Enabel

Social Health Protection, a path to fight against inequalities

International conference

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Report

Belgian development agency

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1 Day one

Day one of the conference was split in two equally important parts. The first part was of a political nature and the second more strategic part discussed Social Health Protection and Universal Health Coverage. However, the general messages of the two parts of day one overlap. The first day's three key messages are listed in Inset 1 below.

1.1 Part one

During the first part of the day several official representatives of the conference's stakeholders took the floor. This included representatives from the Government of Niger and the Niamey region as well as from the international partners co-organising and co-financing the conference. Policy leadership of Niger and the WHO linked the conference with the Sustainable Development Goals (SDGs) and repeated that the will of countries to develop social protection policies also contributes to this global foundation and these international commitments. These are global objectives, which serve as a compass for all countries and all programmes. The fact that they were referred to at the beginning of the conference reminded all participants of their importance. The call for the SDGs was also an opportunity for many speakers to restate their intersectoral perspective and thus the need not to limit Social Health Protection to the care for sick people by formal health systems. Many highlighted the social determinants of health (even if the terms are not used) such as food insecurity, access to water, education or women's empowerment to show that it is essential to have a global and holistic vision of health. The governor of the City of Niamey even used the opportunity to point out that his city and country are also experiencing climate change-related shocks that will have to be taken into account, also in Social Health Protection and the resilience of health systems. While such resilience is often understood as the capacity of systems to cope with shocks, it should also be understood in the sense of its reactivity, i.e. the extent to which the system takes into account the opinions of users, a point put forward by Belgium's Minister of Development Cooperation as well as several civil society representatives in the room. Niger's Prime Minister did remind us of the importance of involving civil society in all health reforms and to make our actions more humane and urged us to act.

In addition, many speakers deplored the fragmentation of health systems and in particular of their financing strategies. Thus, the WHO representative recalled the close links between Social Health Protection, Universal Health Coverage and social inequalities in health, the central theme of the conference. She took the opportunity to highlight the public financing needs of health systems and also showed how estimates of national health accounts, for example of 2020 in Niger, can be very useful to guide thinking. Belgium's Minister of Development Cooperation highlighted the challenges of financial access to health care and the need to find solutions to reduce existing out-of-pocket payments for health care since they still are an insurmountable barrier for many people.

Beside financial protection, the use of data and, more generally, learning and capitalising on experiences were often addressed by panellists of the opening session; "giving and receiving" was evoked to translate this approach. But, as the Ambassador of the Kingdom of Belgium to Niger noted, it is not a matter of transferring ready-made models from one context to another but of taking into account lessons learned elsewhere and adapting them to local environments and particular populations. And in this learning process, many recalled the need for policy dialogue and strong and determined political government leadership to find solutions to people's social protection and health needs. The speeches of Niger's Prime Minister and Minister of Health thus were very powerful moments to show

how unequivocal their commitment is. Thus, Niger has addressed community-based mutuals limits as well as the challenge regarding care payment exemption policies while means to achieve the ambition were lacking, as was also recalled by Geneva WHO speakers. It will be essential to follow through on the commitment of Niger to make its financing systems more coherent, efficient and rational by integrating health insurance mechanisms into the new National Health Insurance Institute. Similarly, the willingness to engage in three districts to test large-scale and professional health insurance, like the Senegalese experience, deserves special attention to ensure that Niger's particularities are taken into account.

1.2 Part two

The second part of the first day presented strategic dimensions of Social Health Protection (SHP) and UHC. Although this was necessarily general, generic and sometimes prescriptive, it allowed participants to have an overall vision of contemporary issues and to better appreciate the second day's more concrete, local and empirical presentations of country experiences. This afternoon's debates were an opportunity to recall a few key principles that we sometimes tend to forget or that we do not always have the time to address in our interventions and actions on the ground. By carefully listening, we might fall into a certain dichotomy or bi-polarity to use a term from the mental health field. Indeed, this first day could be perceived as a call for innovation, whereas many of the presentations suggested that the challenges are ongoing and no solutions have ever been found. Thus, we could be pessimistic or optimistic and take advantage of the window of opportunity offered by the conference to declare that this is the time to change, to test, to reform and above all to innovate, while not forgetting to adapt to local contexts and to rigorously study without conflicts of interest. To illustrate this bipolar vision, the presentations highlighted three main themes on which it seems urgent to act. The Prime Minister's exhortation is certainly to be taken seriously by us technicians.

