooling to reduce inequity and vulnerability. The framework incorporates four strategic pillars[2]:

- Reforming the *institutions de prévoyance maladie*, the social health insurance organizations covering employees of the formal sector and their families;
- Expanding health coverage for people employed in the informal and rural sectors through community-based health insurance (CBHI) organizations and the financial support of state and local governments;
- Strengthening existing policies which exempt the elderly and pregnant women from paying for care; and
- Implementing a new policy which would provide free care for children under-five years of age.

The UHC Strategic Plan is funded through a combination of government subsidies, household contributions, and external funding from development partners. To streamline management of these funds, the government has established two main entities: the National Health Solidarity Fund (*Fonds National de Solidarité Santé*) and the Independent Fund for Universal Social Protection (*Caisse Autonome de Protection Sociale Universelle*). These funds play a central role in strengthening the sustainability and improving the service packages of mandatory, community, and medical assistance schemes. They have become the primary financing instruments for expanding coverage in the informal sector by subsidizing free care for exempt groups.[1]

*World Health Organization (WHO) Global Health Observatory, 2013 **National Agency of Statistics and Demography of Senegal (ANSD), 2014
***WHO Global Health Expenditure Database, 2013 ****Senegal Ministry of Health, 2008

Health Financing Functions

- ***Revenue contribution and collection:*** Analyses of the flow of funds for the health sector between 2006 and 2008 show that the central government and households are the biggest payers of health care services. These payers, which can be divided into public (central/decentralized government, *Institut de Prévoyance Retraite du Sénégal* or IPRES, civil servants fund, and employers) and private entities (*Institut de Prévoyance Maladie* or IPM, *mutuelles,* private insurance firms, households, employers, not-for-profit organizations, and donors), bear significantly different costs for health services. The Ministry of Health (MoH) and households are the primary public and private contributors, spending on average 74% and 77% of public and private expenditures on health, respectively.[3] Per capita health expenditure increased from US$49 in 2006 to US$66 in 2008.[4] Increased public revenue collection from the healthy and wealthy, such as through CBHI, can enhance cross-subsidization and risk pooling. Efficient systems of taxation and premiums that take into account individuals' income levels must be implemented to eliminate payments at points of service delivery.

- ***Pooling:*** There are multiple pooling mechanisms in Senegal, contributing to a fragmented, complex, and inequitable environment. Overall, an estimated 25-30% of the population is covered by schemes made up of an array of funds and payers, which mostly provide coverage to employees and retirees in the formal public and private sectors.[1] People not covered by health insurance face out-of-pocket expenses to access care.

The government covers civil servants and public sector employees. The two payers, IPM and IPRES, provide coverage for private sector employees, retirees, and their families.[1] Another government-run health insurance scheme, *Plan Sésame*, is funded through taxes and provides 100% medical coverage for seniors 65 years and over, regardless of prior professional activity.

Senegal has also seen the development of numerous CBHI schemes, or *mutuelles*, for rural and informal sector workers representing 80% of the population. There are 130 different CBHI schemes, but coverage remains low at 4% of the overall population and 14% of the targeted population.[5] Plans and premiums vary by *mutuelles*, but coverage for primary care is most commonly offered. Efforts to organize or consolidate CBHI schemes into national health insurance plans are needed. Most *mutuelles* operate independently and therefore have no obligation to standardize costs or benefits. The National Health Solidarity Fund will provide a general subsidy for services offered through *mutuelles* and seeks to promote overall membership.[6]

- ***Purchasing:*** Public health care providers are paid on a fee-for-service basis, with payment dependent on an annual global budget. Important backlogs of unpaid fees result in financial debt for the majority of public providers. Public health facilities struggle to manage financial constraints with a constant demand for services, often leading to demotivation among health providers and low quality services.

With support from external donors, a performance-based financing (PBF) program currently in place allows Senegal's Ministries of Finance and Health to co-finance a package of services and improve the quality and accessibility of care. Under this program, health facilities would receive money based on the achievement of incentivized indicators.[7] Such PBF mechanisms have been recognized to improve health indicators, increase motivation among health workers, and improve facility conditions.[8]

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

The government has demonstrated a desire to institutionalize the monitoring of UHC by including indicators for the coverage of health insurance schemes in future Demographic and Health Surveys. The 2013-2017 UHC Strategic Plan also aims to gather outcome-level indicators to better assess equity in access to health care services and financial protection. [1]

Analyses of health care access and insurance coverage indicate that more formal sector workers have coverage than rural residents and the informal sector. Estimates from the MoH show that 3% of households in rural areas belong to the highest economic quintiles, compared to 44% of those in urban areas.[1] Furthermore, nearly 35% of the population faces impoverishment due to the heavy burden of out-of-pocket payments such as user fees.[1]

As Senegal expands coverage through national health insurance and *mutuelles*, it must anticipate ways of tackling the issues of equitable enrollment, adverse selection, and the increase in the demand for health services so as to maximize potentially positive impacts on financial protection.

Endnotes

1. Tine J, Hatt L, Faye S and Nakhimovsky S. Universal Health Coverage Measurement in a lower middle-income context: A Senegalese Case Study. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc. April 2014
2. Abt Associates. President of Senegal launches Universal Health Coverage Program. 10/7/2013.
3. Sylla S. Analysis of Senegal's Health Financing System: Implications for Health Financing Reform and Universal Health Coverage. Rollins School of Public Health of Emory University. Atlanta, GA. 2014.
4. The World Bank, WB. (2014a). Data/ Health Expenditure per Capita (current US$).
5. Mladovsky P, Ndiaye P. Solidarity in community-based health insurance: rhetoric or reality? African Health Monitor. Issue #20. October 2015.
6. Mbengue CSA, Sene Mbaya and Camara M. Political winds blow a new life into Senegal's Mutuelles de Sante. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc. October 2014
7. Vergeer P and McCune S. How governments and development partners can jointly support results-based financing to improve health outcomes and strengthen health systems. World Bank Group. Washington, DC. December 2013.
8. Wadji Ly N and Hatt L. Results-based financing in Senegal: What have we learned so far? Bethesda, MD. Abt Associates. September 2014.

Additional information can be obtained from:
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