STUDY

LABOUR AND SOCIAL JUSTICE

TOWARDS UNIVERSAL HEALTH COVERAGE

The Cases of Benin, Côte d'Ivoire, Ethiopia, Kenya, Senegal and Zambia

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Several African countries have, in recent years, made considerable progress in extending universal health coverage (UHC) to households in the informal economy. However, the rate of UHC coverage varies significantly from one country to another, and none of the six countries has as yet reached the goal of UHC.

The most successful UHC schemes follow standard, country-wide rules and procedures, and combine decentralised financial management and health delivery systems with centralised oversight and risk-pooling.

All successful UHC schemes provide free health coverage for the poorest segments of the population.

FRIEDRICH EBERT STIFTUNG

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This study provides an overview of the progress made in advancing towards the global goal of universal health coverage in six African countries, namely Benin, Côte d'Ivoire, Ethiopia, Kenya, Senegal and Zambia. These six countries took part in the FES-DIE-ILO opinion poll on informal employment, social protection and political trust in sub-Saharan Africa, conducted between 2018 and 2020. The results of the opinion poll are being published in a separate FES-DIE-ILO report (forthcoming). The present study provides background information on current UHC policies and performance in the six countries.

The study reveals a convergence between UHC-related universal goals (SDGs, WHO strategies, ILO instruments), regional priorities (African Union health strategy), national commitments and donor support. The lessons learned from the six country papers point towards a hybrid model of health insurance as having the most potential to achieve universal health coverage. The hybridity has two dimensions: Firstly, a hybrid management and delivery system, whereby essential functions are delegated to local communities, but under the guidance and supervision of a central authority that sets standard rules and regulations, monitors financial flows, and pools risks. Secondly, a hybrid funding scheme, whereby household contributions are complemented by government subsidies and, temporarily, by donor support.

The study stresses that the poorest households must be exempt from paying any financial contributions, because otherwise they would be excluded from UHC. Moreover, health insurance schemes should be mandatory for everyone, whether formally employed or not, because otherwise the healthier and wealthier households would opt out.

Further information on the topic can be found here:
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FOREWORD

Health care plays a crucial role in combating social inequality: people working in the informal economies of sub-Saharan Africa are generally poor and therefore are at much higher risk of falling into financial debt because of the cost of treatment. This often puts them off seeking treatment. Free health care and universal health insurance can break the link between poverty and health care provision.

By putting the topic of health care, including universal health coverage (UHC), at the top of the list of the Sustainable Development Goals (SDG 3) the United Nations acknowledged its critical role in achieving Agenda 2030. Unfortunately, in 2020 about 408 million people in sub-Saharan Africa remained without access to health care. The sheer numbers demonstrate the magnitude of the looming challenges for the countries in the region in their efforts to provide access to health care. These have increased since the global pandemic hit their weak health care infrastructure, especially in urban areas. Despite these challenges, many African governments have made health care and the provision of universal health coverage a top priority in their national policy agendas.

This publication provides an overview of the progress made in advancing towards the global goal of achieving universal health coverage in six African countries, namely Benin, Côte d'Ivoire, Ethiopia, Kenya, Senegal and Zambia. The six countries took part in a survey on informal employment, social protection and political trust in sub-Saharan Africa. The survey was conducted jointly by the Friedrich-Ebert-Stiftung (FES), the German Development Institute, and the International Labour Organization (ILO) in cooperation with institutes of the Afrobarometer network. The surveys were conducted between 2018 and 2020. The results of the survey are being published in a separate report (forthcoming), but the present study provides background information on current UHC policies and performance in these six countries. This publication can thus help to put ›access to health services‹, a central topic of the survey, into perspective.

One of the key findings of this study is that UHC can be achieved only when access to health services and financial risk protection are addressed simultaneously. Equitable financial protection means that everyone, irrespective of their level of income, is free from financial hardship caused by using needed health services. The study also suggests that the poorest households should be exempt from paying any financial contributions. Moreover, health insurance schemes should be mandatory for everyone, whether formally employed or not, because otherwise the healthier households would opt out.

Finally, the findings from the country reports point to the importance of intra-African cooperation in the area of health care and health financing as some African countries have found ways of improving access to health care despite limited resources. We at FES, jointly with our partners from the ILO and the German Development Institute, hope that this publication can support efforts to improve access to universal health coverage in sub-Saharan Africa.

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INTRODUCTION

Universal health coverage (UHC) is a key element of the broader field of social security; the right to social security is a human right, set out in the Universal Declaration of Human Rights (Articles 22 and 25) and in the International Covenant on Economic, Social and Cultural Rights (Articles 9 and 11). In this context, the ILO Social Security (Minimum Standards) Convention 1952 (No. 102) is the only international instrument that establishes worldwide-agreed minimum standards for nine branches of social security, including medical care, sickness and maternity. This Convention provides a benchmark for the progressive extension of comprehensive social security systems (Phe Goursat & Pellerano, 2016). However, because of the fiscal burden that such comprehensive systems represent, so far only 55 countries worldwide have ratified Convention No. 102. The ILO has therefore developed the notion of a more affordable »social protection floor«, which constitutes a basic set of social protection guarantees to all persons in need, to be defined at the *national* level. This floor should guarantee at least access to essential health care and basic income security throughout the life cycle, as a first step toward achieving higher levels of protection. This concept was sanctioned through the adoption of the Social Protection Floors Recommendation, 2012 (No. 202).

In 2005, the 58th World Health Assembly unanimously adopted a resolution calling on member countries of the World Health Organization (WHO) to develop health financing systems to ensure that their populations have equitable access to quality health services. In this context, on 6.12.2012, the 67th session of the United Nations General Assembly adopted a resolution on Universal Health Coverage. This resolution calls on each UN Member State to avoid direct payment for care by users and to finance its health system through more equitable and solidarity-based mechanisms.

These two interrelated concepts – the social protection floor and UHC – are reflected in the UN Sustainable Development Goals (SDGs). SDG 1 on ending poverty includes a Target 1.3, which reads: »implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable«. In addition, SDG Target 3.8 calls upon UN Member States to »achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all«. SDG Target 3.2 commits Member States to »increase substantially health financing and the recruitment, development and training and retention of the health workforce in developing countries, especially in LDCs and SIDS«. SDG Targets 3.8 and 3c encapsulate the three essential aspects of UHC, namely, the *availability* of health services, the *affordability* of medical care, and the *quality* of such care. UHC can be achieved only when access to health services and financial risk protection are addressed simultaneously. Equitable financial protection means that everyone, irrespective of their level of income, is free from financial hardship caused by using needed health services. In September 2019, the UN convened a high-level meeting on UHC, which adopted a political declaration, whereby UN Member States committed to extend health services to an additional one billion people by 2023.

The African Union Health Strategy (AU, 2016), which covers essentially the same period as the SDG (2016–2030), considers the achievement of UHC as one of two strategic objectives. In February 2019, the 32nd Summit of the African Union adopted the Addis Ababa Call to Action on universal health coverage, which was followed a few months later by the signing of an agreement between the African Union and the WHO, whereby the WHO commits itself to supporting the AU Health Strategy.

Many African governments have made high-level political commitments to achieving UHC, and have launched concrete programmes towards that goal. UHC has clearly become a top priority for African governments throughout the continent.

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COUNTRY REPORTS

The six country papers are structured in a way that reflects the concerns, goals and dimensions of universal health coverage. In most African countries, health coverage, in particular its financing aspect, is confined to the formal economy. To achieve *universal* health coverage, governments must therefore find ways to cover the *informal economy* as well. Consequently, the country papers provide a brief overview of the size of the informal economy in the six countries.

This is followed by the most recent statistics on the availability of health personnel and health facilities, and on key indicators of health financing. For lack of adequate data, the *quality aspect* of health services is discussed only indirectly (for example, through changes in the population-to-health-personnel ratio). The central part of each country study focuses on recent initiatives to extend health insurance to the entire population.

BENIN

Benin had a population of 12.3 million in 2020, of whom 4.8 million were active in the labour market (see Table 1).

According to the latest estimates published by the National Statistics Bureau, the share of informal employment in total non-agricultural employment declined to 92.6 per cent in 2018, with a considerable gender gap (males: 87.2 per cent, females: 97 per cent) (INSAE, 2021). Moreover, the informal economy contributes, according to the most recent estimates, some 65 per cent to the country's total economy (LO/FTF, 2018). Benin is thus one of the world's most »informal« economies.

According to the latest statistics, the following number of health workers are presently active in Benin (see Table 2).