1.2.1 The first theme

The first theme is equity, which is public health prehistory that, surprisingly, needs defining still as "pay according to means and use according to need", a perfect definition. The pandemic confirmed that equity is almost never taken into account when formulating policies and then implementing them. It seems to be systematically forgotten and "even if you have to walk before you run", efficiency and performance should not be given priority at the expense of equity.

1.2.2 The second theme

The second theme discussed was that of health financing, which was central because it is central, but it should not monopolise the debate. In several discussions capitation funding was proposed; in particular the relevance of its implementation in our contexts and more precisely the conditions required for its organisation were discussed. It's also interesting that this was addressed because although it is not pre-historical like equity, it is age-old. Capitation has been at the heart of debates among health financing experts for a very long time and has not even yet been fully accepted in many countries in the North, especially by health professionals who remain attached to the fee-for-service payment. In addition, two ancient history topics came up in the debates, namely Primary Health Care (PHC) and the Bamako initiative (BI). It is good to hear that the focus is still on PHC even though collectively we are still not getting it to work at 100% capacity. Indeed, if one refers to studies of Dugbatey from the 1980s comparing African countries with experiences elsewhere in the world, in Asia and Latin-America, there is little doubt about the effectiveness of PHC. Yet, our countries invest little in PHC and hospital-centrism is still

applied on a global scale, with the COVID-19 pandemic only reinforcing the position of hospitals in health care.

1.2.3 The third theme

Finally, the third central theme of the afternoon's discussions was the importance of thinking holistically and systemically, of combating the silo approaches that have, for a very long time, led to fragmentation[1], one of the reasons for the challenges of implementing PHC, which were discussed at length by the panelists and participants. Enabel presented an approach, which in a way operationalises UHC. It has a dual focus: the provision of care and services (PHC) and a single social health protection (SHP) system, which has three functions, namely insurance, guaranteeing access to services and care for the poor and the right to health and defence of the rights of the insured. Donor coordination, health-friendly policy dialogue and social participation for more justice and inclusion were highlighted by participants as possible solutions. The question that needs to be asked now is the current context, has it changed and is it more conducive to a holistic approach against fragmentation.

Inset 1: Three key messages of the first day

1. As part of the dynamics of setting up UHC, using the experience of others is important. Such approach makes it possible to learn from successes of others, avoid their mistakes and thus be more effective.
2. In the process of setting up UHC, there is no ready-made recipe that can work everywhere. Taking into account the context is imperative for implementing UHC.
3. Setting up SHP, as part of UHC, requires a strong political will. As "coordinator of the process", the State must provide additional funding, create a favourable social environment (by means of appropriate legislation) and conditions for social participation and be willing to address access to services and care for all in one system based on solidarity and equity. Some speakers stated, "when leadership is committed, trust is established, and other stakeholders follow" ... mostly. Others argued that the commitment of all stakeholders is not self-evident and that state regulation remains necessary: in a context where 80% of the population is in the informal sector, "people will never want to contribute if they are given a free choice". A consensus has emerged on the need to introduce such an obligation, although some countries now prefer to wait to make universal health insurance compulsory for the population in the informal sector until the provision of health care and the Social Health Protection system have gained sufficient credibility among citizens.

The challenges are many. Several local and national experiences were given the floor on day two.

2 Day two

Day two of the conference focused on more technical and operational aspects feeding on the political and strategic discussions of the previous day. A series of country-specific presentations were given, which highlighted important aspects: The permanence of certain challenges for Social Health Protection and UHC and possible solutions were showcased. A

[1] For example, with projects and funding devoted to certain groups (the poor, children, pregnant women, etc.) or certain diseases, rather than the system as a whole.

cross-sectional and exploratory analysis of the day allows us to shortlist some potential enabling factors.

