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Developing and implementing National Health Insurance: learnings from the first try in Benin

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ABSTRACT

In 2008, Benin government launched a national health insurance scheme, but this had been suspended in 2017. We aim to understand how existing ideas and institutions, stakeholders' behaviour and their interests shaped policy-making process and policy content, from its launch to its suspension.

Methods We used a case study design, framed by the policy triangle of Walt and Gilson. We collected data through document review, quantitative data extraction from routine information, and interviews with 20 key informants. We performed a content analysis using both complementarily deductive and inductive analysis.

Results This study confirms the keen interest for national health insurance scheme in Benin among various stakeholders. Compared with user fee exemption policies, it is considered as more sustainable, with a more reliable financing, and a greater likelihood to facilitate population's access to quality healthcare without financial hardships. Exempting the poor from paying health insurance premiums was however considered as an equitable mean to facilitate the extension of the health insurance to informal sector workers.

The whole arrangements failed to deliver appropriate skills, tools, coordination and incentives to drive the policy implementers to make individual and organisational changes necessary to adjust to the objectives and values of the reform. These deficiencies compromised the implementation fidelity with unintended effects such as low subscription rate, low services utilisation and sustainability threats.

Conclusion Supporting countries in documenting policy processes will ease learning across their tries for progressing towards Universal Health Coverage, as more than one try will be necessary.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ The realisation of a national health insurance is influenced by existing institutions and stakeholders' ideas, behaviour and interests, and several lessons can be learnt from the policy-making process of the first health insurance reform in Benin.

WHAT THIS STUDY ADDS

⇒ This study confirms keen interest for the national health insurance scheme in Benin among various groups including politicians, technicians—being national or international—and civil society actors.

⇒ Politicians' agenda and their hurrying timing, responding to the importance of the civil society's expectations and hope, conflicted at several steps of the process with the technician's wariness and caution.

⇒ Other factors compromising the success of the Benin's first health insurance reform include (1) insufficient skills of the policy actors, (2) a country-context poorly favourable to the implementation of the reform, (3) an uneven process with delays and round-trips, (4) a lack of proper accountability, (5) a poor collaboration and coordination among the actors and (6) sustainability threats because of the low attractiveness of the benefits package, the providers' reimbursement system and the persisting fragmentation of health financing mechanisms.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Supporting countries in documenting policy processes will ease learning across the tries on their progress towards Universal Health Coverage, as several tries can be anticipated.

⇒ Institutional arrangements and the various governance mechanisms should be designed in a way to foster effective collaboration, trust and accountability between the key stakeholders for a successful reform.

INTRODUCTION

Enjoying the highest attainable standard of health is one of the key universal human rights, and the sustainable development goals 3, focuses on ensuring health for all.[1] Health is also a determinant of economic development, poverty reduction, labour productivity and other human capital investments.[2,3] To promote equitable access to health services, governments and policy makers are encouraged to review their healthcare financing system to facilitate access to healthcare inputs. Therefore, recent policy discussions were dominated by how to finance

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low-income countries' health systems through prepayment mechanism that allow for risk-sharing.[4 5]

Benin, such as most sub-Saharan Africa countries, engaged on a reform of its health financing policies through the introduction of a national health insurance (NHI) scheme ('Régime d'Assurance Maladie Universelle' (RAMU) in 2008.[6] RAMU aims at guaranteeing to explicitly identified and affiliated individuals a defined healthcare benefit package, in exchange for contribution prepaid by them or on their behalf. It intends to compensate for the failures of the healthcare market, particularly the exclusion of the poor from accessing quality health services, due to the harmful consequences of some policies, such as the user fees policy, implemented in the health sector following the 1980 crisis.[7–9] Indeed, the user fees policy has had adverse effects on the demand for health services, particularly the poor, on equity in accessing health services, on public health and on the cost-effectiveness of the health system.[10–13] An organised bureaucracy was developed within the health system in favour of the financial self-sustainability of public health structures grounded on user fees, creating a prouser fee organisational culture.[12] For instance, revenues raised from user fees are listed as performance indicators for public health facilities in Benin health statistics.[14 15] Direct household payments represented consistently since 2003 between 40% and 52% of the health expenditure.[15] As a result, the exclusion of certain categories of the population, particularly the poor and vulnerable, by financial barriers has become a public issue attracting the attention of social actors, politicians and development agencies.[14]

However, health financing reforms to address those existing limitations have been reported as complex by nature.[4 16 17] They mobilise resources on the supply side of the policy (the government, the Ministry of Health, the health insurance actors, health districts managers, hospital directors and health professionals) and the demand side (the population or beneficiaries). So, various factors at different levels of the system play a role from a political economy perspective either in relation with actors, context, reforms content and/or processes.

