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Analysis of Key Documents on Universal Health Coverage in Madagascar

Local Health System Sustainability Project
Task Order 1, USAID Integrated Health Systems IDIQ

LOCAL HEALTH SYSTEM SUSTAINABILITY PROJECT

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The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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Contents

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Acronyms

AMO	Compulsory Heath Insurance
CA-CSU	UHC Support Unit
CNSS	National Health Solidarity Fund
DAS	Health Insurance Scheme
EPA	Public Administration Establishment
FANOME	Non-Stop Supply of Medicines
FSS	Health Solidarity Fund
LHSS	Local Health System Sustainability
MINSANP	Ministry of Public Health
NGO	Non-governmental Organization
OPASS	Public Health Insurance and Solidarity Body
PARN	Nutritional Outcomes Improvement Project
PFUS	Financial Protection for Users of Health Services
PMO	Implementation Plan
SNFS	National Health Financing Strategy
SN-CSU	National UHC Strategy
UGSS	Health Solidarity Management Unit
UHC	Universal Health Coverage

1. Background and Objective

The Government of Madagascar has highlighted its commitment to achieving Universal Health Coverage (UHC) through its 2015 National UHC Strategy (SN-CSU). One of the priority objectives of this strategy was to create a national insurance scheme called the National Health Solidarity Fund (CNSS), which would gradually integrate existing financial protection mechanisms into a single purchaser mechanism. This fund was piloted in a few districts but not scaled up due to the lack of supportive regulations.

Several partners support the government's efforts to achieve UHC, but there lacks coordination. The UHC Implementation Support Unit (CA-CSU) within the Ministry of Public Health (MINSANP) has the mandate to define strategies and roadmaps to achieve UHC, as well as to coordinate and engage stakeholders to achieve UHC objectives. Development of the Implementation Plan of the National UHC Strategy (PMO SN-CSU) began in 2018 but it has not been finalized. Many related studies and analyses have also been carried out, but these efforts have not led to decisions and commitment so that all actors can meet the needs of the CA-CSU.

The Health Policy Plus project helped MINSANP analyze the health financing system to guide future reforms and supported the development of the National Health Financing Strategy (SNFS). Efforts are also underway to draft a financial protection law that would likely incorporate the draft decree on *mutuelles* (community-based health insurance schemes) and other existing financial protection regimes. The World Bank conducted an analysis of existing financial protection mechanisms to design a new Health Insurance Scheme (DAS) model that incorporates the voucher system, *mutulles*, and strategic purchasing. This model has not yet been approved but should be implemented in the regions covered under the Nutritional Outcomes Improvement Project (PARN). A communication plan on UHC is also being developed to support the Implementation Plan of the National Health Financing Strategy (PMO SNFS).

A key role of the CA-CSU is to update the information at its disposal, such as the various UHC initiatives, to advance UHC-related reforms. USAID Madagascar's support to MINSANP, through the Local Health System Sustainability (LHSS) project, is therefore strengthening CA-CSU's capacity to carry out its mandate, for example to (i) analyze the various studies and analyses that stakeholders have supported and (ii) coordinate and mobilize stakeholders for the development of the Implementation Plan of the National UHC Strategy, focusing on financial protection.

The objective of this analytical report is to support the CA-CSU in updating the PMO SN-CSU. Specifically, the objectives of the analysis report are to:

- Synthesize key UHC-related documents in Madagascar, especially those that directly support financial protection for health
- Identify information gaps and disparities to achieve the SN-CSU objectives, and
- Propose recommendations.

2. Methodology

LHSS reviewed more than 20 documents on government policies and current priorities; health policies and strategic documents; and UHC in Madagascar. A full list of documents is in Annex A.

Five key documents were selected for an in-depth analysis, given their relevance to increasing financial protection for health. These documents are:

1. National Strategy on Universal Health Coverage, 2015 – SN-CSU
2. Implementation Plan of the UHC National Strategy: 2020-2024 – PMO SN-CSU (Version November 23, 2021)
3. Validated version of the National Health Financing Strategy in Madagascar – SNFS (Version February 25, 2022)
4. Law N°/ 2021 on Financial Protection for Users of Health Services – Law PFUS (Version November 23, 2021)
5. Health Financial Protection pilot, as part of the Nutritional Outcomes Improvement Project (PARN)/World Bank, 2021

The documents studied are complementary and therefore not directly comparable. The analysis consists of identifying the consistency between documents, information gaps and disparities between them, and recommends strategic and operational choices to be made.