Firstly, with regard to the challenges, many presentations showed that although contexts are changing and the health situation of populations is improving in most cases, certain problems persist. These challenges are multifaceted and concern many levels of our health systems, both on the supply side and the demand side, as well as the interaction between the two. The financial barrier to accessing health care was again made explicit in some of the presentations, both by highlighting the challenges of direct payment at the point of care as shown for people with disabilities in Benin (one of the rare studies on the matter) and for the poor in Mauritania. Although exemption from payment for care has sometimes proved to be effective and feasible, like in Senegal where an experiment is attempting to integrate it into a departmental health insurance scheme, or in Rwanda which is one of the few countries to organise progressive payment of the insurance premium, it does not seem to be sufficient for the poorest populations, who need comprehensive payment and need to have their needs taken care of to benefit from their rights. This should remain the focus of our attention.

Presentations showed the role of civil society organisations in structuring the demand for care, such as mutual insurance companies, or in organising the right of users of health services to speak, like in Benin. In order to move towards greater equity, in further discussions, let us always ask ourselves whether we are well representing the populations that we want to defend and especially the poorest.

Also, the alignment of civil registry services and the registration of the poor in insurance systems with a view to promoting equity were perfectly addressed by our Belgian peers noting the need for progressive interoperability without risking an indeed risky merger. Equity therefore remains a huge challenge; obviously not a surprise to those in the room. Yet, the presentation of our ULB colleague showed that its definition was as vague as its practical application was sometimes weak. Equity will be even more at the heart of the discussion when we have to take into account the famous epidemiological transition, explained by our Enabel colleagues, where non-communicable diseases are superimposed, in our context, on communicable diseases and epidemics or even pandemics. The pressure on health systems and their financing, on the care package provided by insurance companies, already far from meeting needs, as presented on the day one, will be great in the future.

Next, because of the permanence of these challenges, many countries have set up a variety of solutions ranging from public policies like in Senegal to more regional actions in Niger or more local actions like in Mauritania. The move to a large scale, whether national like in Rwanda or departmental like, for the time being, in Senegal, shows the relevance that large-scale risk sharing is essential. Experiments that are too local should not last too long after the first proof of concept experiments. The comparison of the experience of Senegal with that of Mauritania and certainly that of Burkina Faso, which will be discussed later in the conference, shows that mutuals can be potentially useful for the integration of payment exemptions but only when scaled up. The delegation of certain duties from the State to mutuals, both for management and for medical control or social activities for example, is at the heart of an international debate and will be discussed at a meeting organised at the end of June by the ILO in Geneva. This is not to say that local and small-scale initiatives are not

useful, but they should, if (rigorously) proved effective, equitable and socially accepted, be scaled up more quickly and contribute to the development of national SHP. States and development partners certainly have a responsibility in this regard. The case of Mauritania shows that it is easier said than done for the poor, but our Mauritania peers will present more convincing experiences later in the day. An important aspect in the matter of scale is the voluntary nature of insurance membership. Mutuals in Rwanda have made membership almost obligatory. In civil registry discussions we noticed it is certainly useful to remember that several States in the region are currently considering how to use civil registry documents to encourage people to take out insurance. In addition, the question of professionalising the management of mutuals as well as civil society organisations was addressed in several presentations and will certainly be an important point of attention as the discussions showed the complexity of bureaucratic operations of insurance companies, of RBF, of mutuals, etc. Furthermore, the vast majority of the presentations showed that state subsidies are indispensable both for subsidising contributions to mutual insurance companies and for covering the full cost of contributions for the poor. This brings us back to the need for increased public funding and sustainability issues, which were discussed at length in the discussions on the link between PBF and insurance, since we know that the former is almost totally dependent on international funding.

The additional funding was only given on the condition that certain aspects of 'quality' and 'equity' were present. It has therefore made it possible both to improve the performance of supply and to recapitalise the care system. Prospective reflections are being carried into how health insurance can replace all or part of PBF, which could remain a modality of institutional financing of the health care offer (see the reform of public finances and the programme budget which is developing in several countries that were represented at the conference).