Benin government officially launched the overall framework for RAMU implementation in 2011, with projected targets of coverage rates of 100% by 2020 for workers in the formal sector, 70% for the poor and vulnerable, 45% for the workers in the informal sector and 45% for children.[15] The subsequent pilot phase of the RAMU encountered operational difficulties.[6 18] For instance, a mission report identified poor planning, funding gaps and politicisation of the reform as operational challenges.[19] The implementation of the reform has been relatively low. Understanding these challenges could give future public health insurance reforms in Benin and Africa better chance of success by providing to the policy makers the information they need to structure the decision-making process for future public health policy-making, and particular for large-scale decisions. However, the lessons learnt from Benin's experience in RAMU formulation and implementation remain insufficiently documented. Fantodji presented an overview of the process, focusing mainly on its history without analysing how and why this policy was made and the factors that influenced the policy makers, and how they shaped the institutional arrangements that characterise it.[6] Institutional arrangements refer to the regulatory and legislative specifications structuring the design and implementation of a policy or intervention and play a key role in its success.[20 21] This paper analyses how the interactions between contextual factors and actors influenced and structured the technical and strategic content of RAMU, including the institutional arrangements that shape specific decisions taken by each actor to respond to the opportunities offered by the reform. The aim is to understand how the context (including existing ideas and institutions in the health sector and at the national level), the actors, and the reform process shape the policy options and their maintenance over time from 2008 to 2017.

METHODS
Study design, data collection and data analysis
We used Walt and Gilson's policy triangle framework to guide the design of the study and frame its analysis. The case study design was used because it allows in-depth investigations of many aspects of the RAMU policy—history, institutional, context, etc—to seek patterns and cause of behaviour of actors. Walt and Gilson's framework of health policy analysis incorporates interactions between contextual factors—social, economic, cultural and political —content of the intervention—policy options, nature and scale of the policy—actors involved in decision making—individuals, organisations, formal and informal networks—and the process—agenda setting, policy development and implementation. Use of this framework helps understand the dynamics of these four elements that shaped the formulation and implementation of the RAMU.

We performed a mixed methods data collection using in depth interviews, quantitative data extraction from routine information systems and document review to collect both qualitative and quantitative data. In-depth interviews were done with the main stakeholders involved in the formulation and implementation process (decision-makers from ministries of Health, Finance, Social Affairs and Microfinance, NHI-Agency, health officials and healthcare providers working in the health districts involved in the implementation of the RAMU; development agencies; insurance companies; professional organisations and non-governmental organisations). Using the snowballing technique, we identified new respondents, based on their knowledge and involvement in the RAMU process. Twenty Individual in depth interviews were conducted between may and august 2018. Six participants were from the Ministries of Health, Finance, Social Affairs and Microfinance, five were from

NHI-Agency, four were from the Technical Working Group of the NHI (TWG-NHI) and five were health officials and healthcare providers working at operational level. Among the participants, 30% were female. The full list of participants was anonymised and categorised by level of seniority and job roles (see online supplemental appendix 2). The interviews covered testimonies of the stakeholders' direct participation and observations of the process; context of the emergence of the RAMU on the political agenda, appreciation of the governance of the process, the healthcare benefit package, reimbursement flows of providers, premiums, nature of the relations between the main actors in the process. The interviews lasted 35 min on average, and notes were taken.

Furthermore, we performed a document review related to the formulation and implementation of RAMU. We searched official policy documents, legal documents related to health insurance or particularly to RAMU scheme, implementation guides, workshops and study reports, publications in scientific journals from various sources including key informants and online digital literature repositories. Review focused on how the dynamics between stakeholders, contexts and processes structured the key functions of RAMU,[22][23] namely mobilisation of resources (eligibility and target enrolment rules), pooling of collected resources (resource pooling architecture and management of revenues) and purchasing of healthcare providers according to contractual clauses (design of the healthcare benefit package and type of services covered, status of contracted providers, method of payment of providers).

Actors' discourses were analysed through content analysis. The results are presented as key themes.

Patient and public involvement

Patients were not involved in this study. However, the development of the research question was informed by patients' priorities and public interest as this research aims to contribute to a better accessibility of healthcare through an improved implementation of health insurance reforms. The findings of the study have been disseminated to the participants through local workshop gathering experts from local universities, policy makers from various ministries and civil society actors. The results will be also published in peer-reviewed journals.

RESULTS

We first present findings regarding the context, actors, content and the timeline of RAMU policy development and implementation. We second identify the factors affecting the realisation of the reform. Third, we discussed the findings in the light of the literature on health insurance.

Context, actors, content and process of the RAMU policy
The context

The context within which RAMU policy was developed was marked by poor socioeconomic and sanitary conditions that generated a strong pressure on the government. Regarding healthcare, out of pocket health expenditure represented 44.77% of the total health expenditure in 2008, which was higher than the 30% targeted by the WHO.[24] The incidence of catastrophic health expenditure was 10% in 2008. Life expectancy at birth and infant mortality rates were 60 years and 99‰ in 2008, respectively (online supplemental appendix 1). In November 2007, a multistakeholders forum, the 'Etats Généraux de la Santé Publique', was organised, bringing together all the actors in the Beninese health system (government, development agencies, civil society organisations, trade unions, ministry officials, etc).[19] This forum recommended, among others, that the government effectively implement social health insurance and invest more in health to reduce the financial exclusion of the poor and vulnerable to quality health services.[25] Until 2007, transforming user fees financing mechanism towards health insurance scheme did not appear in the proposed changes,[26] in a context of organised bureaucracy in favour of user fees in public health facilities.[14] Indeed, despite the political discourse of radical change in economic, political and social governance embodied by the President of the Republic, elected in April 2006 election,[14][26] there seems to be little change of the existing ideas and institutions of governing the health sector. Moreover, the ruling party lost its majority, and the opposition parties dominated the Parliament over the period from 2011 to 2017.