Three documents, the SN-CSU, SNFS, and PARN pilot, were the subject of discussions and analysis during meetings with the CA-CSU team. The objectives of the meetings were to:

- Improve participants' knowledge of the contents of the documents and ensure a common level of understanding among the CA-CSU staff,
- Assess the logical framework of UHC,
- Identify disparities and areas for resolution,
- Develop strategies to address disparities and advance UHC, and
- Assist the CA-CSU in conducting strategic discussions on the PMO SN-CSU.

3. Summary of Key Documents

Table 1 at the end of this chapter summarizes the five key documents and high-level observations.

3.1. National Strategy for Universal Health Coverage, 2015

The SN-CSU comprises six strategic directions: 1) Protection against financial risks, 2) Improvement of services, 3) Reduction of environmental risks, 4) Resource mobilization for UHC, 5) Incorporating citizens' wishes, and 6) Providing a basic level of social and health protection for the extreme poor.

Given the SN-CSU's cross-cutting nature, the creation of a steering committee is proposed in the document. An operational unit to support the implementation of UHC (namely, the CA-CSU) is also proposed to avoid any dispersion of activities. The strategy proposes that the most important and significant implementation step is the gradual implementation of a Health Insurance Scheme (DAS) that incorporates three groups:

1. Members of the civil service and workers in the formal sector via a Compulsory Health Insurance (AMO) mechanism
2. Members, on a voluntary basis, hitherto managed by *mutuelles*
3. Members of target groups, including the poor population

The SN-CSU addresses but does not specifically define the role of mutuelles: "it is thus necessary to reflect on the place of mutuelles in the DAS" (SN-CSU 2015, 25). Additionally, "the feasibility and operational strategic direction will require an in-depth study. Such a feasibility study will therefore be started as soon as possible" (SN-CSU 2015, 25).

In this way, it proposes two priority actions:

1. Discussions and agreement on the role of *mutuelles* in the DAS
2. A feasibility study on the mechanism (DAS) developed

3.2. Implementation Plan of the National UHC Strategy: 2020-2024 (Version November 2021)

The 2020-24 PMO SN-CSU outlines the steps necessary to implement the SN-CSU. However, because the scope of the strategy is so broad, finalizing the implementation plan is proving difficult. MINSANP strategic directorates have updated it over time, with different drafts. For example, the PMO SN-CSU proposes the creation of a technical monitoring committee for the SN-CSU, which would link the steering committee and the CA-CSU; this committee has not yet been set up. The latest available version of the implementation plan, 2021, is partially budgeted. As mentioned above, the role of *mutuelles* is not defined in the SN-CSU. The PMO SN-CSU still mentions scale-up of the CNSS, a body based on voluntary membership, which was created in 2017, implemented in 2018, and abandoned in 2020. It also proposes innovative financing and recommends reforms to compulsory insurance (AMO) to improve the performance of these schemes for public servants and workers in the formal sector.

3.3. National Health Financing Strategy, February 2022 version

As previously mentioned, the CNSS was abandoned in 2020. Its failure was due in part to its lack of a legal framework. Thus, the first step proposed in the National Health Financing Strategy is to draft a social protection law (SNFS 2022).

The SNFS is a crucial step toward UHC in Madagascar. It responds to the SN-CSU's plan to develop the national Health Insurance Scheme. The SNFS structure follows one of the logical frameworks of health financing: mobilization of funds, pooling of resources, and allocation or purchasing. The SNFS structure has four strategic areas:

1. Increase total health care spending from US$20 to $60 per capita per year by 2030
2. Improve the pooling of resources and strengthen protection against health-related financial risks
3. Develop strategic purchasing
4. Improve the efficiency of expenditures for better health outcomes

As part of the first strategic area—and in alignment with the SN-CSU—the SNFS proposes the creation of a Public Health Insurance and Solidarity Body (OPASS) to replace the CNSS and a Health Solidarity Fund (FSS) to enable the most disadvantaged populations to join the OPASS. Reform of current health financing schemes for the formal public and private sector is also encouraged and aligns with the PMO SN-CSU. The SNFS proposes strengthening the existing equity funds until the OPASS is functioning effectively; doing this requires better supervision, an information campaign to publicize the funds, and a 'passive' approach to identifying beneficiaries. As part of the third and fourth strategic areas of the SNFS, the OPASS is also responsible for the implementation of strategic purchasing. This is logical but will require capacity development. The SNFS makes no detailed proposal on the relationship between or merger of the OPASS and the existing *mutuelles* or the coordination of the OPASS and strategic purchasing.