Our peer of UCL showed us that in Europe and North America the notion of fee-for-service payment is tending to give way to a 'lump-sum' payment per local system of services and care where indicators are only used as a learning tool on local systems.

But the countries of the North are far from always being right; the future will tell. Next, it is also necessary to make payment terms more transparent for those who are able to pay, hence the interesting experiments on flat-rate pricing, which can initially be subsidised. This transparency for users and the population refers, once again, to the previous day's debate on the need to strengthen the reactivity of health systems and of their human resources, but also their capacity to control costs, particularly with medical control, and the quality of care.

Finally, a cross-sectional analysis of these presentations and of all the reflections and comments made during the discussion sessions may indicate factors that are conducive to Social Health Protection and UHC development. Here are some of the elements that we felt are essential:

- Ensure public funding and reduce dependence on international donors
- Plan activities for sustainability at the beginning of mostly long-term projects and interventions; three-year projects are too short
- Have political, organisational and individual leadership to drive and sustain change
- Evaluate, analyse, learn, correct and advance, be part of learning organisations and use knowledge based on experience (e.g. calculations of costs, disease burdens, etc.) and research

- Take advantage of the potential of digitisation but take into account its challenges and local contexts
- Have local and regional, political and community embedment and ownership
- Mobilise human resources (both supply and demand) that are motivated, dedicated, professional and fairly paid
- Organise inclusive and responsive governance
- Think about the feasibility of proportionate universalism

The three key messages of the day are presented in Inset 2.

Inset 2: Three key messages of Day two

1. Civil society has an important role in the implementation of social protection policies. It has a counter-power role: It protects people's right to health (through the management of complaints, the denunciation of abuse) (case of the health service users platforms). It also carries out advocacy and awareness-raising activities; it takes an active part in the implementation of programmes (ROASEN Niger); it is locally embedded and maintains relationships of trust with the populations.
However, the commitment of civil society can sometimes be limited by volunteerism and the effective representativeness of the populations it so ardently defends, especially the poorest.
2. Importance of constructive communication: The President of Senegal's Departmental Health Insurance Units stated, "You have to accept to lose time at the beginning to gain time afterwards"; "There is no point in running..."; "For the population to take ownership of the model, it is necessary to communicate with them", through its various segments (elected representatives, administrative authorities, opinion leaders, etc.);
However, this communication must be marked by mutual respect between the various actors and respect for the commitments made by each of them, particularly between supply and demand
3. Social protection is truly protective if it is large scale and offers professional help. In Senegal "those who have their membership card can benefit from all services within the department", and "those who have a health problem are those who are not insured".
However, there are challenges of equity (Rwanda case) and sustainability (case of the Dar Naïm mutual (Mauritania) whose Deputy Director said, " after 17 years we couldn't get to where we could be", and "people who left the mutual insurance scheme very quickly faced health problems" and "fell back into the poverty spiral").

3 Day three

On Day three, we had presentations from the 10 participating countries and worked in groups on 8 central themes. In the presentations of the 10 countries, four points were addressed: i) the national context, ii) the option chosen by the country, iii) the state of progress of UHC implementation, and iv) the lessons learned, distinguishing between what has worked, the challenges and the perspectives. Thus, the presentation can be narrowed down to three points: (a) current experiences, (b) what might have worked and (c) lessons to be learned.

3.1 Current experiences

3.1.1 With regard to the organisation of social protection

The establishment of a legal and institutional framework for the implementation of social protection is effective or underway in all countries. In most of them, the government has defined a policy in this area. It has issued texts to organise this reform and set up bodies to manage it. Texts can always be revised or institutional arrangements improved, but the existence of the framework is, in itself, an achievement. The options chosen vary greatly from country to country. Most of them have opted for separate management of the core functions of SHP:

a) individual management of the assistance function, which translates into total or partial free of charge assistance for certain categories (pregnant women, children aged 0-5, people living with a disability, people living in poverty, people living with HIV, etc.) or for certain pathologies (tuberculosis, breast cancer, cervical cancer, dialysis, etc.)

b) the isolated management of the foresight function, often referred to as the social security function, which involves either a compulsory contribution, particularly for state employees for example, or a voluntary contribution organised by private insurance companies or mutual health organisations.