The number of health workers varies widely between administrative regions; in all cases, the highest ratio occurs in the Littoral Department, where the capital Cotonou is located. For example, in the Littoral Department one medical doctor covers a population of 8,312; in the Borgou Department, the equivalent ratio is 1:102,983. Moreover, Table 2 shows a very disturbing decline in the number of medical personnel, in all categories. The reason for this decline is unknown, but may be due to the migration of medical personnel from the public to the (better paying) private health sector. The same table shows the evolution of medical facilities during the same period of time. The increase in the number of facilities, coupled with the reduction of medical persons, must have had a significant negative impact on the quality of health care in Benin.

Table 1
Benin: Labour market indicators

Indicator	Labour force (thousands, 2019)	Labour force participation rate (per cent, 2019)	Unemployment rate (per cent, 2018)	Informal employment (percentage of total employment, 2018)	Average monthly earnings (FCFA, all workers, 2018)	Vulnerable employment rate (per cent, 2018)	Working poverty rate (per cent, 2019)
Total	4,826.4	70.8	2.3	92.6	65,468	84.1	38.9
Male	2,450.6	72.8	2.3	87.2	64,739	86.6	47.9
Female	2,375.8	68.8	2.3	97.1	66,305	94.4	29.6
Youth (15–24)	984.8	42.0	3.5	n. d.	n. d.	n. d.	44.4

Source: ILO Stat (https://ilostat.ilo.org/data/), INSAE (2021), UEMOA (2019)

Table 2
Health personnel and facilities in Benin

Indicator		2014	2019
Medical doctors	Number	1,507	561
	Citizens per doctor	6,628	21,137
Nurses	Number	4,821	2,670
	Citizens per nurse	2,072	4,441
Midwifes	Number	1,415	905
	Women of childbearing age per midwife	1,699	3,202
Hospital beds	Number	4,837	5,119
	Citizens per bed	2,050	2,316
Hospitals (all types)		55	59
Health centres		571	787
Dispensaries (without a maternity ward)		118	58
Maternity wards (without a dispensary)		113	123

Source: MINSANTE (2015, 2020)

The statistics in Table 2 cover only public health personnel and facilities. No equivalent statistics on private personnel and facilities are available. However, we can assume that informal-economy workers, the target group of the present report, would be unable to afford private health care. Moreover, it has been reported that over 80 per cent of all citizens of Benin occasionally rely on traditional healers for their medical treatments (Xinhuanet, 2018).

Total annual health expenditure amounted to 30.9 US dollars per capita in 2018, or 2.5 per cent of GDP, a decline of about one percentage point compared with 2012. Out-of-pocket expenditure for health services amounted to 44.6 US dollars per capita in 2018 (World Bank, 2021).

Article 8 of the Constitution of Benin (adopted on 11.12.1990) recognised access to an adequate level of social protection for all as a fundamental right. It took 18 years before the government of Benin, in 2008, began to look for ways of extending health coverage to the entire population; three years later, in December 2011, government formally launched a national universal health coverage scheme *(régime d'assurance maladie universelle*, or RAMU) whose implementation was delegated to the Agence Nationale d'Assurance Maladie (ANAM), which will operate in cooperation with existing institutions, such as the national pension fund (Fonds National de Retraite du Bénin (FNRB)) and with community-based mutual benefit associations (»*mutuelles de santé communautaires*«). The latter were given the responsibility of extending health coverage to the informal economy. On 28.12.2015, the parliament of Benin adopted law No. 2015-42 introducing compulsory health insurance (RAMU), while the government elaborated a national health financing strategy with a view to achieving universal health coverage by 2022, and carried out a study to identify innovative financing methods to support UHC (Fantodji, 2018). RAMU was designed to cover a broad range of inpatient and outpatient medical services. In 2014, RAMU had enrolled just 48,817 individuals (of whom 32,354 were from the informal sector), representing three per cent of the population. Even worse, a mere 3,076 RAMU affiliates had actually paid their contributions. The annual contribution to RAMU amounted to 12,000 FCFA (19 US dollars) per year for adults, plus 1,000 FCFA per year for each child under 18. A family with two adults and four children would therefore pay an amount of 45.2 US dollars per year. The poorest families (as identified by the community) did not have to pay any premium. Patients seeking treatment in a departmental hospital paid, in addition to the premium, ten per cent of the actual costs, and those visiting a university hospital paid twenty per cent as a co-payment (Ministère de la Santé du Benin, 2017).

By the end of 2016 Benin had registered 175 »*mutuelles*« (down from 313 in 2012), covering 73 per cent of the nation's »communes«. The total number of members was estimated at 65,000, and the number of beneficiaries 197,000, representing two per cent of the population. By 2019, the number of members in Benin's *mutuelles* had dwindled to 43,904, with 96,124 beneficiaries (CONSAMUS, 2019). The annual contribution per member amounts to 2,400 FCFA (4.40 US dollars), and medical expenditures are reimbursed at 75 per cent (Gbemenou, no date). Those participating in the health insurance component of the Caisse Mutuelle de Prévoyance Sociale (CMPS) pay a monthly contribution of 850 FCFA (1.30 US dollars). In December 2014, the individual *mutuelles* formed the Fédération Nationale de la Mutualité Sociale (FENAMUS) as an apex body.

According to the most recent estimates, all health insurance schemes operating in Benin (CNSS for formal sector workers, *mutuelles*, RAMU/ARCH, private insurers) cover no more than nine per cent of Benin's population (Koto-Yerima, 2017); the proportion is even lower in rural areas (six per cent). The low coverage of the *mutuelles* has been attributed to a number of factors, such as:

- their fragmentation (many parallel initiatives driven by different development partners and NGOs);
- their small size (an average of 330 paying members per group, which makes it hardly possible to hire a professional manager);
- their costly multi-level structure (in 2014, 203 primary *mutuelles*, 52 regional unions or networks of primary *mutuelles*, six departmental councils, one national federation (FENAMUS) and one coordinating body (CONSAMUS) (Koto-Yerima, 2016)), as well as a strong donor dependency (the premiums collected cover just 50 per cent of the costs of health care). Moreover, the individual *mutuelles*, which belong to various, donor-dominated networks, are not covered by a centralised risk-pooling and financial management institution (as is the case in Rwanda, for example);
- the voluntary nature of membership in mutual health insurance schemes;
- the lack of consistent government support to *mutuelles*.

In 2017 the Government of Benin introduced a new scheme entitled ARCH or Assurance pour le Renforcement du Capital Humain (Insurance for the strengthening of human capital). ARCH was to provide four services, namely health insurance, vocational training, micro-credit and a pension scheme for informal economy actors, at a total cost of 313 billion FCFA (575 million US dollars). ARCH was formally launched by the government in May 2017, and replaced (or absorbed) RAMU at the end of 2018 (Ministère du Travail et de la Fonction Publique, 2017). Under the health insurance component of ARCH, the government is expected to provide full health insurance coverage for persons in extreme poverty, and partial coverage for persons affected by moderate poverty (as was the case with RAMU). Health insurance is compulsory by law for all persons residing in Benin (as was the case with RAMU as well). Every citizen, including those in the informal economy, must subscribe to at least basic health insurance. The pilot phase of ARCH's health insurance component was officially launched in seven pilot communes in July 2019, where 105,000 people living in extreme poverty were identified. Of those, 2,251 were being cared for in public health facilities covered by health insurance as of March 2020. The programme to identify persons in situations of extreme poverty is being extended to 14 additional communes; in total, it is expected that 180,000 persons in those 21 communes will receive free medical care for a period of three years (GoB, 2021).[1] Up to April 2021, however, only 5,000 of this priority target group were effectively covered. In January 2021, the government launched the gradual expansion to all 56 Beninese communes. Persons participating in the health insurance component of ARCH on a voluntary basis pay a monthly contribution of 850 FCFA (1.30 US dollars) to the Caisse Mutuelle de Prévoyance Sociale (CMPS).

Benin is far from achieving universal health coverage. Although no recent data are available,[2] it is quite likely that the low coverage rate of nine per cent reached in 2016 has declined further, as a result of the confusion around RAMU-ARCH,[3] the dwindling in the number of *mutuelles*, and the decline in health care quality because of the shrinking number of health personnel. If, after 24 months of implementation, only 5,000 persons – representing only 0.04 per cent of the population – are effectively covered by the ARCH scheme, it could take a century before the entire nation is covered by health insurance. For a large majority of the population, the social protection system will continue to consist of self-organized informal social networks established to tackle the financial risks of illness, such as local micro-health insurance systems functioning on a solidarity basis.

A new law (N° 202-37) on health protection for persons residing in the Republic of Benin, adopted in January 2021, makes health insurance compulsory as from January 2021; this could help the country to achieve its objective of universal health coverage. This would require the effective involvement of all relevant actors, in particular insurance companies and community *mutuelles*.

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1 At present, the number of persons living in a situation of extreme poverty amounts to 285,000 in 28 communes; applying the same ratio to the entire nation, which is composed of 84 communes, would raise the number of persons in extreme poverty to 855,000, or 7.1 per cent out of a population of 12.1 million.