The SNFS proposes the following timeline for the development of the DAS (see also Figure 1):

- From 2021 to 2022, the development and endorsement phase of the Financial Protection Law will be completed; the law will be submitted by the Government to Parliament and becomes a law.
- From 2022 to 2025, the DAS will be set up, composed of two bodies, namely:
    - The OPASS, which is proposed as, possibly, the only mechanism overseeing the different protection schemes with the intent of merging publicly financed schemes
    - The FSS
- From 2025 to 2030, the rapid development of health insurance, which will include:
    - The scale-up of the OPASS to the district level
    - The initiation and validation of reform of the civil servants' health system
    - The initiation and validation of reform of the AMO of the formal private sector

Figure 1. Estimated Timeline for the Development of Health Insurance in Madagascar

The governance structure of the SNFS follows the structure outlined in the PMO SN-CSU. The same steering committee could support the implementation of the SN-CSU and the SNFS, as the SNFS is an integral part of the SN-CSU.

3.4 Law No. / 2021 on Financial Protection for Users of Health Services, November 2021 version

The draft law is the first step recommended by the SNFS to set up the DAS, as a result of the lessons learnt with the CNSS. The law aims, on the one hand, to simplify and strengthen the national institutional framework, and, on the other hand, to preserve, expand, and institutionalize the principles of national solidarity, equity, and universality as defined in the Malagasy Constitution.

The draft law follows the outline of the SN-CSU and SNFS. It stipulates that "All Malagasy must be affiliated to a health insurance organization regardless of the scheme and receive an insurance card" (Law No. / 2021, November 2021, 11). This is the first and only mention of mandatory insurance in the documents studied. As per the SNFS, the law proposes three approaches:

1. Affiliation/assistance by the State and free health services established by this law and financed by a fund, which would cover the most vulnerable populations
2. Compulsory AMO schemes, which would cover State employees, workers in the formal sector, and students
3. Voluntary schemes, managed by the OPASS

The draft law proposes a single package of services and health care for all. It defines the high-risks beneficiaries as follows:

- Any person meeting vulnerability criteria defined by regulations
- Any person over the age of 65
- A child under 5 years of age

- Any person who is not able to contribute to the OPASS, regardless of socio-economic status or possession of valid administrative documents, by the sole fact that they are a Malagasy national, on the territory of Madagascar

The law details the administrative organization and functioning of the OPASS stating, “a Public Health Insurance and Solidarity Body is created, which is a national public institution with a vocation of health insurance for the entire Malagasy population, with legal administrative and financial autonomy.” The OPASS will be responsible for:

- Collecting and managing members' contributions, including transfers from the FSS to enrolled vulnerable persons, transfers from the State budget, and managing aid and miscellaneous donations,
- Establishing contracting agreements with service providers for the care of its members,
- Reimbursing the costs of health care and services provided to members and affiliates through the contracted service providers,
- Ensuring the transparency of the financial management and assets of the OPASS, while establishing a monitoring system involving all donors of funds,
- Checking the conformity of the services and care authorized and delivered by level of service with the reimbursement requests issued by the providers, and
- Informing and raising public awareness on the procedure for becoming a member of the OPASS.

As part of the implementation of the affiliation/assistance scheme, the FSS is also created. The FSS is a public administrative establishment with a legal framework. Its creation, organization, and operation will be determined by regulation.

The law also defines and details the framework for the creation and operation of *mutuelles*.

3.5. World Bank's Financial Protection Pilot, December 2021 version

The overall objective of this World Bank-funded pilot is to provide and test a health financial protection mechanism (“the pilot”) for the eight target regions of the Nutritional Outcomes Improvement Project, and to develop strategies for its extension and sustainability. The Pilot proposes an architecture that evolves in phases over five years. An NGO, the Health Solidarity Management Unit (UGSS), is proposed that gradually takes over the management of the three components starting with the *Mutuelles*. The three components are:

1. *Mutuelles*
2. Free health care and subsidized care
3. Strategic purchasing

The process for the Pilot is supported by a Project Coordination Unit. The unit, as the main recipient of funds from the technical and financial partners, is responsible for coordinating and supervising stakeholders. Thus, its creation and performance are critical.

The NGO structure of the UGSS should make it possible to (a) strengthen the confidence of members, (b) strengthen the good governance of funds, and (c) strengthen donor oversight of funds. The main mission of the UGSS is to:

- Provide basic and local insurance coverage, following existing regulations, for its voluntary members and those affiliated or sponsored by other organizations
- Provide free care to specific target population in accordance with the guidelines of the State's general health policy
- Manage, with a vision to improve the quality of the health care services, the financing based on the performance of health facilities

The Pilot details the functioning of the individual *mutuelle* at the health facility level. *Mutuelles* are formed into a union or federation at the regional level to eventually evolve into a national federation. An agent of the *mutuelle* is responsible for the identification and enrollment of beneficiaries at the level of the *fokontany* (village). The Pilot proposes to set up co-payments for members who are not vulnerable, even with a symbolic participation of 10 percent, or a floor or cap fee.