It is clear that this diversity of organisational forms accounts for the fragmentation of the social protection system in most countries. However, many are still in the pilot phase and will eventually find their bearings through successive adjustments.

3.1.2 With regards to care

The implementation of social protection mechanisms would have changed the lives of several million people: thousands of lives saved, disabilities avoided or reduced and, finally, hours of work gained and thus billions of dollars earned. In addition, the establishment of social protection mechanisms has triggered a process of professionalisation of the sector. It is now providing work for thousands of people, enhancing the skills of many others and improving the lives of thousands of families.

3.1.3 With regards to financing

States are making efforts to advance reform. Thus, in Burkina Faso, the public authorities pay 80% of the bills; in Senegal, the State respects its commitments by paying its share. The same is true for Côte d'Ivoire or Mauritania where resources are not an issue. Finally, in Togo, 50% of the contributions of public and private sector employees are paid by the State.

3.1.4 With regards to regulations

In some countries, this is regulated by Regional Committees which meet once a year to assess satisfaction. These entities are largely made up of employee representatives, who, in Togo for instance, occupy six out of ten seats in the Board of the National Health Insurance Institute. In this country, some disputes are settled through the internal mechanisms of mutuals. Within the same institute, there is an internal derogation committee that receives and processes beneficiaries' appeals, as well as a toll-free number to receive complaints. In Côte d'Ivoire, NGOs are enlisted to monitor mutuals and identify possible fraud. In Burkina Faso, the system now uses digital invoices: "transactions" are carried out online, which saves time and minimises fraudulent arrangements.

3.2 What might have been organised better

In general, there are two main challenges in the implementation of Social Health Protection. On the one hand, the weakness of political will and, on the other, the weak institutionalisation of Social Health Protection mechanisms.

3.2.1 Weak political will

Social Health Protection is a priority for states in terms of discourse but not in terms of practice. Indeed, it relies more on external funding than on domestic resources. Budgets allocated to health are below the threshold set by the WHO, let alone that of the Abuja Heads of State Conference (15%). Indeed, most states do not mention sources of sustainable funding for their social protection systems. As for the local authorities, which are expected to act as local relays for social protection systems, they do not have a sufficient financial base or the capacity to mobilise resources to carry out this mission. Niger and Guinea contribute only 0.2% to the health budget. In terms of the distribution of available resources, a large share of the health budget is absorbed by the central level. This distribution is therefore to the detriment of rural areas. However, in addition to the low allocation of resources, there are problems with the consumption of available funds by the administrations' managers. In Guinea, for instance, only 46% of the annual health budget is actually spent. This situation is not always conducive to consistent funds being allocated to health. There does not seem to be enough social dialogue, institutionalised meetings between the State and citizens.

3.2.2 Institutionalisation of Social Health Protection

There is a low level of Social Health Protection coverage in the region, including mutual health insurance. It is therefore important to intensify communication in particular. Furthermore, the scope of services in the framework of Social Health Protection remains ill-defined: for example, non-communicable diseases (hypertension, diabetes, cancer, etc.) are not always covered by these mechanisms, even though their frequency is high. Moreover, the mechanisms put in place to regulate social protection have not always worked well. This is the case for the Foresight Fund and the universal scheme in Benin, or the National Indigence Fund, which may experience funding shortfalls for at least 6 months. One can add the entities intended to receive contributions from civil servants in 2016 in Togo or Guinea, which never functioned. Likewise, in many countries the advisory medicine function is not yet sufficiently well-established. The same applies to protection of users' rights (workers' representatives), instances for which are not very active in these countries. Finally, in most countries, the informal sector employs a significant proportion of the population (80% in Niger). This population does not feel the need to join a social protection scheme unless the issues are explained to them. It is essential to raise that population's awareness and foster its enrolment in the social protection system.

Inset 3 summarises the lessons learned from country experiences.

Inset 3: Lessons learned from country experiences.

