EVOLUTION OF UHC IN

MADAGASCAR

Countries learning from each other to achieve and maintain Universal Health Coverage (UHC)

Capital	Antananarivo
Official language	Malagasy and French
Ethnic groups	26% Merina 15% Betsimisaraka 12% Betsileo 7% Tsimihety 6% Sakalava 5% Antaisaka 5% Antandroy 24% others
Area	• Total 587,041 km² • Water 0.9%

GENERAL INFORMATION

Madagascar is the fifth largest island in the world, with a land mass of 587,000 km2 and 27.3 million inhabitants. The Malagasy population, predominantly rural (80%), is characterized by his very great youth with almost half (47%) under the age of 15. Despite having considerable natural resources, Madagascar has among the highest poverty rates in the world. Madagascar has a per capita gross national income of USD 1,358 and ranked 161st of 189 countries on the 2018 Human Development Index. Previous periods of growth have been followed by recurrent political crises leading to economic downturns that have eroded Madagascar's wealth.Natural disasters such as cyclones, drought and epidemics exacerbate Madagascar's fragility and affect the stability of the national health care system.

NATIONAL UHC DYNAMICS CARD
www.p4h.world
towards SDG 3.8.2

2009

Coup d'Etat

Loss of international support.

2010

Adoption of the new democratic constitution and establishment of the Fourth Republic

STRUCTURE OF THE NATIONAL HEALTH CARE SYSTEM

Central level
In charge of general coordination and political guidelines, and sector strategies.

Intermediate or regional level
Mission of planning and supporting the health districts to achieve the country's health goals.

Peripheral or district level
Responsible for the implementation.

Community level
Takes part in the promotion of health, the functioning and the management of basic health structures.

MAIN CHALLENGES

Poverty remains a structural problem, aggravated by past political instability, natural disasters, environmental degradation, epidemics and growing insecurity. Regular allegations of corruption at various levels erode international donor and public confidence in public services.

7,7% 80%

80% of public finances in the health sector comes from external funds, while the share of the state budget devoted to health is 7,7 % in 2020. This situation raises serious concerns about the sustainability, appropriation and efficiency of existing resources and the provision of quality care.

US $ 22 HEALTH EXPENSES

US $ 60 REQUIRED

Low financial access to care is favored by the absence of an appropriate prepayment system for the informal sector and rural areas. Per capita spending in real terms on health has not much changed since 1995, hovering around US $ 22. There is a consensus to say that US $ 60 is needed to reach UHC.

5 KM

Over 60 percent of Madagascar's people live more than 5 kilometers from a health center, often in very remote and difficult to reach areas without roads or communications. Health personnel are unevenly distributed. Drug and medical supplies are prone to stock outs and are unavailable in some areas.

Only 8% of population is covered by an health insurance scheme in 2019. Households contribute massively to the financing of their health expenses. Despite the effort to reduce prices and considering the poverty of the population, this direct payment constitutes a brake on access to care.

OUTLOOK

Since the adoption of the SN-CSU, activities have been carried out by the CSU Implementation Support Unit, in collaboration with the Technical and Financial Partners (PTFs), mainly WHO, The World Bank, USAID and the French Embassy. Main challenges consist in identifying what should be the basket of health services to be covered by the insurance scheme, in carrying out the analysis of financial resources and potential for the financing of the system, and in developing the institutional, administrative and legal framework for progressively instituting Universal Health Coverage (UHC).

2015

Enrolement of a National Strategy for Universal Health Coverage (SN-CSU)

It is based on the following six strategic directions:

1. Protect individuals and their families from the financial risks linked to their access to health services;
2. Improve the effective availability of quality health services;
3. Decrease the exposure of the population to risks affecting health;
4. Mobilize financial resources for the implementation of Universal Health Coverage;
5. Take more account of the wishes of the population;
6. and Access the population in extreme poverty to a social protection and health foundation.

Envisagement of a mixed financing system in the SN-CSU, the health insurance mechanism (DAS), with two institutions to be created to play a key role:

1. The Caisse Nationale de Solidarité en Santé (CNSS) as a pool for the contributory aspect of the system (who can contribute should pay).
2. The Fonds dédié which should correspond to the non-contributory aspect of the scheme (the Fund should pay the contribution for all those who cannot pay to the CNSS).

CNSS caisse nationale de solidarité pour la santé

2017

Adoption of decree 2017/0601, establishing the CNSS as a public administrative institution with a legal basis and administrative and financial autonomy.

The CNSS is under the MoPH technical supervision and under administrative and financial supervision of the Ministry of Finance. At the district level, the CNSS is represented by branch offices that are responsible for collecting resources from the population and sending these funds to the national level where all contributions are pooled.

THE CNSS IS SUPPOSED TO PURCHASE A LIMITED SET OF ESSENTIAL SERVICES INCLUDING:

- Primary care services
  - Cesarean deliveries
  - Preventive care
  - Curative care
  - Promotional care
- Private emergency transport and consultations
- Hospitalization
- Surgeries at the district hospital level

2018

Start of a pilot action program in the district of Vatomandry which serves as the first full working model of a CNSS branch office and provides the government with a better understanding of the human and financial resources required to set up and sustain the CNSS mechanism.

Political tension and formation of a transitional technocratic government, tasked with organizing presidential elections.

Major reshuffling in the ministries of health, water, education, justice and social protection, with a loss or shift of political will, institutional knowledge and long-term engagement capacity.

2019

Finalization of the UHC Implementation Plan (PMO-CSU) which is supposed to bring clarity and coherence and reduce fragmentation of works and activities.

Development of a health sector development plan (PDSS).

Temporary suspension of the CNSS's works and activities due to institutional paralysis.

Presidential elections marked the first political alternation of power.

President Rajoelina won 55.6% of the votes and leads the country alongside his Prime Minister, Christian Ntsay, and 22 ministers. Some ministries were merged to improve public administration efficiency.

2020

Drafting of a Bill whose very purpose is to ensure Financial Protection in Health for All. Historic step for Madagascar. The Bill should include the CNSS, the Fonds dédié and the Mutuelles de santé, thus instituting an innovative governance model in health at worldwide level.

"In Madagascar, only 8% of the population are covered by an health insurance scheme in 2019. Our fight, the fight of the UHC Unit, the fight of the MoPH, the fight of the Government, the fight of the President is to protect the remaining 92% of the population. Our goal is to make the right to health for all a reality in Madagascar, thus ensuring universality, thanks to equity and solidarity. Our vision is Madagascar being an emerging country, healthy with economic growth and social welfare."

Dr. Diana Ratsiambakaina
Director of UHC Unit /Ministry of Public Health

For reference, please visit: https://p4h.world/en/madagascar | Maps are an approximation of actual country borders.