The payment of health facilities under contract with the Pilot should be straight forward for Public Administrative Establishments (EPA), or government health facilities. For other health facilities, the Pilot offers a payment method similar to the current "voucher" mechanism. The mechanism can process payments of non-EPA health facilities under contract, using the account for Financing of the Non-Stop Supply of Medicines (FANOME), pending the setting up of the OPASS.

Two conditions are necessary for the success of the Pilot: (i) the existence of branches of the mutuelles federations and agents in the beneficiary villages and towns, and (ii) the funds must pass through the Regional Directorate of Public Health and the District Public Health Service.

Table 1 summarizes the five key documents analyzed for this study.

Table 1. Summary of the Five Key Documents Analyzed and High-Level Observations

Document (*Situation*)	Content	Date	Comments (further detailed in Chapter 4)
Universal Health Coverage National Strategy – SN-CSU (*Validated*)	National: 6 strategic directions: 1. Protect against financial risks 2. Improve service delivery 3. Reduce environmental risks 4. Mobilize resources for UHC 5. Incorporate citizens' wishes 6. Provide a minimum base of social and health protection for the extreme poor. Priority is on the implementation of a DAS, a dedicated fund for the care of the poor (FSS), and free services.	December 2015	● A feasibility study is recommended but has not yet implemented. ● Role of *mutuelles* still to be defined and agreed upon. ● The steering committee, chaired by the Prime Minister, is the multi-sectoral forum for coordinating implementation, and plays a critical role in guiding and supporting UHC implementation. However, the committee is not functional. ● Attention should be paid to the possibilities for and likely risks of the planned development of voluntary health insurance, given the experience of other countries. ● The strategy does not present a sequencing of the strategic directions.
Implementation Plan of the National UHC Strategy – PMO SN-CSU (*In Draft Form*)	● National: Implementation of the SN-CSU. ● The PMO SN-CSU aims to implement the SN-CSU. It needs to be detailed and multi-sectoral.	November 2021	● The current version is inconsistent with the CN-CSU and SNFS; some sections have been updated and others need to be updated. The activities under each strategic direction are detailed but not all are budgeted. The same is true of the monitoring framework and indicators. ● The PMO SN-CSU does not prioritize or sequence implementation activities. ● Innovative financing is proposed but not detailed. ● Introduction of a technical monitoring committee has not yet been set up.
National Health Financing Strategy – SNFS *(Validated)*	● National with 4 strategic directions: ○ Increase total health care spending by US$20 to $60 per capita, per year by 2030. ○ Improve the pooling of resources and strengthen protection against health-related financial risks ○ Develop strategic purchasing	March 2022	● The SNFS is explicit and proposes the law as a priority for its implementation. ● OPASS membership is voluntary, the role of the *mutuelles* is not clear, and a feasibility study of the DAS is not mentioned. ● Innovative financing proposals should be updated with the latest version of the PMO SN-CSU, which seems more evolved.

Document (*Situation*)	Content	Date	Comments (further detailed in Chapter 4)
	○ Improve spending of resources on better health outcomes ● Introduction of the OPASS to replace the CNSS, and the Health Solidarity Fund (FSS). ● Gradual integration of the different schemes (including *mutuelles* and AMO) into the OPASS. ● Implementation sequence and proposed timeline.		● Operational level of OPASS is undefined. ● Attention should be paid to the possibilities for and likely risks of relying on voluntary health insurance.
Law / 2021 on Financial Protection for Users of Health Services (*November 2021)*	● National: The main objective of the law is to implement the SN-CSU, in particular Pillar 1 of UHC: protection against financial risk. ● The law details the administrative organization and functioning of the OPASS and the regulation of *mutuelles.* ● The law proposes to abolish the equity funds once the OPASS is operational, thereby reforming FANOME.	November 2021	● Consistent with SN-CSU and SNFS. It proposes a single package of services and care and traces the legislative and regulatory process for the implementation of the OPASS. ● The experience with the CNSS shows that a DAS must have a legal framework that allows and promotes its establishment and operation. To develop a legal framework for the OPASS, the functions and role of the OPASS and the FSS must be defined. ● There is no description of the relationship between the OPASS and the *mutuelles,* which remains to be discussed with *mutuelles* federation. ● Subsidizing "any person who is not able to contribute to the Public Health Insurance Body" (Law / 2021, 10) is not feasible and could have financially catastrophic consequences
Health Financial Protection Pilot (part of the PARN) **(*In discussion with the CA-CSU)***	PARN regions: Creation of an NGO and UGSS composed of three components: *mutuelles*, free health services, and strategic purchasing. Local *mutuelles* unite into a union or federation. The three components merge into a single national structure, phasing in over five years.	December 2021	● Contains many practical details about how the UGSS works at the basic level, which serves as a useful model for how the PMO should be drafted. ● Relationship between the UGSS and health facilities at the district and regional level are well defined. ● The place of strategic purchasing at the operational level is envisioned in the conceptualization of payments and reimbursements. ● Implementation of the Pilot would provide useful lessons on the role of *mutuelles* and strategic purchasing in UHC. ● The relationship between the UGSS and OPASS, and UGSS and *mutuelles* are not defined. ● Beneficiaries of free health care programs require a better definition.