1. The State's respecting its obligations is essential for the implementation of a SHP policy. This shows that without political will, any social protection policy is bound to fail.
2. There is no such thing as a SHP policy without a comprehensive strengthening of the health system (supply side). This strengthening presupposes a judicious policy on the quantity of human resources, substantial and well-distributed funding and a policy of

supply and use of medicines, in short, good governance.
3. The lifting of the financial barrier is a necessary condition for the implementation of SHP, but this condition is not sufficient.
4. The quality of reception in health facilities is essential to support the process.
5. The defence of people's rights is an essential factor in social protection. It involves, among other things, communication and information on their rights as well as strengthening of appeal and complaint management bodies and the participation of civil society organisations, including representatives of the informal sector and local administrative and political authorities in decision-making bodies.

To come to a general summary, it seems useful to first look back at the conference to then attempt to summarise the content of our debates, notwithstanding the group work discussions and the panelists' debates.

So, before discussing the content of the debates, it is useful to highlight the proceedings of the four-day conference. The organisation of the conference and the studious and efficient attitude of all on-site and online attendants are obviously to be commended. Such meetings are always essential and, after two years of the pandemic, obviously all are very happy to meet and talk to each other, with or without masks, with or without dance music. The proceedings allowed all those involved in the interventions to share their experiences. Knowledge based on experience is essential to the discussions and exchanges and participation and willingness to share is to be welcomed. The reflective analyses presented by the various speakers were often carefully prepared and useful for the discussions in the group workshops. Of course, it is never easy to reflect on the way one works and it is never easy, considering you are representing your country abroad, to take a critical stance on your actions. But criticism must be constructive. However, it would certainly have been beneficial to supplement this tacit knowledge with knowledge from evaluations or research on policies and interventions from more distanced sources, including scientists from the countries concerned. Perhaps this is a lesson to take away to the next conference. However, regardless of the varying reflection intensity between presentations, many elements and dimensions of Social Health Protection that need to be strengthened were identified at the conference. So, together we have a myriad of challenges and actions to take!

3.3 Debate

Let us now turn to the content of the discussions. What is the most important thing to share? Firstly, the key message of the conference remains the importance of developing, financing and maintaining a contributory and equitable Social Health Protection system in the sense that those unable to pay will be covered by solidarity including public subsidy. This can then be grouped into three main categories: governance, financing (which was central to the debates and in particular equity), and finally services.

3.3.1 Governance

- Most, if not all, countries have an arsenal of legal, regulatory and policy documents in support of UHC and Social Health Protection. Our peers from Benin referred to the Law of February 2021 making insurance compulsory. However, some complain about the long debating, discussion, consultation and political dialogue time needed to establish a consensus ("consensus is good, but when time is lost in discussion"; "10 years after the texts...") and above all for the situation to change on the ground for the population and professionals.

- It was noted that in many countries, contrary to popular belief, public administrations often prove to be agile, to adapt to changes and to sometimes difficult security situations. In the Sahel region, for example, they have been responsive.

- It seems to us, however, that there are still major governance issues to be addressed in relation to insurance regulations, advisory medicine and medical control, digitisation and respect for privacy in a context where attempts are being made (quite rightly) to digitalise both supply and demand.

- While the issue of agencies has received relatively little attention in research on public administrations in Africa, it is interesting to note that almost all countries are engaged in the creation of National Agencies or National Institutes to federate, coordinate, oversee or govern the multiple social protection policies and programmes. These agencies face huge challenges, such as having sufficient funds and human resources, not becoming political instruments, and being able to resist possible "fragmenting" pressures from donors.

- Finally, it can also be noted that almost all countries recognise the challenges of the fragmentation of multiple exemption policies for vulnerable groups and are now almost all trying to integrate them into their existing or emerging agencies. These combinations and integrations therefore remain to be studied, evaluated and certainly supported by all actors.

3.3.2 Financing

- The long-standing findings on the fragmentation of funding mechanisms and the dependence on international funding were not missing at this conference. We can still see that donors have enormous financial (and therefore certainly conceptual) weight and that some countries are still struggling to commit themselves to the health sector. However, there have been interesting examples, like in Burkina Faso, of increasing the state budget for health, even though it has been facing a major crisis in recent years. But one should never rest on one's laurels and remember that the UHC law in Burkina was to be voted on the day of the popular revolt and the burning of the National Assembly. Things change fast indeed.