With respect to economic conditions, between 2007 and 2008, Benin has experienced several crises, namely food, energy and financial crises that have had severe negative impact on the welfare of the population.[27] For example, there was a surge in the prices of necessities such as wheat, corn, sugar and edible oils passing the inflation rate from 1.3% in 2007 and 7.9% in 2008, exceeding the limit of 3% authorised by the West African Economic and Monetary Union convergence pact in Benin.[25][28] The decline in the purchasing power of the population due to the high rate of inflation generated social movements, in particular the beaded strikes by trade union confederations affecting the sectors of health, justice and education.[25] The trade union confederations call on the government to fight against job insecurity, poverty and for the social protection of the poor. From 2007 to 2008, Benin communicated seven severe episodes of strike of civil servants, some of which lasted more than 2 months without minimum services. In summary, a decrease in welfare coupled with a lack of social health protection constituted a problem to which health insurance scheme was considered an appropriate response policy option by researchers and other stakeholders.

To respond to the increasing demand for social protection, particularly those of civil servants' trade unions, the Minister of Health introduced on 19 May 2008 a draft policy document proposing and organising a health mutual for civil servants into the Council of the Ministers. But after discussions, government noted that the

implementation mechanisms of the project were not clear. Moreover, the government decided to expand the implementation of the initiative to all the population including informal sector workers. The RAMU policy was then decided by the government.

The actors
The policy makers

First, the President of the Republic leading the Government, not only placed RAMU policy on the political agenda but also supported the process through the setting-up of the interministerial committee (led by the Minister of Health) to conduct the initial reflections. He also took several actions regarding regulatory and legal aspects that structured the policy. For instance, the special agency called the 'Agence Nationale de l'Assurance Maladie' hereafter called the NHI-Agency, a public and autonomous structure has been established by presidential decree (Decree no 2011–089 2012, 9 May). Similarly, the Presidency of the Republic installed the National Steering Committee, an instrument of popular management and periodic control by citizens (decree no 2014–361, article 2). Under his supervision the RAMU bill was drafted and submitted to the parliament for vote. This bill met the opposition of the parliament, and the government withdrew the bill and resubmitted it in February 2015. The President also allocated resources for the development of the initiative.

The cabinet of the Minister of health reported the process to the government and participated in the political and budgetary arbitration done by the Council of Ministers. It consisted of validating the recommendations of the TWG-NHI based on political and budgetary constraints and authorised the NHI-Agency to implement the recommendations.

NHI-Agency was assigned RAMU management under supervision of the Ministry of Health. NHI-Agency was thus entrusted with the conception of implementation guideline and communication strategy, members registration, resource mobilisation and pooling, accreditation of healthcare providers, purchase of services from health facilities and the medical control. The NHI-Agency can contract with health facilities and inform managers of approved health facilities about the content of the reform, administrative procedures and government directives. It can also train healthcare providers on the tools for managing and reimbursing care received by beneficiaries.

Under the supervision of the deputy Secretary General of the Ministry of Health, the TWG-NHI played a technical role during the policy development and implementation (Arrêté MS 2013/140/MS/DC/SGM/CTJ/ANAM/SA). The TWG-NHI was composed of experts from international organisations, national universities, civil society organisations (trade unions, mutual health insurance companies, healthcare providers' associations) and executives from the sectoral ministries, particularly those of Health, Social Affairs and Finance. The objective of the TWG-NHI was to lead the reflections for the harmonious implementation of the RAMU by working on the following key questions: (1) determination of the healthcare benefit package and its cost; (2) setting of the premiums rates; (3) elaboration of the manual of procedures for the reimbursement of providers. The TWG-NHI organised various workshops to which many players participated and contributed. The TWG-NHI's works, and its recommendations were expected to be used by the NHI-Agency. The TWG-NHI was supposed to provide the NHI-Agency with scientific evidence to support the design and the implementation of the reform. However, it appears that the core management staff of the NHI-Agency did not collaborate with the different successive technical committees set up, including the TWG-NHI.

The other ministries participated in the design and implementation of the RAMU through the interministerial committee. However, it seems that the collaboration between the various ministries was not effective. For instance, the Ministry of Labour has also conducted reflections on health insurance at the same time as the Ministry of Health (2008), with no consultation between the two structures, leading them to introduce different communications at the Council of the Ministers.[6]

As for the local authorities (mayors and other local elected officials), they were supposed to contribute financially to the reform. However, many interviewees reported that these authorities were not involved in practice.

The healthcare providers

Healthcare providers participated, through their representatives, to the many seminars and meetings organised during the intervention process. The representatives of the service providers come from the technical departments of the Ministry of Health and from health districts. Consequently, participation of actors at the operational level has been indirect. During these meetings, discussions focused on the role and performance of healthcare providers, the quality of healthcare as well as organisational arrangements. The providers were not properly involved in the decision-making particular the design of the guidelines which they were supposed to use when providing healthcare services to the population.

The civil society

The civil society, including trade unions, participated actively to the agenda setting step as highlighted above in the reform context. As a member of TWG-NHI, the representative of the civil society attended many workshops organised during the implementation of the reform.