Document (*Situation*)	Content	Date	Comments (further detailed in Chapter 4)
			• The basis of affiliation is voluntary, and the beneficiaries of the health care programs, and other free services, need to be better defined. • No transition plan after PARN.

4. Analysis of UHC Key Documents

The analysis in this chapter provides observations on points of agreement, points to be resolved, and remarks to be considered by the CA-CSU in line with experiences of other countries.

4.1. Points of agreement among the key documents

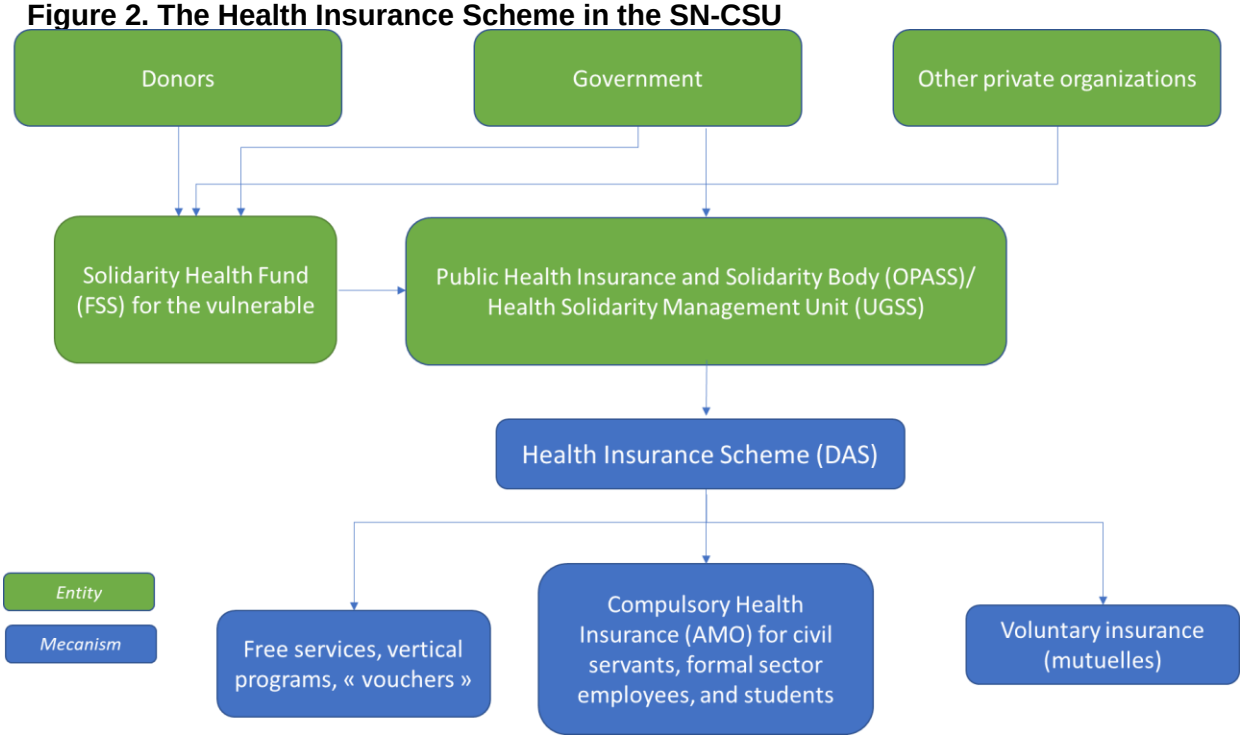
Promoting strategic purchasing.

The SNFS envisions the DAS as the global mechanism to move Madagascar toward UHC (Figure 2). To improve the quality of services and the efficiency of the system, the SNFS advocates for strategic purchasing which is consistent with many countries what are using strategic purchasing to improve health outcomes with limited resources. In the long term, strengthening the OPASS is intended to establish contracts with both public and private providers.

Covering individuals who cannot pay or contribute.

Currently, individuals who cannot pay or contribute to a health insurance scheme are supported by the equity funds, or care is provided free of charge by health facilities. The documents agree on the transfer of these responsibility to the DAS. The current funding via FANOME is modified and equity funds will disappear but not before the OPASS or the UGSS has proven itself. The FSS will finance the care of these vulnerable individuals, and this will be managed by the DAS.