2 The FES-DIE-ILO opinion poll (see introduction) found that only 2.3 per cent of Benin's informally employed persons are covered by health insurance.

3 Many people did not understand why RAMU, launched with great fanfare in 2011, was suddenly discontinued in 2017, to be replaced by the much more complex and ambitious ARCH.

CÔTE D'IVOIRE

Côte d'Ivoire was one of the most stable and economically successful countries in sub-Saharan Africa until 1999, when a military coup – the first in the country's history – overthrew the government. This was followed by ten years of instability and civil strife, which ended in April 2011, when the current president Ouattara took power with the help of French and UN forces. Ouattara won a second term in 2015, and declared that he would focus his energy on rebuilding the country's economy and infrastructure.

Table 3 provides a few key labour market indicators, extracted from two labour market surveys carried out in Côte d'Ivoire in 2013 and 2018:

Table 3 shows that the (already low) labour force participation rate in Côte d'Ivoire declined by more than four percentage points between 2012 and 2017, mainly because of a fall in the male participation rate. The share of informal employment has declined by more than six per cent; this, together with a drop in official unemployment rates, seems to indicate an expansion of formal sector employment. The average monthly earnings of informal economy workers in Côte d'Ivoire in 2017 were equivalent to 70.6 US dollars, or 69 per cent of the minimum wage[4] of that year.

The availability of medical personnel and medical infrastructure has greatly improved in Côte d'Ivoire over recent years, as shown in Table 4; the table does not include private and faith-based medical facilities, nor the 8,500 traditional healers registered with the Ministry of Health:

Two-thirds of the Ivorian population reside less than five kilometres away from a primary health care centre, although in some parts of the country, this proportion is just three per cent.

As can be seen from Table 4, Côte d'Ivoire has exceeded several international health targets, and has decreased the burden of the population (decline in OOP) by increasing per capita government expenditure on health. The decline in health spending as a percentage of GDP may be because between 2010 and 2018 Côte d'Ivoire experienced strong economic growth, rising from 24.9 billion US dollars to 41.8 billion US dollars (constant 2010 US dollars), so that the relative weight of health spending shrank.

Article 9 of the Constitution of Côte d'Ivoire of 2016 stipulates that »everyone has the right of access to health services«, further declaring in Article 32 that the State »is committed to ensuring that vulnerable people have access to health services, education, employment, culture, sports and recreation«. Consequently, one of the goals of Côte d'Ivoire's National Health Development Plan 2016–2020 (MSHP, 2016) consists of achieving universal health coverage. UHC is considered one of the flagship programmes of Ivorian President Ouattara's second term (Mieu, 2020). The UHC regime was introduced by law in 2014, but became operational towards the end of 2019,[5] after three years of piloting, which involved primarily university students. The scheme is managed by the Caisse Nationale d'Assurance Maladie (CNAM), which has been mandated with the implementation of UHC in Côte d'Ivoire. The Ivorian UHC is a compulsory health insurance scheme which, in theory, every person residing in Côte d'Ivoire must join. All existing health insurance systems, whether public, private or community-based, have become complementary insurers, which means that all individuals must subscribe to the CNAM first, even if they are already covered by another health insurer.

The CNAM provides two options:

- The standard scheme (Régime de Base), with a monthly fee of 1,000 FCFA (1.83 US dollars) per member. In the case of formal-sector workers (public and private), the employer pays 50 per cent of the contribution.

- The non-contributory scheme (Régime d'Assistance Médicale), which provides free health insurance to the poorest segments of the population, i.e., persons registered as needy by the village or city council. The funding from the central government for this option is projected to be 30 billion FCFA francs (63 million US dollars) per year (Anne, et al., 2014).

The monthly contribution covers the member, their spouse (if unemployed), plus up to six children below the age of 21. However, the CNAM covers only 70 per cent of medical expenses (including medicines); the remaining 30 per cent are borne by the patient, and must be considered as out-of-pocket payments (OOP). There are currently (February 2021) 181 accredited sites where citizens can enrol with CNAM, located mainly in larger cities and towns.

UHC covers a wide range of medical services, including hospitalisation and supply of medicines, through (currently 716) accredited health centres and hospitals and (currently) 815 accredited pharmacies.

The CNAM has been conceived as a light structure that shall, where possible, delegate certain functions to existing institutions that possess expertise in the management of social risks (CNPS, CGRAE, *mutuelles*, private health insurers and so on). The delegation of functions may relate to:

- the collection of financial contributions from insured persons, and the transfer of those contributions to the CNAM;

- the administrative management of medical services, such as the settlement of invoices and of payments to healthcare providers.

4 Côte d'Ivoire has two minimum wages: 60,000 FCFA in urban areas and 35,000 FCFA for agricultural occupations. The 69 per cent ratio relates to the urban minimum wage.

5 However, it was reported in February 2021 that many clinics and hospitals have not (yet) agreed to operate under the CNAM scheme.

Table 3
Côte d'Ivoire: Labour market indicators

Indicator	2012			2019		
	Total	Male	Female	Total	Male	Female
Labour force ('000)	7,079.9	4,390.7	2,689.2	7,603.5	4,521.1	3,082.5
Labour force participation rate (%)	57.9	70.2	45.0	53.8	63.1	44.3
Informal sector employment (%)	94.8	93.3	96.5	86.7	83.9	90.7
Unemployment (%)	7.2	7.1	7.3	3.3	2.9	3.9

Source: UEMOA (2019) and ILO Stat

Table 4
Côte d'Ivoire: Medical personnel, facilities and funding

Indicator	2010	2018	WHO-Standard
Population per medical doctor	15,810	7,534	10,000
Population per nurse	6,959	2,259	5,000
Population per woman of childbearing age	3,219	1,104	3,000
Population per primary health care centre	11,722	10,164	10,000
Population per reference hospital	309,753	213,522	150,000
Out-of-pocket expenditure per capita (US dollars)	43.28	28.34	5–6 per cent of GDP and 10–15 per cent of OOP are recommended by WHO
Health expenditures as a % of GDP	6.1	4.2	
Government health expenditure as a % of general government expenditure	4.1	5.1	
Domestic general government health expenditure per capita (current US dollars)	9.84	20.7	

Source: MSHP (2013, 2019) and WHO (2021)

By 2015, health insurance coverage in Côte d'Ivoire had reached 7.08 per cent of the population, of which 2.93 per cent were insured by two public social protection institutions (CNPS and CGRAE), 3.25 per cent by the country's 61 *mutuelles*, and 0.90 per cent by private insurers (Bissouma-Ledjou, et al., 2015). By October 2019, the CNAM had insured 1,550,000 persons, representing 6.5 per cent of the population (Mieu, 2020). In theory, the CNAM scheme, which is mandatory, should have replaced all existing health insurance schemes, so that health insurance coverage would have declined from 7.08 per cent in 2015 to 6.5 per cent in 2019. However, as CNAM covers only a small fraction of the Ivorian population, one can assume that most of the »old« schemes continue unabated, which means that, de facto, the two systems operate in parallel. Moreover, the number of persons covered by CNAM is likely to have grown since October 2019, when the latest statistics were released. This means that, in all likelihood, effective medical insurance coverage in Côte d'Ivoire will have exceeded 10 per cent of the population. This is consistent with the finding of the FES-DIE-ILO opinion poll, according to which 10.3 per cent of informally employed persons are covered by health insurance.

Côte d'Ivoire has made great strides in expanding its medical facilities, and the relatively low population-to-doctor/nurses ratio might be seen as an indicator of medical service delivery quality. But with a coverage rate of (at best) 13.6 per cent the country lags far behind in ensuring UHC. The slow pace of expanding health insurance coverage could be due to two factors: (i) the UHC scheme is not embedded in community-based structures – CNAM does not have decentralised structures, the cooperating agencies CNPS and CGRAE have branches in major cities only, and the *mutuelles*, which could have served as a link to local communities, are far too few (61 in total) to be able to play this role; (ii) the fact that insured persons still have to bear 30 per cent of all medical expenses might discourage potential candidates.

ETHIOPIA

It has been impossible to ascertain the share of informal employment in total employment for Ethiopia. The latest comprehensive Ethiopian labour force survey (LFS) dates back to 2013 and is not accessible online. A study carried out in 2015, which compared the LFS of 2005 and 2013, reported a share of informal employment in total employment of just 13.5 per cent (Tadele & Kebede, 2015, p. 47), which appears extremely low, even when considering that this indicator was confined to *urban areas only*. The most recent employment and unemployment survey, also confined to urban areas and based on a sample of 23,500 households, reported a similarly low rate of informal employment (in urban areas): 16.2 per cent on average, with a wide gender gap of 24.4 per cent for women and 10.5 per cent for men (CSA, 2020). Two factors may be responsible for such a low rate of informality: (a) rural areas, as well as subsistence agriculture and household services were excluded from the survey altogether, and (b) any economic unit that keeps accounts and/or has a license is considered formal. In Ethiopia, it might be scarcely possible to carry out any economic activity without a license. According to one source (DTDA, 2020), the rate of vulnerable employment, which could be seen as a proxy for informal employment, was estimated at 86 per cent in 2019. In the same year, Söderborn et al. (2020) came to the somehow surprising – and hardly plausible – conclusion that »indeed in Ethiopia, the informal economy is estimated to account for over 38 per cent of GDP with data from the Ethiopian Central Statistical Agency showing that formal employment accounted for below 70 per cent of total employment in 2012«.