The donors

Several donors supported the RAMU by financing the scheme or providing technical assistance. However, there were some pitfalls, such as a lack of coordination leading to variability in implementation or difficulties for the NHI-Agency to get complete information.[6]

Table 1 Key RAMU policy features

Characteristics	Key design of RAMU
Organisation form	Public health insurance scheme with general director of the NHI-Agency appointed by the government. It is a kind of Bismarckian social security model.
Membership	Compulsory for all citizen (formal sector workers, self-employed, poor, unemployed).
Regional distribution	National territory.
Fund collection	Annual premium by affiliates, children less than 17 years old: 1000 XOF, Adult: 10000 XOF and Management cost : 2000 XOF. Contribution of the poor households and recurrent costs are paid by the Government through Government budget transfer and donations from international organisations.
Risk-pooling and sharing level	Management of the pool is done by NHI-Agency; No waiting period between enrolment and use of services.
Providers and payment mechanisms	Public-based and faith-based health centres and hospitals, Fees-for-services is the method of providers payments
Healthcare Benefit package	Preventive care, basic curative care, hospitalisation at the health centre, essential medicines on the NHI-Agency list, reference by ambulance to hospitals if referred by the attending health worker. Copayment: 0% at Health centre, 20% at hospital level except the poor
Identification strategy of the poor	Unique method of identification was applied to idenfify those to be exempted from premiums.

Note: XOF: Benin currency, roughly XOF1=US$0.0017.
NHI, National Health Insurance; RAMU, Régime d'Assurance Maladie Universelle.

The content

The key RAMU policy features that emerged from our findings are presented in table 1.

RAMU was financed by the annual premiums of affiliates, state budget including taxes allocated to health insurance (taxes on mobile telephony, taxes on financial transactions outside the West African Economic and Monetary Union and excise duties on heavy vehicles), the budget of local governments and subsidies from development partners.[29] However, poor and vulnerable people, the majority of whom work in the informal sector, are exempted from paying the contribution. For the authorities, targeted free healthcare for the poor remains a strategy to ensure equity.

In its design, RAMU opted for a single pooling system for the resources mobilised, which theoretically maximises its distributive capacity. The compulsory nature of RAMU (law no 2015-42) implies that all socioeconomic categories of the population must pay contribution to NHI-Agency. This was considered as a mean to avoid problems of adverse selection and allow for a strong pooling of risks. Indeed, all socioeconomic groups, including employers and employees in the formal sector, were meant to contribute to its financing. Arguments against multiple pools revolved around efficiency and cost of running the system. However, in practice the other pooled funds (civil servants contributions, indigent funds, various fee-exemptions schemes) remained separated from the RAMU until it was stopped.[6]

The RAMU is a third-party payment system.[19] So, there is a defined healthcare benefit package that is reimbursed if consumed by its members. The heathcare benefit package consisted of clinical consultations and hospitalisations, drugs, medical consumables, blood products, laboratory and radiology tests, surgical procedures, rehabilitation, compulsory vaccinations, locally manufactured orthopaedic equipment, transportation of the patient from one health facility to another in case of referral, and services related to pregnancy and childbirth (Article 29 of Law No. 2015-42). There is a consensus that purchasing healthcare will be through a common pool. A copayment that varies according to the level of the health system was introduced to regulate the demand for care and allow for cost sharing between NHI-Agency and consumers: 0% at the primary level, 10% at the intermediate level and 20% at the national level.[30] The reimbursement of the providers is based on a fee-for-services system. However, the tariffs at which the NHI-Agency will buy healthcare services have been negotiated with the providers. During the period the RAMU has been implemented, only public health facilities have been contracted.

Although the RAMU law made it compulsory for all the population, the first phase focused on people from the informal sector and the extreme poor. The former should pay the NHI membership fees while the latter are exempted from it. The definition of poverty the government has adopted was food poverty. A household is considered as poor if its per capita food expenditure fell below the XOF400.3 per day cut-off. The targeting strategy used by the government consisted of a community-based method in which villagers' committees selected potential poor households based on local perception of food poverty. Then eligibility was determined by conducting proxy mean test (PMT) on this

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Table 2 The key events that made the process of RAMU policy