Figure 2. The Health Insurance Scheme in the SN-CSU



4.2. Point to be resolved

The role of the mutuelles in the health financial protection architecture

The SN-CSU proposes that *mutuelles* should gradually be integrated into the DAS and serve as complementary health insurance. "[E]lsewhere, the added value of health *mutuelles* is rather on the side of fundraising and mobilizing populations. *Mutuelles* can also become delegated management bodies for other insurance bodies such as the national health insurance fund" (SN-CSU 2015, 23). Consideration of the role of *mutuelles* in the health financial protection system must be initiated as soon as possible.

Voluntary affiliation. The Financial Protection for Users of Health Services draft law refers to compulsory enrollment in a health insurance organization, while the other four documents propose coverage as voluntary, especially for the informal sector. This inconsistency in the role of *mutuelles* must be considered and resolved.

International experience does not advise voluntary health insurance to achieve UHC. Allowing health insurance to be voluntary poses several inherent problems:

- Encourages adverse selection
- Has high administrative costs
- Used mostly by the wealthy, thus increasing disparity in access to care (Mathauer and Kutzin 2018)

UHC requires that health systems be funded primarily from public sources, that is, they must be mandatory and prepaid (Mathauer and Kutzin 2018). As a health financing mechanism, voluntary health insurance plays a marginal role in most countries: it accounts for more than 5 percent of total health expenditure in only 41 countries. One must be attentive to both the possibilities offered and the likely risks posed by the development of voluntary health insurance.

The National Health Financing Strategy must clearly define the role of the voluntary health insurance, and how mutuelles will be regulated, so that they complement state-funded *mutuelle* systems and allows for equitable progress toward UHC (Mathauer and Kutzin 2018). In the case of AMO, it is necessary to consider how to implement it and for what period. Some low- and middle-income countries have made insurance compulsory, but insurance coverage is still lower than the entire eligible population.

Mutuelles stakeholders in the African health sector—after learning from their 20 years of experience, progress, and challenges— gathered in Togo in 2019 (Lome Platform) and called for compulsory health insurance (Bista 2019). It will be difficult to implement AMO for the informal sector, but the SN-CSU as a strategic document should have presented this goal for the long term, or at least reflected on a long-term plan to obtain funding from mandatory sources, of which *mutuelles* can play a transitional role.

The involvement of the *mutuelles* promoters. The PFUS law proposes regulating *mutuelles* but does not detail the relations between *mutuelles* and the OPASS, which is “to be discussed with the National Federation of *Mutuelles*” (Law No. 2021 2021). The inclusion of *mutuelles’* regulation was a point of contention during the presentation of the draft law in December 2021 because promoters of *mutuelles* described a lack of consultation. The section of the law that includes regulation of *mutuelles* has apparently not been discussed with stakeholders, the

State, *mutuelles,* and *mutuelles'* promoters. The regulation of *mutuelles* should include discussions on the role of the *mutuelles* in UHC.

Definition of the beneficiaries of the dedicated fund.

The definition of people who are not able to contribute and who will be supported by the government should be discussed and clarified because the impact of this on costs and financial sustainability, and consequently financial health protection, could be catastrophic. For example, why contribute to *mutuelles* if one is covered by the Health Solidarity Fund? Identifying the most vulnerable is a technical and political challenge. Since those who are not able to contribute are already covered by the group "people meeting vulnerability criteria", it is recommended to eliminate the group "any person who is not able to contribute to the Public Health Insurance and Solidarity Body" to avoid duplication (Draft No. 2021 2021, 10).

The structure of the DAS.

A public entity with autonomous management is proposed for the OPASS, and in the World Bank Pilot an NGO is proposed for the UGSS. The World Bank document has a table showing the pros and cons for the Pilot, but the Annex is not available. The Pilot proposes an NGO (UGSS) that would work closely with a project coordination unit. The NGO is proposed to regain the trust of the beneficiaries in the health protection mechanism. However, the government is proposing an EPA for the OPASS. If the OPASS represents the reformed CNSS, it is important to consider the lessons learned from the CNSS and experiences of other existing and ongoing health coverage mechanisms.

The package of care services for insurance.

The draft law proposes a single package of health care services for all, not detailed, but this package has not yet been costed. The experience of countries such as Ghana demonstrates how critical it is to identify a feasible and affordable health care service package. If the country starts with a generous package but can no longer pay when demand increases, the credibility of the entire insurance system will fail, and it is politically impossible to restrict the package later. Success stories have shown that it is better to start with a very simple care package of services that is affordable and can be guaranteed to the entire population and then expanded as it is financially possible. It would be prudent not to define the service package in the law to allow for flexibility to adapt to8 available resources.

The crucial need for the feasibility study of the DAS.