Table 5 provides a few recent labour market indicators for Ethiopia.

The average monthly wage in urban areas (formal and informal economy, and all occupations combined) amounted to 3,734.8 Ethiopian Birr per month in 2020, almost exactly 100 US dollars when applying the average exchange rate of that year. Men earned on average 50 per cent more than women. We can assume that earnings in the informal economy and in rural areas were considerably lower.

The Ethiopian Constitution of 1994 contains two prudently formulated references to health care. Article 41.4 stipulates that the »state has the obligation to allocate ever increasing resources to provide to the public health, education and other social services«, whereas Article 90.1 specifies that »to the extent the country's resources permit, policies shall aim to provide all Ethiopians access to public health and education«.

In 2016/17 (2009 Ethiopian Calendar, EC) the Ethiopian Ministry of Health reported the following health facilities.

The availability of primary and secondary public health facilities (health posts and centres) slightly improved from 5,366 population-per-unit in 2009/10 to 5,088 population-per-unit in 2016/17. Table 7 shows the availability of medical personnel in 2016/17 (public facilities only).

Table 5
Ethiopia: Labour market indicators

Indicator	2010			2019		
	Total	Male	Female	Total	Male	Female
Labour force ('000)	39,200.1	21,159.5	18,040.5	53,022.1	28,320.2	24,701.8
Labour force participation rate (%)	81.2	88.9	73.8	79.3	85.4	73.3
Unemployment (%)	2.3	1.7	3.0	2.0	1.5	2.7

Source: World Bank data (https://data.worldbank.org/indicator/SL.TLF.TOTL.IN?locations=ET), [Accessed 08 December 2021]

Table 6
Health facilities in Ethiopia (2016/17)

	Health posts		Health centres		Hospitals	
	Number	Population per unit	Number	Population per unit	Number	Population per unit
Public	17,187	5,485	3,724	25,303	302	312,013
Private	5,401	17,446	1,844	51,100	62	1,519,806
Total	22,588	4,172	5,568	16,923	364	258,868

Source: MoH (2009) and EC (2017)

Table 7
Medical personnel in Ethiopia (2016/17)

Medical doctors		Nurses (all levels)		Midwives	
Number	Population per doctor	Number	Population per nurse	Number	Women of reproductive age per midwife
9,117	10,335	78,914	1,194	7,275	3,238

Source: MoH (2009) and EC (2017)

In addition, Ethiopia had 39,878 health extension workers in 2016/17 (one health worker for a population of 2,363 citizens). Health extension workers are tasked with transferring knowledge and skills to the families they serve so that households have better control over their own health (MoH, 2015).

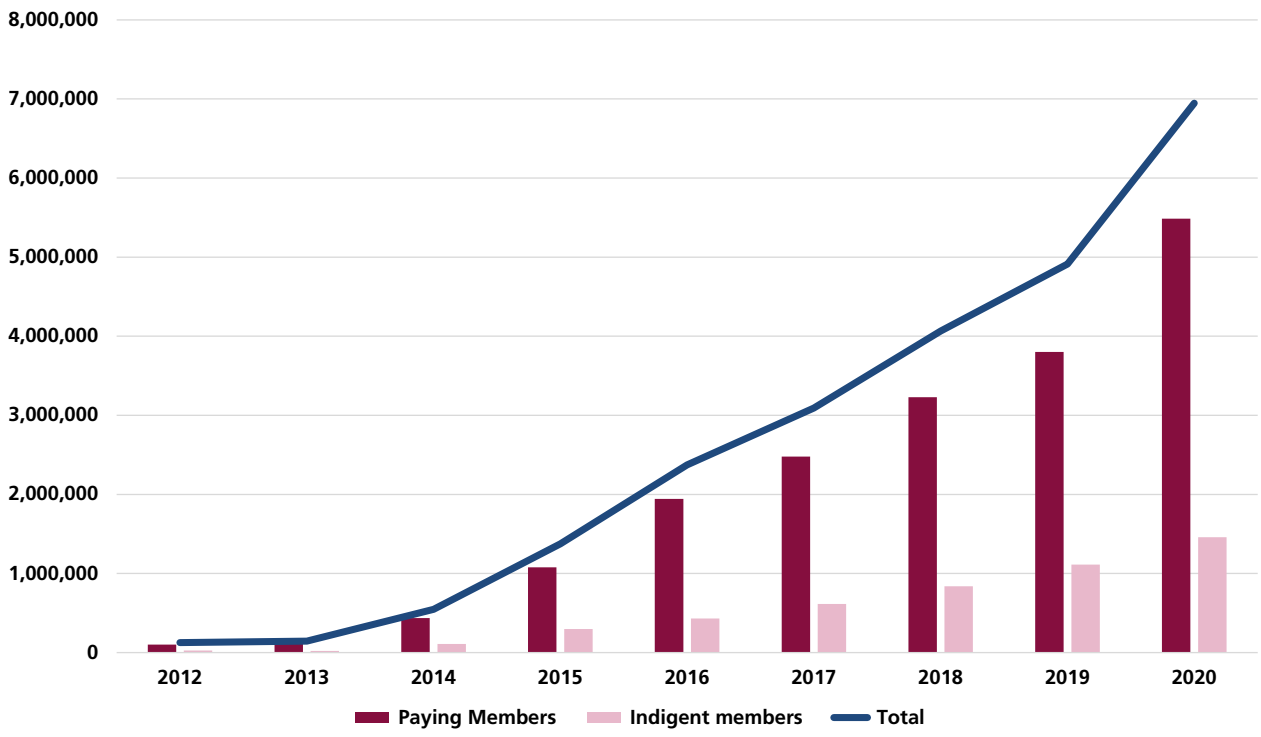
Government health expenditure represented 3.3 per cent of GDP in 2018; per capita health expenditure increased significantly from 5.38 US dollars in 2000 to 24.23 US dollars in 2018. In the same year, out-of-pocket payments for health represented 35.5 per cent of total health expenditures, down from 46.5 per cent in 2011. Since 2010/11, domestic government spending on health per capita tripled to reach 10.6 US dollars in 2016/17. Total health spending during 2016/17 was 3.1 billion US dollars, a 45 per cent increase in nominal terms from 2.5 billion US dollars in 2013/14. Expenditure on health as a share of total government expenditure increased from 7.6 per cent in 2013/14 to 8.1 per cent in 2016/17 (MoH, 2019).

Community involvement stands at the centre of Ethiopia's health sector strategy. Households and communities are engaged and empowered through the national Health Extension Programme (HEP) and the Health Development Army (HDA). These complementary programmes made it possible to reach communities and households with health promotion and prevention initiatives, and to mobilise resources from households and communities, both in kind and in cash, for the construction of health posts, for environmental health campaigns and for other public works that promote health and prevent diseases. Such community contributions enhance community ownership of health care, and foster health system sustainability. The stark decline of Ethiopia's maternal mortality ratio from 728 to 357 deaths per 100,000 births between 2003 and 2016 has been attributed to the HEP and the HAD (Rieger, et al., 2019). The positive impact of voluntary health extension workers has been acknowledged by the WHO as well (see story).