Date	Key events
2004–2006	Discussions on the ideas and draft statuses and internal rules of a health insurance scheme for public workers by the representative of Ministry of labour and Civil service and Ministry of Health with the support of the International Labour Organization.
2007	Organisation of the 'Etat généraux de la santé' by the government where healthcare financing issues were discussed by the health system actors. The workshop recommended to the Government to set up health insurance scheme for the population. Public Health Insurance coverage remains an option for healthcare financing.
2008	Universal Health insurance coverage has been put into political agenda by the government (29 May 2008). Setting up of the 'omité Technique Interministériel' (interministerial committee) under the leadership of the Ministry of Health. Visiting studies to learn from the experiences of countries that are in advance on the issue.
2009–2010	Adoption of the concept of RAMU (July 2009). Technical support from international organisations (French Agency for the Development, WHO, World Bank, Belgian Technical Cooperation). Organisation of several workshops with the participation of many institutions including the trade unions, representative of the providers, Mutual health organisations, civil society organisations, Private insurance compagnies.
2011	Appointment by the government the Director General and the Deputy Director General of The National Health Insurance Agency (August 24, 2011). Official launching ceremony of RAMU development by the President of the Republic (19 December 2011).
2012	Joint experts' mission from the World Bank, WHO, Belgian Technical Cooperation, USAID to operationalise the RAMU implementation strategy (February 2012). Creation of the National Health Insurance Agency (9 May 2012). Launch of first operational phase and symbolic delivery of the first insurance cards by the Minister of Health to mutual members of the Municipality of Nikki (28 May 2012).
2013	Signature of agreement with health facilities (18 March 2013) Launch of multiple awareness, information and social dialogue campaigns around the concept (4 October 2013) Decrees relating to the identification of health facilities and diagnostic centres to be agreed under the RAMU (9 July 2013). Establishment of a healthcare benefits package under the RAMU and establishment of an indicative list of reimbursable drugs under the RAMU. TWG-NHI to lead discussions for the harmonious implementation of universal health coverage was established Workshop on health financing in Benin (June 2013). Adoption in the Council of Ministers of the unique method of identifying the poorest. First Launch of pilot implementation phase one in six health districts: Cotonou 6, Nikki-Kalalé-Péréré, Cové-Ouinhi-Zangnannado Porto novo-Sémé-Aguégué, Bassila and Comé-Bopa-Houéhouogbé. The RAMU bill was submitted to the Parliament (Decree no 2013-507, 24 December 2013).
2014	Creation of the RAMU National Steering Committee by decree no 2014-361 of 16 June 2014). RAMU implementation conditions workshop (February 2014).
2015	Vote by the Parliament of the law on universal health insurance in Benin.
2016	Promulgation of the law on RAMU by the President of the Republic (7 March 2016) Second launch of the pilot implementation phase with support from the World Bank. The target concerns the extreme poor and covered eight health districts: Lokossa-Athiémé, Ouidah-Kpomassè-Tori, Porto-Novo-Aguégué-Sèmè, Adjohoun-Bonou-Dangbo, Zogbodomey-Bohicon-Zakpota, Covè-Ouinhi- Zandjannado, Banikoara and Kérou-Kouandé-Péhunco in August 2016. Discussions about the abolition of RAMU policy during the formulation of the Government Action programme 2016–2021 (April 2016).
2017	Abolition of the RAMU policy and adoption of a new Health insurance project Called Projet d'Assurance pour le Renforcement du Capital Humain by the new elected government Agenda.

NHI, National Health Insurance; RAMU, Régime d'Assurance Maladie Universelle.

limited list. This targeting strategy aimed to use the communities' knowledge, while using the PMT as a check on potential elite capture. Any household with a total score below the eligibility threshold was declared extreme poor. These poor households were reported on a list. The list constituted the register of beneficiaries eligible for exemptions from NHI- membership fees and/or state subsidies. Ultimately, the households exempted from paying contributions are those whose names appeared on the final list of households recognised as poor at national level.

The RAMU reform process

Table 2 shows the historical development of the RAMU policy process with a focus on key events. The ideas of setting up a health insurance scheme started back in 2004 when some Benin government officials participated in regional health insurance workshops organised by the development agencies to build the capacity of health policy makers.[30] With the support of the Programme of Social Protection sector of International Labour Organization, these government officials, particularly those from the Ministry of Labour and Civil Service, and the

Ministry of Health started to propose, during policy discussions, health insurance as an alternative option to users fees (see context for more details on RAMU agenda setting). In 2008, the government set up the interministerial committee for proposing an effective design and implementation strategy of the policy. Many players said this committee lacked the technical capacity to achieve the missions the government assigned to it. Indeed, the policy document the committee was supposed to elaborate lagged. Due to this limitation, the government asked for the technical and financial support of several development agencies such as the French Agency for the Development, WHO, World Bank and Belgian Technical Cooperation (BTC) to carry out the first studies to support policy decision. Therefore, international consultants reviewed healthcare financing and feasibility studies and organised many workshops with the participation of several institutions, including the trade unions, representatives of the providers, representatives of the mutual health organisation and private insurance companies. A second joint expert mission from the World Bank, WHO and BTC was opened in 2012 with the aim to operationalise the RAMU implementation strategy. This mission assessed the progress made in terms of formulation and implementation of RAMU policy and derived some recommendations to the government such as need of a proper costing of the benefit package, a structured registration fee and dealing with the legal aspect of the universal health coverage. They also recommended to base RAMU on the existing mutual health organisations and finalised the formulation and the implementation guideline of the intervention.[6] The interministerial committee was expected to draft RAMU policy formulation document using the results of the review and feasibility studies.

In 2011, the government appointed the director and deputy director of the NHI-Agency, with the missions of managing the RAMU policy reform, reporting to the government and establishing the NHI-Agency. The latter (created in 2012) launched the first operational phase and proceeded to symbolic delivery of the first insurance cards by the Minister of Health to mutual members of the Nikki Municipality in May 2012. The signature of agreements between the NHI-Agency and health facilities to provide healthcare services to the NHI members occurred later, on 18 March 2013. A ministerial decree was taken on 9 July 2013, to define the healthcare benefits package. Furthermore, through NHI-Agency, the government launched several awareness, information and social dialogue campaigns around RAMU concept and submitted the RAMU bill to the Parliament in December 2013. In 2014 (2 years after the launch), a communication strategy was elaborated with the objective of improving the stakeholders' adhesion to the RAMU. This strategy was implemented (including communication for behaviour change and training sessions). However, there were shortcomings in terms of expression of the voice of stakeholders and knowledge transfer.[6]

The same year, the government adopted in the Council of Ministers the method for identifying the poorest to be subsidised. Then, a pilot implementation started in 14 health districts with support from the World Bank and BTC (six districts in 2013 and eight more in 2016). Moreover, several tools and technical documents (eg, for guiding the enrolment, patients management or reporting from the health centres) were designed and deployed by the NHI-Agency for supporting the RAMU's implementation. However, these tools and documents were only available several years after the RAMU's launch (many of them only being available in 2016-2017[6]).