"The feasibility and operational transformation of this strategic direction will require an in-depth study. Such a feasibility study will therefore be started as soon as possible" (SN-CSU 2015, 25). This feasibility study is critical to the success of the DAS. To be able to conduct this study, the DAS, *mutuelles*, and the interface with strategic purchasing must be better specified.

Establishment of the steering committee and the technical monitoring committee.

A steering committee was set up following the validation of the SN-CSU, but with the changes of government, it is not functional. The PMO SN-CSU proposes a technical monitoring committee, and this proposal is included in the SNFS. The CA-CSU needs support and guidance for the effective implementation of the SN-CSU. Efforts should be made to at least re-establish the steering committee.

4.3. Other points for reflection and discussion

Reform of the AMO.

The SNFS proposes reform of the AMO, which involves:

- Rigorous monitoring of the compliance of formal sector companies with enforcement of the legislative and administrative documents
- An update of a single health care package
- A shift from a reimbursement pilot to a system of coverage without a cash advance for the basic health care package

Although it is easier to reform the AMO because the legal and regulatory framework already exists, it will be important that the reform does not monopolize the capacity of the DAS since the largest part of the population without coverage should be the priority.

Innovative financing.

Innovative financing is proposed but is at a very early stage. The potential of innovative financing to generate additional income for health is not yet clear. During discussions on potential innovative financing, it is important to consider all options and not only those that are most feasible to implement but are not necessarily the most innovative, such as taxes on harmful products. Ministries of finance are rarely enthusiastic about targeted taxes or levies that reduce their room to maneuver. Experience with innovative financing shows that it rarely provides large amounts of financing.

Capturing opportunities through the World Bank's Pilot.

The financial health protection mechanism Pilot is detailed at the operational level with functions and personnel identified at the fokontany level, and roles and relationships with health structures at the district and regional level. The Pilot presents a detailed architecture of implementation on the ground for the area of intervention of the World Bank PARN and answers questions relevant to the DAS (or OPASS): who oversees? what is the channel of funding? who verifies the benefits and initiates the payments or refunds? These details should be considered in developing the DAS. The proposed Pilot would therefore be an opportunity to implement a DAS at the operational level and to learn from this experience.

5. Recommendations to Consider for the SNFS and the SN-CSU Implementation Plan

To finalize the national health insurance scheme before its implementation, certain points must be resolved because the parameters of the responsibilities of the DAS (and OPASS) will be codified in the PFUS law.

5.1. Engage in discussions on the role of *mutuelles* in UHC

The SN-CSU suggests consideration of the role of *mutuelles*. As the subject is complex, it would be advantageous to plan a series of meetings and discussions. In the meantime, the other documents studied all play an essential role in the *mutuelles*, though this role is not clearly defined. Even the Pilot proposed for the PARN regions, which defines in detail the role of *mutuelles*, is unclear on the relationship between *mutuelles* and the OPASS.

The consensus on the role of *mutuelles* is that *mutuelles* can play an important role in UHC if:

- There is a strong political commitment (often expressed through subsidies)
- Health insurance is mandatory for all
- Management autonomy is respected (Lomé Platform)

The World Health Organization recommends that if *mutuelles* are established:

- They should cover a basic health care package, and
- They should integrate and merge existing funds into a single national health insurance fund. The International Labor Organization also recognizes *mutuelles'* role in the transition toward a single regime.

Mutuelles in Madagascar are not yet established in the World Health Organization definition. As part of the SNFS, this transition should be discussed with existing and future *mutuelles*. The CA-CSU should conduct a consultation between the government, the *mutuelles*, and the promoters of *mutuelles* to better define the place of *mutuelles* in UHC, particularly in the implementation of the SNFS, while considering the lessons learned.

5.2. Learn about strategic purchasing to define its place within DAS

Strategic purchasing is defined as the process by which the transfer of funds to providers is linked to certain aspects of their performance or linked to the health needs of the populations with which they work (Mathauer, Mathivet, and Kutzin 2017).

The SN-CSU, the SNFS, and the Pilot advocate for strategic purchasing in more detail, with previous drafts advocating for "scaling up." The purchase, or payment of the providers, would be the responsibility of the DAS.

Strategic purchasing is one of the three main principles that guide health financing reforms to accelerate progress toward UHC. The first is mainly through mandatory (i.e., public) sources of funding. The second is to reduce the fragmentation of resource pooling to improve the redistributive capacity of these prepaid funds. The third is to move toward strategic procurement, which seeks to align funding and incentives with promised health services.

The proposed Pilot for the PARN regions details the role of the UGSS in strategic purchasing. To include strategic purchasing in the responsibilities of the OPASS, the CA-CSU should learn about existing experience in Madagascar, such as with Results Based Financing, and engage the managers/promoters of this approach to clearly define the vision for strategic purchasing and the role for OPASS.