Community involvement is further realised through the expansion of community-based health insurance (CBHI) throughout Ethiopia. The CBHI, which targets primarily the informal economy, is to be complemented by a Social Health Insurance (SHI) regime for civil servants and formal sector workers. Ethiopia's CBHI design has been strongly influenced by Rwanda's *Mutuelles de Santé*; during a study tour to Rwanda in 2007, Ethiopian health officials were greatly impressed by the high enrolment rate and inclusivity of Rwanda's *mutuelles*. In the following year, the Ethiopian Council of Ministers approved a Health Insurance Strategy with the aim of making CBHI and SHI schemes operational within a year. While this goal was not achieved entirely, the 2010 Health Sector Development Plan set a target of 50 per cent health insurance coverage by 2015 (of which 10 per cent SHI and 40 per cent CBHI). An SHI proclamation was approved in 2010, making enrolment mandatory for formal sector workers and establishing the Ethiopian Health Insurance Agency (EHIA) to administer the scheme. However, SHI has still not become operational (Lavers, 2019). CBHI, on the contrary, began scaling up in 2013, expanding from 13 pilot woredas (districts) to currently 827 woredas (out of the 1,100 that exist in Ethiopia); however, some of the Ethiopian regions, such as Somali and Gambella regions, are just about to be covered by the scheme (EHIA, 2020). In 2015, the MoH launched the Health Sector Transformation Plan (HSTP), which targeted 80 per cent health insurance coverage by 2020. While this target has been missed, Figure 1 illustrates the impressive growth of the CBHI scheme since its launch (on a pilot basis) in July 2011. Given an average household size of 4.6 in Ethiopia, the scheme is believed to cover 32 million individuals, or 28 per cent of the population of 115 million in 2020 (UNFPA, 2021). This is consistent with the findings of the FES-DIE-ILO opinion poll, which reports 34.9 per cent health insurance among the informally employed in Ethiopia. In comparison, health insurance coverage was just 1.25 per cent in 2011–2012 (CSA, 2021). By the early 2000s, the only insurance provider was the Ethiopian Insurance Corporation (EIC), which covered a mere 0.02 per cent of the population (Lavers, 2019, p. 63).

The Ethiopian version of CBHI is unusual in that it consists of a *yearly* contract agreed between the member and the insurance scheme, upon which the member makes an *annual advance* payment of the insurance premium. Existing CBHI members are expected to renew before the expiry of their contract. The renewal rate rose from 54 per cent in 2015 to 82 per cent in 2020, indicating a high degree of satisfaction with the health insurance scheme (EHIA, 2020). This high satisfaction level can be explained by the fact that CBHI enrolees experience a 30 to 41 per cent increase in health care utilisation, while at the same time witnessing a 56 per cent decline in cost per visit (Mebratie, et al., 2019). It was also reported that CBHI-affiliated facilities experienced a 111 per cent in-

Figure 1
Ethiopia: Community-based health insurance – member households



Source: EHIA (2020)

crease in annual outpatient visits, while their annual revenues increased by 47 per cent. Despite the increase in patient volume, there has been no discernible increase in waiting time to see medical professionals (Shigute, et al., 2020).

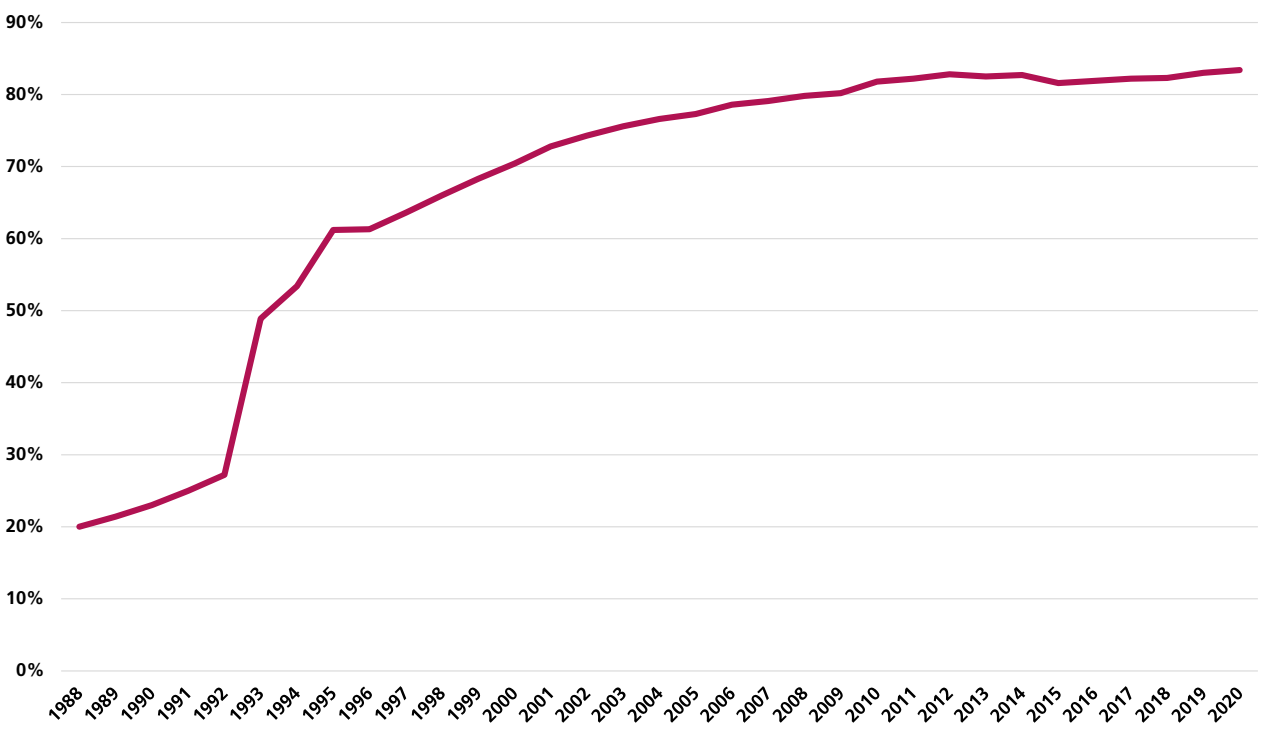
CBHI members pay a 240 birr (US dollars 6.86 at the average 2020 exchange rate) annual premium per household, with additional payments for adult children (Mebratie et al., 2019).[6] This premium includes a 25 per cent federal government subsidy. Regional and woreda (district) governments meanwhile cover premiums for a small proportion of »indigent« households deemed unable to pay (Lavers, 2019). In 2020, the entire scheme mobilised 1.64 billion Ethiopian Birr, equivalent to around 47 million US dollars, of which 80 per cent represented member contributions.

In conclusion, Ethiopia has made great strides during the past decade in enhancing medical facilities, in training and recruiting health personnel, and in expanding voluntary based health insurance coverage and reaching out to a larger part of the population by implementing community-level interventions, such as the Health Extension Programme and the Health Development Army. Such progress has been made possible as a result of strong economic growth (an average of 10 per cent GDP growth per year since 2004), as well as substantial donor support. The decentralised health care and health insurance premium collection system, combined with a centralised risk pooling and oversight arrangement (via the EHIA) and strong linkages with existing social protection programmes, such as the Productive Safety Net Programme (Shigute, et al., 2020) have proven their effectiveness. However, the fact that the formal sector, Social Health Insurance, is not yet operational limits the possible cross-subsidisation between the formal and the informal sectors. And the voluntary nature of the CBHI schemes offers no guarantee that households in good health will not drop out of the scheme.

The undeniable success of Ethiopia's CBHI is due, in addition to the factors mentioned above, to its anchoring in a traditional Ethiopian practice known as the »Idir«, a local financial institution established to assist community members in case of an emergency, notably funerals (Bekerie, 2003). The functioning of the CBHI at the local level resembles the modus operandi of the Idir, while offering additional advantages, such as enlarging the risk pool from the local community to the entire nation. In fact, »previous positive experience by community members with other solidarity-based community-based organisations and associations outside of health also contributed to enhanced community participation and enrolment in the CBHI schemes« (USAID, 2015, p. 11). Such community participation is naturally limited by the need to ensure uniformity of the rules and procedures governing CBHI throughout the country. This dilemma – the desire to ensure strong community involvement, coupled with the need for centralised oversight and decision-making – are inherent in hybrid CBHI schemes, which are, however, the most effective means to achieve the goal of universal health coverage.

6 It was reported that in 2011, the premiums amounted to about 2–3 per cent of household monthly income.

Figure 2
Kenya: Share of informal employment in total employment (%)



Source: KNBS (1992–2021)

KENYA

Kenya is in a sense the »birthplace« of the informal economy,[7] also known as »Jua Kali« (hot sun) in East Africa. Kenya's informal economy represents 83.4 per cent of employment, mainly involving men. More than two-thirds of informal sector jobs are in trade, restaurants and hotels (World Bank, 2016). The informal economy is said to contribute 34.3 per cent to GDP (Institute of Economic Affairs, 2012). Figure 2 shows that the share of informal employment in total employment increased from 20.0 per cent in 1988 to 83.4 per cent in 2020 (KNBS, 1992–2021). Between 1988 and 2020 the *absolute* number of Kenyans employed in the informal economy increased by 42 times, from 346,400 in 1988 to 14,508,000 in 2020 (of whom 64.5 per cent are in urban and the remainder in rural areas) (KNBS, 1992–2021). During the same period of time, Kenya's population grew by just 143 per cent. The stark increase in informal employment rate registered in the late 1980s and the 1990s must be attributed to the implementation of neoliberal structural adjustment programmes during that period.

The Kenyan Constitution of 2010 in its article 43 declares that »Every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare«. In practice, however, the exercise of this right is constrained by insufficient health facilities, insufficient health care personnel, and the lack of universal health coverage.