Table 3 shows some aggregated data on the financing structure collected from the NHI-Agency and related to concrete realisations of the pilot implementation. Over the period 2012–2017, the share of the national budget represented on average 72.93% of the funds mobilised by the NHI-Agency against 27.06% for the development partners. Membership contributions was 2.48% of the collected funds. The reimbursements to healthcare providers were marginal, falling from XOF23.44 million (US\$39 848) in 2015 to XOF8.8 million (US\$14 960) in 2017. According to our interviewees, the low level of healthcare consumption could be explained by the fact that the names of some beneficiaries who are up to date with their contributions did not appear in the members' register located in the health facilities contracted by NHI-Agency. Similarly, many households that had paid their membership fees did not receive membership cards. In other cases, the entitled persons received the cards but were turned away when they visited the healthcare centres because some healthcare providers had not yet received the list of beneficiaries and the NHI tools.

With respect to the membership, the data we accessed reveals 48817 persons affiliated to NHI-Agency with 11293 extreme poor, 5170 dockers, 32354 informal sector workers.

Identify the factors affecting the realisation of the reform

The RAMU policy is well intentioned as it provided an opportunity for the Beninese to benefit from health insurance at low cost. However, the realisation of its objectives was limited by some weaknesses in policy implementation.

First, the NHI core managers and implementers did not have full operational and managerial skills in building health insurance. These gaps generated delays and misconception around the purpose and how the reform was implemented. For instance, despite the communication strategy, the public was still lacking clear and appropriate information regarding the benefits package, accredited healthcare providers, or mechanism for affiliation to the NHI-Agency. Also, there was not a formal complaint system, and the information system was not optimal.

Second, the country context may have not been the most favourable to the success of the RAMU policy. There was an ideological conflict between the political will from

Table 3 Financing structure and reimbursement expenses of the RAMU (in millions of XOF)

	2012	2013	2014	2015	2016	2017
National budget	300	940.8	450	675	500	500
World bank, WTO, UNFP, Swiss Cooperation, BTC	107	355	427	246.865	187.868	–
Contributions collected	–	–	–	23,44	23	8,8
Total resources	407	1295.8	877	945.305	710.868	508.8
Reimbursement of healthcare providers	–	–	–	–	14	1013
Equipment and materials	–	54.46	76.82	25.02	153.69	93.71
Maintenance costs, room rental, electricity, fees, miscellaneous legal costs, security and guarding, mission costs, staff recruitment, etc)		176.97	127.87	56.17	170.68	111.15
Wages		119.49	175.74	126.45	156.77	
Other expenses	401	335.26	60.91	70.77	95.15	0
Total expenses	401	686.18	441.34	278.41	590.29	205.873
Balance	6	609.62	435.66	666.895	120.578	302.927

Source: Ministry of Health (2018).
BTC, Belgian Technical Cooperation.

the President to implement health insurance and the overall pro-user fees culture in the country. The RAMU policy needed a paradigm shift with respect to this pro-users fees culture. The organisational changes (steering documents, changes of the attitudes and the way of working, etc) required for this paradigm shift did not occur. There was also a need to establish trust between providers, consumers and NHI-Agency as health insurance is a relative recent health financing mechanism in Benin. Another contextual issue was that the President lost the majority in the parliament between 2011 and 2016, which probably contributed to delay the adoption of the RAMU law.

Third, there was an uneven process in the reform's implementation. The health insurance technical documents and tools were finalised very late, several months and even years after the launch. Moreover, although there was an active strategy to raise awareness by involving stakeholders during the development of the implementation guidelines, these discussions did not occur the before the launch of the pilot. The audiences targeted by these guidelines, in particular the healthcare providers, were somewhat sceptical about the capacity of NHI-Agency or the government to mobilise financial resources, including members' contributions, and to organise the timely reimbursement of health facilities. This was because the district health managers and hospital directors interviewed have noted that in past experiences the government did not respect its commitment towards the health facilities. Moreover, the main actors of the RAMU policy at national level did not show a discourse of persuasion to convince healthcare providers on the interest of the RAMU's success.

Fourth, no mechanism of incentives, persuasion, control and accountability was put in place to constrain both NHI-Agency and care providers to deliver the reform properly and improve their productivity. Appropriately designed, such mechanisms could generate good policy implementation outcomes. The transmission of decisions or directives from managing agency to the managers of health facilities and healthcare providers was problematic, reflecting its poor information capacity. Degree of compliance of health facilities with the RAMU objectives and the practice at district health level showed significant differences. The perceived mistrust affected active engagement of all key players and some actors interpreted the situation as a lack of government commitment to transparency and good governance. The lack of trust on government leadership including from private sector eroded the confidence that have been gained. Transparency and trust were factors that dampened the support and the willingness of the population to pay for their contribution.