- As a result of these challenges of public financing, it is still the households that pay a heavy price for health care. The health care utilisation rates shared by some countries remain alarming and we all have a collective responsibility to find a solution, beyond the solutions that many countries have talked about, for the care of the poor. All countries have shown how essential public subsidies are for access to health care and insurance coverage, including for people living in poverty. The issue of navigation of the health system, i.e. the need to support the poor in exercising their rights to access health care, which is often free in principle, was highlighted on many occasions during the conference for many countries, and it will be essential that we do not forget them. Issues regarding the necessary upscaling of our insurances and the means to make it compulsory are certainly among the challenges for the coming years. The role of finance ministries, poorly represented in this conference, will be central.

- Moreover, although little was said about it, the role of local and regional authorities, both in governance and funding, is crucial. We noted that Guinea contributed only 0.2% of the budget whereas it should commit 15%, which is reminiscent of the case of Mali where these local authorities were supposed to pay 25% of Medical Assistance Scheme expenses for the poor, which was never possible. There are certainly venues to be explored from this point of view, even if we must not forget the issues of regional equity, as was brilliantly presented to us in Uganda.

- Finally, at a more micro level, we have seen the challenges for many countries to have up-to-date pricing, which takes into account the current reality and burden of disease, the challenges of defining the care package, the evolution of needs and technologies, quality control, etc. Several countries are embarking on digital payment, which will soon go hand in hand with digitised demand and face similar challenges of technology, data protection, interoperability, etc.

3.3.3 Service/Supply

- Quality of care received relatively little attention in our four days as our discussions focused on Social Health Protection. However, the issues of medical control have sometimes been highlighted in the context of contracting demand and supply. One of the challenges addressed by some countries is that of sanctions, or simply the procedures put in place following a patient's complaint or medical control. Scaling up health insurance will have to ensure that it remains 'social' by placing citizen participation at the centre of the construction of the insurance system. The COVID crisis showed that the relatively strong state responses often ignored citizen participation in the North and in Africa where citizen participation is well developed.

- Indeed, one of the important debates of the conference was the place of users and citizens in the governance of health systems and Social Health Protection bodies. Examples from various countries to address this have been presented, achieving participation through hotlines and call centres, satisfaction surveys, mutual health insurance companies, beneficiary committees, etc. The place of citizen social participation mechanisms is becoming increasingly clear and countries are gradually learning to take them into consideration in the construction of their Social Health Protection system.

Let us conclude with two points; the first is something we regret, the second is a piece of hope.

We regret, as often happens at conferences on inequalities and elsewhere, that we talked mainly about poverty, indigence and charity and little about inequalities. Fighting inequality is not just about focusing on the poorest, which is necessary but not sufficient. Indeed, in order to fight against inequalities, we must act by taking into account the social gradient in health, which shows that the hardest to reach are often the ones we need to reach most, hence the challenge of proportionate universalism, dear to Michael Marmot, which we discussed: to act for all but also to act in a way that is proportionate to the needs of each sub-group of the population. A permanent and dynamic framework for exchanging good practice in this regard is urgently needed, as the panelists mentioned, but it will need to be based on solid evidence, beyond knowledge based on experience.

Hope, to end on a positive note, compels us to go back to the beginning of the conference and recall the words of our WHO colleagues who explained to us that the umbrella of UCH had been pierced and told us of the challenges of going beyond declarations on social participation, and finally the words of His Excellency the Prime Minister of Niger, who urged us to find "more humane" solutions. Indeed, the Director-General of the WHO recently stated that "the roof (of UHC) must be repaired before the rain comes". However, in his latest novel, the well-known Mauritanian writer Beyrouk had one of his characters say, "Doctors on strike? Have them treat the rich and keep quiet; the poor will turn to the marabouts! ". This writer's phrase alone expresses the main challenges of the vast collective ambition that we have been talking about for four days: public financing, large-scale risk sharing and professionalism, the fight against inequalities and social participation, and finally quality of care.

Finally, a declaration of intent was drawn up by the two ministers present and the three ministerial delegations. It is given below.