Kenya's health care system comprises public, private and faith-based health providers. The government is the main provider of health services, owning (in 2019) 44.3 per cent of all health facilities. The private for-profit sector owns 43.7 per cent of total facilities (mostly medical clinics), while the private not-for-profit (largely faith-based institutions) owns 12 per cent (KNBS, 1992–2021). In line with Kenya's national policy of »devolution«,[8] health facilities are managed as follows:

- at the national level: health policy; national referral health facilities; capacity building and technical assistance to counties;
- at the county level: county health facilities and pharmacies; ambulance services; promotion of primary health care; licensing and control of undertakings that sell food in public places; veterinary services; cemeteries, funeral parlours, and crematoria; refuse removal, refuse dumps, and solid waste (Ministry of Health, 2014).

7 The term ›informal sector‹ was first coined in 1972, at the conclusion of a comprehensive ILO employment advisory mission to Kenya, and was later converted to ›informal economy‹ to underline the fact that informality is not a ›sector‹, but a certain way of carrying out economic activities.

8 According to the Constitution, the 47 county governments and the national government are ›distinct and interdependent‹, and are expected to operate through ›consultation and cooperation‹.

A recent study observed that devolution brought about an improvement in health care structural development as a result of greater local ownership and commitment. However, the study also observed inadequate resource allocation from national government, as well as understaffed health facilities (Masabaa, et al., 2020).

The public health system begins with primary health care, the lowest unit being the community. More serious cases are referred to higher levels of health care. The current health service structure consists of six levels (i) community; (ii) dispensaries; (iii) health centres; (iv) primary referral facilities; (v) secondary referral facilities and (vi) tertiary referral facilities. Table 8 provides details about the distribution of health facilities in Kenya.

These facilities are spread quite unevenly across the country; while there were 48.1 health centres and dispensaries per 100,000 population in Nyeri county the indicator drops to only 7.3 in Mandera county. The city of Nairobi hosts 10.5 per cent of the level four to six hospitals (Ministry of Health, 2014).

Table 9 shows the number of registered health personnel in 2019. The ratio of health personnel (all categories combined) per 100,000 population increased from 226 in 2015 to 313 in 2019.

Health care in public hospitals is free for some services, such as maternity care, and in-patient treatment is free for those with national health insurance. Health care provided by private hospitals, faith-based institutions or NGOs usually comes at a cost and charges vary (Mohiddin & Temmerman, 2020).

Kenya's annual health expenditure amounted to 88.35 US dollars per capita in 2018. This represented an increase of more than 400 per cent since the year 2000. Health expenditure was equivalent to 5.2 per cent of Kenyan GDP in 2018. Interestingly, the out-of-pocket share of health expenditure declined from 47.1 per cent in 2000 to 23.6 per cent in 2018. This seems to indicate that the steady expansion of UHC has resulted in a significant reduction of the amount that patients had to pay in cash. Similarly, the share of domestic *private* health expenditure as a percentage of total health expenditure declined from 59 per cent to 42.4 per cent during the same period of time. This can be interpreted as another indicator of the benefits of UHC (all data from World Bank, 2021).

Kenya's main social security institutions are the National Social Security Fund (NSSF), which provides pension, work injury, disability and survivors coverage, and the National Hospital Insurance Fund (NHIF), which operates a comprehensive, contributory social health insurance scheme, which informal-economy operators have been able to join voluntarily[9] since 2004. Anyone is eligible to join the national scheme who possesses Kenyan citizenship, is 18 years of age and has monthly earnings of more than 1,000 Kenyan Shillings (KES) (around ten US dollars). Applicants are not filtered for pre-existing conditions and there are no limits on included dependents (Bosch, 2019). Once insured, members enjoy full and comprehensive cover for maternity and medical diseases, including surgery in government hospitals, as well as full medical coverage for outpatient services.[10] The NHIF also operates a Health Insurance Subsidy Programme which, being co-financed by the World Bank, currently provides non-contributory health insurance to 181,415 poor households (over 600,000 people). In 2018 the government allocated 19 million US dollars to subsidise the scheme.

The NHIF currently insures 8.5 million paying members (see Figure 3),[11] each with three or four dependants. In total, the NHIF covers around 28 million Kenyans, equivalent to 58 per cent of the population (excluding the 2.3 per cent affiliated with private health insurers). The number of self-employed (informal economy) members of the NHIF has been growing, rising from about 110,000 in 2005–2006 (6.7 per cent of total membership) to over four million in 2018/19 (49.2 per cent of the total). The FES-DIE-ILO opinion poll found that 25.6 per cent of Kenya's informally employed persons are covered by health insurance. The premium for informal-economy members is set at 500 Kenyan Shillings (KES) (five US dollars) per month. It is not clear whether all registered NHIF members in fact pay their monthly contribution.[12] If they did, Kenya would have achieved a big step towards universal health coverage, which the country aspires to achieve by 2022 as one component of the »Big Four« agenda.[13] However, since the President's proclamation of the Big Four, no official national policy document has been published on UHC.[14] Kenya's health insurance coverage is higher than in many other African countries and has clearly developed beyond the informal sector. However, it varies hugely between the regions, and particularly between urban and rural loca-

9 The NHIF website clarifiers that »NHIF registers all eligible members from both the formal and informal sector. For those in the formal sector, it is compulsory to be a member. For those in the informal sector and retirees, membership is open and voluntary«.

10 The full benefit package includes: (i) outpatient services: general consultations, diagnosis and treatments of common conditions and sexually transmitted diseases, laboratory diagnosis, prescription drugs, chronic disease management (HIV/AIDS, diabetes, asthma, hypertension, cancer), radiology, physiotherapy, referral to specialised services, family planning, midwifery services, ante- and post-natal care, health and wellness education and health counselling, screening and immunization and vaccines; (ii) inpatient services include surgical procedures, specialist consultations, delivery, ante- and post-natal care, renal dialysis, cancer treatment, emergency road evacuation, overseas treatment and rehabilitation for drug and substance abuse. (Bosch, 2019).

11 In Figure 3, the left axis concerns number of people and the right axis the number of insured *persons* as a percentage of the population. The percentage of persons covered is much higher, as explained above.

12 Members who have been unable to pay their monthly contributions remain insured if they clear all arrears by the end of the calendar year. Otherwise, they lose their insurance coverage.

13 Manufacturing is supposed to reach 20 per cent of GDP (compared with 9.2 per cent currently), and there is also supposed to be 100 per cent food security, 100 per cent health care coverage and 500,000 new affordable homes.

14 However, the government has elaborated a comprehensive, results-based national health policy covering the period 2010–2030 (Ministry of Health, 2014). The overarching goal of the strategy to achieve universal health coverage.

Table 8
Health facilities in Kenya (2019)

	Level 2		Level 3			Level 4	Level 5	Level 6
	Dispensary	Medical clinic / stand-alone	Medical centre	Health centre	Nursing home	Primary hospital	Secondary hospital	Tertiary hospital
Number	5,655	5,016	717	1,295	301	782	18	6
Unit-to-population ratio	8,417	9,490	66,388	36,757	158,140	60,870	2,644,444	7,933,333