Fifth, there was a glaring lack of collaboration between country stakeholders which led to missed opportunities for enhancing the RAMU approach and leveraging existing resources and expertise. For instance, policy makers from the Ministry of Health and the Ministry of Labour worked separately in proposing a Health insurance scheme for Benin. Also, the local authorities were meant to contribute financially in the RAMU process. However, they were not considered as major players and their role at the various stages of the process were not specified. No incentive mechanism (contract, strategic communication, advocacy efforts, full participation, etc) has been put in place to make them participate

actively. The NHI-Agency could have contractually delegated some responsibilities to local authorities. That could concern not only the sharing of annual insurance premium subsidies for the poor with the government but also policy responsibilities in the expansion of coverage. The contract of objectives between the government and the local authorities would be accompanied by criteria for evaluating the performance of local authorities and officials. If these targets are not met, elected officials and local civil servants would receive low scores that will have negative impacts on their future promotion. This mechanism could have increased coverage and enrolment activities. Above all this, the lack of coordination of the donors' activities did not help in getting the necessary effectiveness and efficiency for the schemes' sustainability.

Finally, the financial sustainability of the RAMU was threatened by several factors. Although it opted for a unique pooling system, the RAMU has not been able to integrate the other pooled funds, probably because the policy makers lacked the time for the necessary reforms and because of the late adoption of the law. Furthermore, the benefits package (although generous) was not necessarily attractive to beneficiaries because of the poor quality of care in public health facilities, the only ones to contract with the NHI-Agency.[31] In these conditions, and in a context where enforcing enrolment was not easy, it is not surprising that the members' contributions fell from 23.4 million in 2015 to 8.8 million in 2017.[6]

DISCUSSION

The first try of the health insurance scheme in Benin was decided by the government using a window of opportunity as a problem, a policy and a political stream converged. The problem stream was illustrated by the emergence of several workers strike, food, energy and financial crisis. On the existence of mutual health organisations and interests in health insurance by international organisations represented the policy stream to address the problem of lack of social protection for the population. The pressing demand of social protection including health insurance coverage by the population constituted the political stream.

In the following, we discuss some of the key choices that ground the specificity of this policy reform.

Exempting the poor from paying contributions is a relevant strategy for extending health insurance to the informal sector. The excluded from access to quality healthcare services are often the poor.[13] Exempting them from paying contribution could allow the country to quickly increase the potential number of people that access healthcare. The coverage of the disadvantaged groups reduces access inequality. The literature also shows that the low-income and middle-income countries that have made substantial progress in expanding health coverage to the informal sector have adopted that strategy.[23 32–34] However, the sustainability of fiscal transfers to cover the contribution of the poor remains a challenge due to the budgetary constraints of those countries.

The compulsory nature of RAMU may increase the number of people in the scheme and improve risk diversification. It is the starting point for improving the redistributive capacity and reducing inequalities in access to health services.[34 35] Like in many African countries, there is a need to reduce the fragmentation of Benin's health financing system by introducing a risk-equalisation mechanism between benefit options that operate as separate schemes (eg, user fee exemption policy for caesarean section, Indigents Funds, user fee exemption for the treatment of malaria in children under five and pregnant women). This remained a challenge for the NHI-Agency because of political economy factors and because this needs of a legal framework which came only late in the process. Fragmentation reduces the possibilities for income and risk cross-subsidies in the overall health system. Note that including the poor and non-poor in the same scheme does not always benefit the poor because the non-poor consume more expensive health services, and they are more informed and reside in areas where quality health services are available. Consequently, government subsidising the poor's contributions may benefit more the non-poor if the redistributive capacity of the scheme remains undefined.

The provider payment mechanism adopted by RAMU (fee for services) is a potential source of cost inflation because it provides incentives for providers to induce demand for care by providing unnecessary and more expensive treatments and leads to overconsumption of health services.[32 34 36] Although many African health insurance schemes have adopted user-for-fee payment, there is a need to transform this into a strategic health purchasing to be more efficient. As argue by El-Jardali et al.,[16] supply-side cost control is economically and socially preferable to demand-side cost sharing measures such as copayments mechanisms. International experience shows that supply-side cost control measures are effective when well designed. Therefore, the cost control mechanisms proposed under RAMU should account for these inefficiencies.

The health benefit package of RAMU was large and covers primary, secondary and tertiary levels of care. However, this is nothing if the quality of healthcare is poor. There is a considerable disparity in healthcare service coverage between rural and urban areas in Benin. The RAMU policy makers did not incorporate measures on how to improve the quality of healthcare to be provided to the affiliates with NHI-Agency. The inconsistent availability of healthcare services including medicines and lack of skilled human resources negatively affects health service utilisation.[37–39] The perceived quality of care and the attitudes of providers may have negatively affected people's healthcare use.[40 41] The health sector's coverage of skilled human resource needs was 4.5 per 10 000 inhabitants compared with WHO recommended standard of 25.[42] All this may explain the decreasing number of people enrolled in the RAMU over the years. Ensuring an equitable access and the quality of healthcare remains a challenge of many health financing mechanisms in sub-Saharan Africa.[43]