5.3. Review the law based on 5.1 and 5.2

The draft law should be reviewed based on the results of consultations on the role of *mutuelles* and strategic purchasing. The law should define the high-level objectives and strategies, its purpose, and principles. It is therefore recommended not to have too many details that could be binding in implementation. For example, it is not necessary to define in detail the package of care and services covered, but the principles of a care package and services for all should be reaffirmed.

Consultation on the role of *mutuelles* should include the legal and regulatory framework of *mutuelles* to ensure that once their role in the DAS is defined, there are no legal or regulatory obstacles to their proper functioning. This is particularly important if there is a decision to subsidize the operation of *mutuelles*.

The current draft of the law proposes that the OPASS form contractual agreements with service providers, whether private or public. Contracting is a form of strategic purchasing, but it is not the only one. This possibility should be kept in the law. Again, it is not necessary to go into detail (on what basis, how, who, etc.) but to affirm the option of using strategic purchasing.

The CA-CSU will have to seek legal expertise support in the revision of the law. The expertise could be within MINSANP or within the government. If this expertise is not available, an expert or consulting firm could be contracted to finalize the law. It is essential that the CA-CSU can work closely with experts, government, or contractors, to ensure that the law accurately reflects the decisions made.

5.4. Prepare a DAS feasibility study based on the conceptualization of the DAS, OPASS and FSS

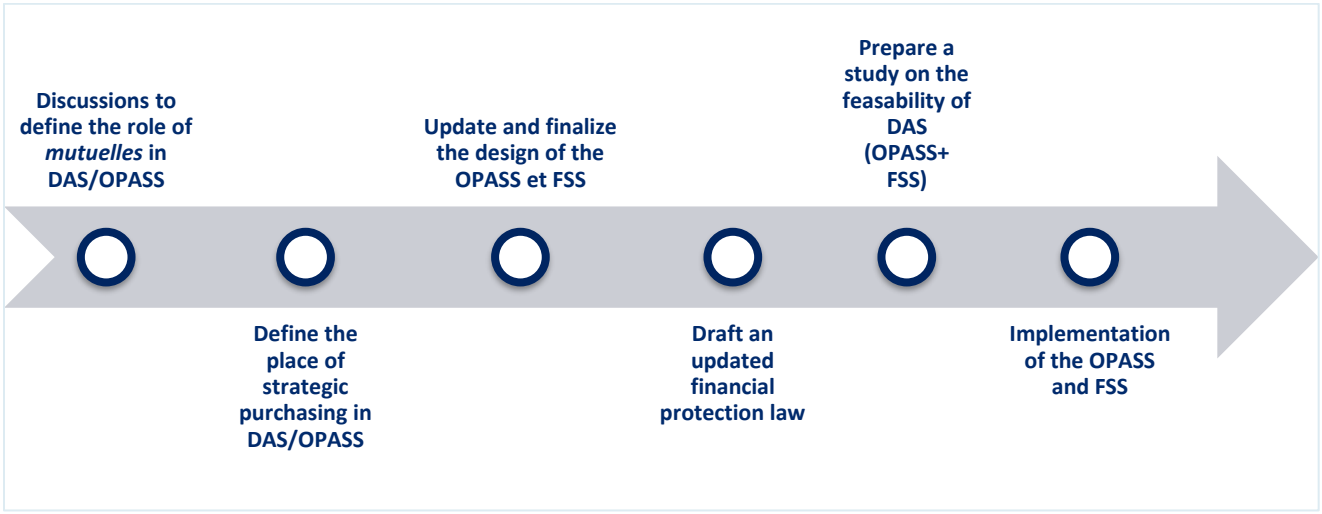
One or more feasibility studies should consider the following areas:

- The definition and identification of persons who may not be able to contribute and who will therefore be eligible for subsidies.
- The identification of a care package that is affordable and feasible and that can be guaranteed to the entire population in the DAS, through a costing study.
- The functions and role of the OPASS and the FSS must be clearly defined to finalize the draft law on financial protection. The SNFS is explicit and proposes the financial protection law as a priority for its implementation. This is also the case for *mutuelles*, whatever their role in UHC.

- Leverage the World Bank's financial health protection mechanism Pilot, and other financial protection initiatives, to integrate operational details into the OPASS.
- Develop a dashboard to monitor the current efforts of *mutuelles* and other functional mechanisms with a plan to incorporating lessons learned.

The sequence of these actions is suggested in Figure 3 and should be captured in the PMO SNFS and included in the PMO SN-CSU.

Figure 3. Sequence of Actions to Advance Financial Protection to be Considered by the CA-CSU



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