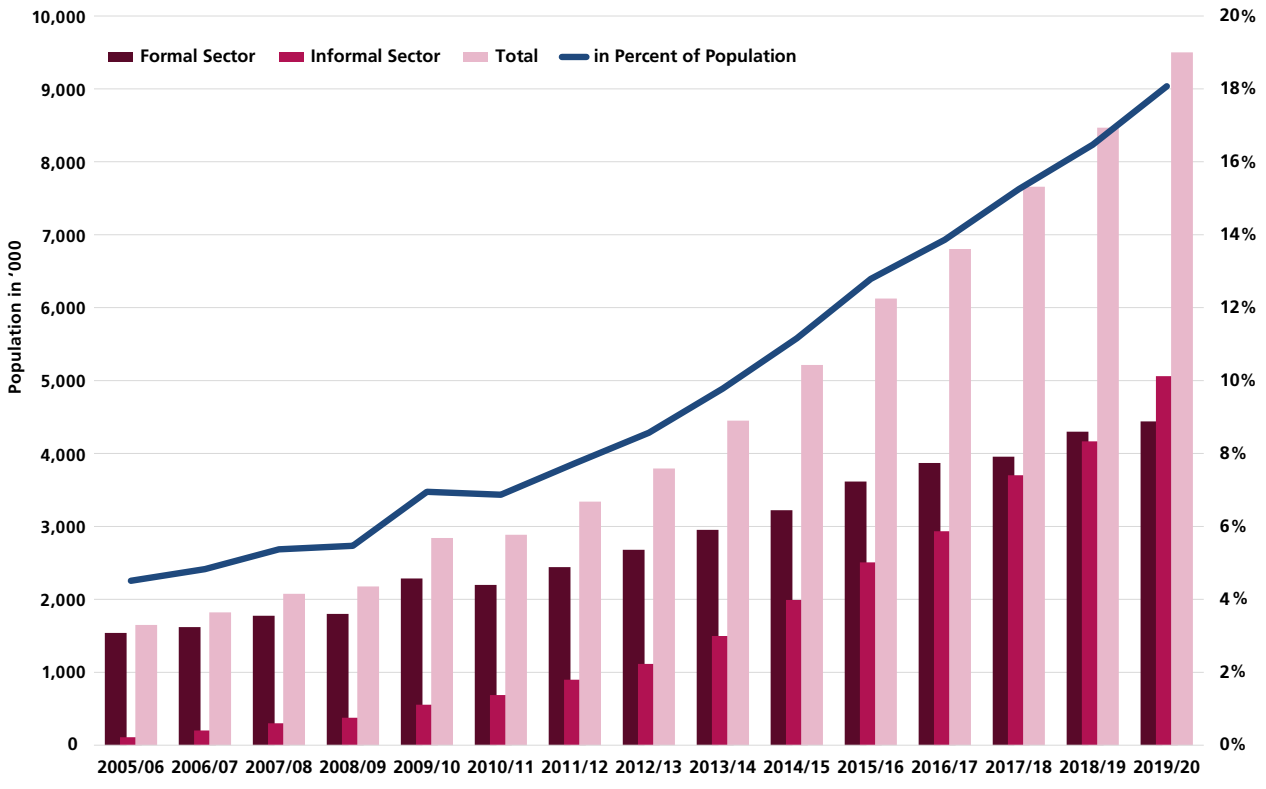
Source: KNBS (1992–2020)

Table 9
Registered medical personnel in Kenya (2019)

Category	Medical officers and dentists	Pharmacists and technicians	Health officers and technicians	Laboratory technicians	Nurses	Nutritionists and dieticians
Number	13,378	14,640	5,718	17,030	94,311	9,784
Per 100,000 population	28	31	12	36	198	21

Source: KNBS (1992–2020)

Figure 3
Kenya: Health Insurance Coverage by the National Hospital Insurance Fund (NHIF)



Source: NHIF Kenya

tions. Some 40 per cent or more are covered in Nairobi, while marginalised rural areas have coverage of below three per cent.

We can conclude that Kenya has made impressive progress in extending health insurance coverage to all, including to the informal economy. Progress has also been registered in the extension of medical facilities throughout the country, in the medical personnel-to-population ratio, and in the reduction of out-of-pocket expenditures for health. Of great significance is the fact that UHC has been recognised by the government as one of the nation's four overarching goals (the »Big Four«). However, the rural–urban gap in the availability and accessibility of medical facilities still persists, and will not be easy to close.

SENEGAL

The Republic of Senegal has a large informal economy, as shown in Table 10.

According to a recent study, the informal economy contributes 41.6 per cent to the country's GDP. Some 97 per cent of all economic units in the country belong to the informal economy;[15] 79.2 per cent of informal-economy operators are own-account workers, and 51 per cent[16] of them earn less than the country's minimum wage (currently 36,243 FCFA, or 66 US dollars) (Guérin & Bonnet, 2020).

The availability of health care services and infrastructure in Senegal was as follows in 2019.

On average, a Senegalese citizen has access to a health care unit of some kind within a distance of 4.9 km. In the capital Dakar (0.4 km), however, this distance is much shorter than in the remote region of Kedougou (10.7 km). Similarly, while in Dakar one medical doctor serves a population of 3,962, this rises to 46,084 in the region of Sedhiou. A total of 31,292 persons work in Senegal's health facilities (public and private, all facilities and occupations combined); this is equivalent to 1:520 (health professionals: citizens).

In 2018, total health expenditures per capita amounted to 58,9 US dollars; out-of-pocket payments represented 55.9 per cent of this amount. Current health expenditure was equivalent to 3.98 per cent of GDP.

Article 8 of the Constitution of Senegal recognises the right to health for everyone, and Article 17 stipulates that »the state guarantees all families, in particular those living in rural areas, access to health and welfare services«. In line with these commitments, the Plan Sénégal Emergent (PSE), the country's long-term strategic planning tool towards 2035, has identified the extension of social protection as one of three top priorities. The PSE defines social protection »as a set of measures to protect people against the occurrence of social risks. It integrates public social security schemes as well as private and community schemes« (République du Sénégal, 2014). The Government of Senegal has formulated a National Social Protection Strategy 2013–2017, now revised and updated to cover the period 2016–2035 (DGPSSN, 2016). As regards the health sector, a Strategic Development Plan for Universal Health Insurance Coverage 2013–2017 was launched in September 2013 by the President of the Republic.[17] The Plan set as an intermediate target the achievement of 75 per cent health coverage by 2017. In order to accomplish this task, the Ministry of Health adopted a strategy composed of two pillars: (i) free health care for vulnerable groups (children, the elderly, the disabled and so on), and (ii) the promotion of community-based mutual health insurance system, targeting specifically rural areas and the informal economy. The implementation of the programme was delegated in 2015 to the Agency for Universal Health Coverage (ACMU), which is being supported by several bilateral and multilateral development partners. Currently, there are four types of financial protection scheme in the country: (i) schemes for formal sector employees; (ii) free health-care initiatives (for example, for children aged 0 to 5, adults aged 60 and above, and persons with disabilities); (iii) private insurers; and (iv) community-based health insurance schemes, designed primarily for rural areas and the informal sector.[18]

Since the launch of the UHC programme in 2013 the health coverage of the Senegalese population, according to official data, has evolved as follows:

All 552 Senegalese municipalities are presently covered by at least one community-based health insurance scheme (or *mutuelle*); as some have more than one, the total number of *mutuelles* reached 676 in 2018, with 455,659 member-households and close to three million beneficiaries. The annual premium amounts to 7,000 FCFA (13 US dollars) per person,[19] 50 per cent of which are subsidised by the state (ACMU), which also subsidises 100 per cent of the premium for the poorest households. The insurance covers 80 per cent of the provision of care in public facilities and generic drugs, and 50 per cent of the cost of drugs purchased in private pharmacies.

15 In the study, the use of a formal accounting system was considered the criterion demarcating the formal from the informal.

16 Low incomes are particularly widespread among women employed in informal enterprises. More than three-quarters (77.9 per cent) earn less than the minimum wage, compared with 42.6 per cent of men.

17 In Senegal, only 2.68 million people (20 per cent) of the 13.4 million population were covered by health insurance schemes in 2012, and of those 1.60 million (59.7 per cent) were registered under health financial protection schemes for formal sector employees (Daff, et al., 2020)

18 »Community« may mean both a geographical area (commune) or a common bond (for example, a common occupation). Transvie, one of Senegal's most successful mutual health insurers, was originally established to provide health insurance coverage to workers in the informal transport sector. It is now open to all (non-agricultural) professions, including those in the formal sector, and covers more than 100,000 households (Transvie, 2019).

19 Aged 6 to 59, because health coverage outside these age brackets is free.

Table 10
Senegal: Labour market indicators

Indicator	Labour force (thousands, 2018)	Labour force participation rate (per cent, 2018)	Unemployment rate (per cent, 2018)	Informal employment (per cent of total employment, 2016)	Vulnerable employment rate (per cent, 2020)
Total	4,122.3	48.8	15.5	87.0	64.0
Male	2,456.6	69.4	7.4	85.6	59.2
Female	1,665.7	50.7	26.0	89.0	72.0
Youth (15–24)	845.0	37.9	20.4	n.d.	n.d.