The NHI-Agency did not put in place a monitoring and evaluation system to collect information and statistical data during the pilot phase. That constitutes a major limitation to the learning process as information on the monitoring of membership, contributions, use of health, etc was not well recorded. Similarly, outcome indicators are not defined in any NHI-Agency document. NHI-Agency could not answer many questions because of the lack of data. For example, assessing the effects of RAMU on members' financial protection, health service demand/use behaviour, health equity and access to healthcare and beneficiaries' satisfaction, etc could inform future reform options. Similarly, understanding the effects of providers' payment methods on their service delivery behaviour in health facilities, the effects of administrative and institutional procedures on the provision of care, etc are all useful analyses. The collection and availability of these data (eg, patient satisfaction through exit surveys, healthcare utilisation, perception of provider on payment mechanisms) will not only allow performance monitoring and planning but also the evaluation of the effects of the changes brought about by RAMU on the health system and the well-being of the beneficiaries. Lack of data to conduct performance analyses implies that effects of resources mobilised by RAMU are not known. Because of the fundamental role of performance evaluation in health system reforms, we suggest that it should be integrated into the formulation of the reforms and budget regularly allocated to it. This requires the commitment and support of government authorities. The capacity to evaluate public policies, particularly in the health sector, needs to be strengthened and developed. Representatives of civil society suggested the establishment of an independent evaluation commission for the RAMU with support from the authorities at the highest level. However, concrete efforts to facilitate such evaluations by making databases more transparent, accessible to academics and the public for independent analysis were not identified. These weaknesses in the information system and the availability of data for decision making have also been identified in other health insurance schemes in Africa.[44 45]

The incentives policy to be set up to encourage and motivate NHI-Agency and care providers to better perform may be financial and non-financial. When designing such mechanisms, caution should be taken in identifying good practices because of the unexpected perverse effects of financial incentives, as it is well known for per diems.[46]

Benin has implemented performance-based financing using both the World bank approach and an alternative integrated approach by the Belgian Development Agency.[47] The Belgian Development Agency approach appeared to be at the same time less resource consuming and promising in terms of effects, especially with respect to local health system strengthening compared with the World bank approach. We noticed that the payment of per diems by the NHI-Agency and TWG-NHI to the representative of the civil society that participated in the various implementations workshops reduced the pressure of the civil society on policy makers in achieving the policy reform goals. The experience accumulated by these interventions can provide valuable lessons when identifying the most appropriate, efficient and sustainable incentive mechanisms.

Finally, the lack of collaboration between the actors and coordination of their actions has greatly hindered the success of the RAMU. This in unfortunately the case for many policy processes in sub-Saharan Africa. Yet, effective multisectoral collaboration and dialogue have long been recognised as critical to the design and implementation of public policies.[43 48] The adverse consequences of the lack of collaboration on RAMU, once again, call for the need to work together despite the challenges in achieving such collaboration.

CONCLUSION

We analysed how the RAMU policy was made with a focus on how interactions between the context and the behaviour of the major stakeholders involved in the process shaped the policy. We concluded first that RAMU policy was a political decision taken by the government to resolve the financial obstacles to quality healthcare access. Second, it resulted in a compulsory scheme for all with single pooling and exempting the poor from paying premiums. Healthcare services were delivered by both states owned and non-state-opned facilities. Third, the weak collaboration between the NHI-Agency and other key players such as the TWG-NHI, the healthcare providers, the civil society and the local authorities during the policy-making process affected the realisation of the policy. Urgency, gaps in transparency, in trust and in governance, and capacity of policy implementers particularly the NHI-Agency were factors that affected the realisation of the reform. Two lessons were learnt for future health policies. The first is to set up an appropriate and effective mechanism and incentives to make the core management staff of the reform effectively collaborate with key players. The second is to prepare the healthcare providers to make the necessary organisational change that allow them to adapt adequately the implementation challenges.

allow data collection in order to formulate health insurance component of ARCH projet. The Health insurance component of ARCH projet replaced the RAMU policy suspended by the government. Participants gave informed consent to participate in the study before taking part.

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APPENDIX

Appendix 1 : Details of study participants' job roles and level of experience

	ID	Job roles
Ministries of Health	1	Senior policy makers
	2	Senior policy makers
	3	General hospital director
	4	Policy maker
Other Ministries	1	Senior policy makers (Ministry of social Affairs)
	2	Senior finance manager (Ministry of finance)
NHI-Agency	1	Managing staffs
	2	Managing staffs
	3	Senior policy maker
	4	Senior policy maker
	5	Finance manager
TWG-NHI	1	Senior policymaker/programme manager/ Development partners
	2	Health economist & Health policy
	3	Managers of private health insurance
	4	Representative of trade union
Health care providers	1	Senior health district manager
	2	Hospital managers
	3	Hospital managers
	4	Health care facilities managers
	5	Health care facilities managers

Note: To preserve confidentiality, participants have been categorised by level of seniority and job roles. .

Appendix 2: Selected socio-economic indicators including health.

Indicators	Values (2008)
Socioeconomics indicators	
Economic growth rate (%)	5.00
Inflation rate (%)	7.9%
The poverty rate (%)	37.5
GINI index (%)	43.44
Health indicators	
Health expenditure, public (% of government expenditure)	9.27
Health expenditure, public (% of total health expenditure)	50.95
Hospital beds (per 1,000 peoples)	0.5
Out of pocket health expenditure (% of private expenditure on health)	91.14
Out of pocket health expenditure (% of total expenditure on health)	44.71
Improved water sources (% population with access)	73.7
Birth rate, crude, per 1,000 people)	38.36
Cause death, by non-communicable diseases (% of total)	26.1
life expectancy (years)	60
proportion of births attended by skilled personnel (%)	77
under-5 mortality rate (‰)	99
Incidence of catastrophic health expenditure ()	10
External sources in (% of total health expenditure)	24.3
Social movements	
Number of strikes by trade union of civil servants	2 in (2007) and 5 in (2008)

WDI (2016) and WTO (2019)