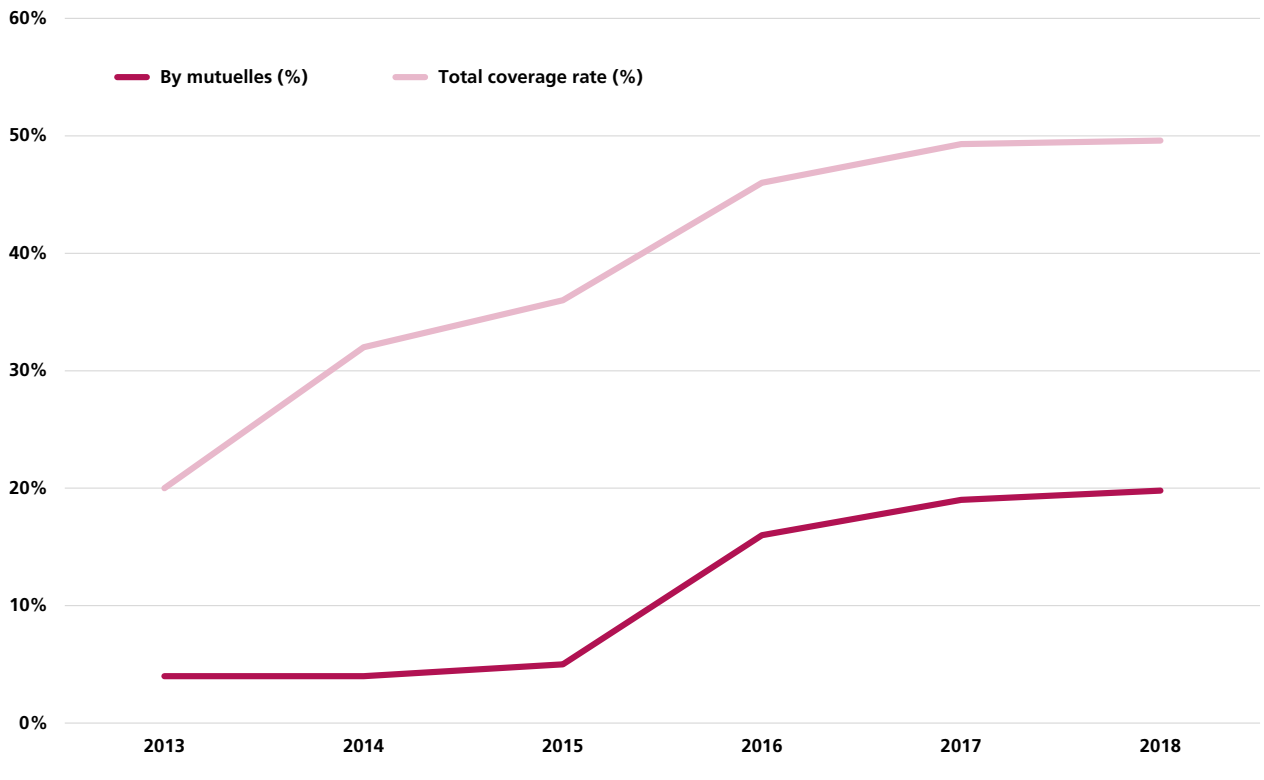
Source: ILO Stat et ANSD (2020), online available at: https://www.ilo.org/shinyapps/bulkexplorer46/?lang=en&segment=indicator&id=SDG_0831_SEX_ECO_RT_A (ILO Stat)

Table 11
Senegal: Health facilities and personnel (public and private)

	Health post	Health centre	Hospital (all types)	Population per medical doctor	Population per health centre	Population per hospital
2019	4,041	392	75	10,424	54,755	411,361

Source: MINSAS (2020)

Figure 4
Health Insurance Coverage Senegal



Source: ACMU (2019)

Although the *mutuelles* are independent and self-managed, they apply the same rules (with regard to premiums and benefit packages) throughout the country, and they are all affiliated to a secondary structure (a union) at the departmental level. These unions oversee the financial coverage for services offered in referral-based hospitals at departmental, regional and national level, and they pool the unused resources of primary *mutuelles* to finance health services and drugs that are provided or prescribed by referral hospitals (tertiary health care). As such, at least for tertiary care, larger financial risks can be pooled by larger groups of people than any community-based organisation (Daff, et al., 2020). The ACMU, although established as a parastatal agency, can be considered the apex body of Senegal's *mutuelles*. In 2018, a computerised UHC management information system was established in Senegal. It has seven components: (i) biometric identification and management of beneficiaries; (ii) a money processing centre for collection of premiums and other funding; (iii) a data warehouse; (iv) registration and monitoring of the beneficiaries; (v) information management for payments and bills; (vi) information management for insurance operations; and (vii) a mobile phone app for beneficiaries.

The officially announced ratio of health insurance coverage in Senegal of 53 per cent (Daff, 2021) appears very high. Three alternative sources report much lower coverage rates, however. The FES-DIE-ILO survey found that only 8.2 per cent of informally employed persons were covered by health insurance; a regional informal economy survey (UEMOA, 2019) reported five per cent coverage in 2017–2018; and a recent ILO report (BIT, 2021 (forthcoming)) reported a 38.3 per cent coverage rate, including the 22.5 per cent of the population who, because of their low incomes, receive subsidised medical assistance (and are therefore not »insured« in the technical sense of the term).

In parallel with the efforts to extend health coverage to all, the Senegalese Ministry of Labour has been examining, since 2013, the feasibility of creating a social protection scheme for entrepreneurs and workers in the informal sector, named »simplified regime for small taxpayers« (RSPC according to its French acronym, i.e., *Régime simplifié de protection sociale pour petits contribuables*). The RSPC was conceived primarily as a platform for consultation between social security schemes and informal economy actors; it is linked to existing social security schemes, and will rely on *mutuelles* established by informal sector organisations. The RSPC will initially cover social risks related to health and old age. It will also offer health insurance coverage, as well as pension benefits to *urban* informal economy actors. In the medium term it would also cover compensation for work-related accidents, as well as maternity benefits. The health branch of the RSPC would be financed from a standard contribution of 5,000 FCFA (nine US dollars) per month and family,[20] whereas the pension fund would be financed by a monthly contribution of eight per cent of a member's monthly income. Actuarial projections undertaken by the ILO indicate that this level of contribution would guarantee the scheme's financial sustainability in the medium term. The RSPC would be introduced as a voluntary scheme, but is envisaged to become compulsory over time. Although designed as far back as 2013, the RSPC is still in a trial phase.

The coexistence between CMU/UHC and RSPC illustrates a key problem affecting Senegal's social protection system, which in general suffers from a multiplicity of actors, institutions, policies, strategies, legal frameworks and supervisory authorities. This necessarily increases transaction costs. It is, for example, difficult to understand why the CMU and the RSPC are placed under separate ministries (health and labour, respectively), while targeting essentially the same group of beneficiaries and providing similar services. Otherwise, Senegal has achieved remarkable progress in extending universal health coverage within five years from 20 to 50 per cent. This demonstrates the importance of a strong political will in setting ambitious goals, and concentrating efforts, resources and partnerships to achieve them.

ZAMBIA

The indicators in Table 12 are extracted from Zambia's labour force surveys in 2008 and 2019. The most recent survey is based on a sample of 9,300 households. As some of the definitions had changed between 2008 and 2019, additional sources, namely ILO Stat, were consulted to complement the table.

The share of informal employment declined slightly between 2008 and 2019, whereas the proportion of workers in urban areas grew significantly, illustrating the progressive urbanisation of Zambian society. The average monthly earnings of an informal economy worker increased slightly, and are about 40 per cent higher than the lowest minimum wage category (79 US dollars/month).

The latest official report on the availability of health facilities dates back to 2017. At that time, the following infrastructure was reported.

The total number of health facilities in 2017 had increased by almost 1,000 since 2012. Of those facilities, 81.3 per cent were owned by the government, 5.9 per cent by faith-based organisations, and the rest by private providers. The survey further reported a total of 25,806 hospital beds, equivalent to 561 inhabitants per bed at the time. The evolution of health personnel in Zambia is summarised in Table 14.

In 2011, 58 per cent of established medical positions were vacant; this ratio had decreased to 32 per cent by 2016 (MoH, 2017, p. 72). However, the distribution of health personnel was (and remains) heavily skewed towards urban areas. Huge disparities in access to health care put further pressure on the system. In rural areas, for example, only 46 per cent of residents live within a five kilometres radius

20 Compared with 7,000 FCFA per year and person under the CMU scheme.

Table 12
Zambia: Labour force indicators

	Indicator	Total	Male	Female	Rural	Urban
2019	**Labour force ('000)**	7,402	3,825	3,577	4,041	3,361
	LF participation rate	75.3	79.4	71.3	n. d.	n. d.
	Unemployed	13.2	13.0	13.4	14.2	12.6
	Informal economy (%)	87.5	81.1	93.3	94.5	79.2
	Average monthly income (US dollars)	115	n. d.	n. d.	n. d.	n. d.
2008	**Labour force ('000)**	6,716	3,302	3,414	4,274	2,442
	LF participation rate (per cent)	74.5	78.8	70.3	81.1	63.0
	Unemployed	7.9	8.1	7.7	3.5	18.0
	Informal economy (%)	89	85	94	96	71
	Average monthly income (US dollars)	109	120	89	73	199

Source: CSO, 2008 and 2019

Table 13
Health facilities in Zambia (2016)

Hospitals			Health centres	Health posts	Total
Third level	Second level	First level			
8	34	99	1,839	953	2,933

Source: MoH (2017)

Table 14
Zambia: Health personnel, main categories (2005, 2011 and 2016)

Indicator	2005		2011		2016	
	Number	Population per category	Number	Population per category	Number	Population per category
Dentists	56	211,786	278	50,432	312	52,436
Doctors	646	18,359	1,076	13,030	1,514	10,806
Laboratory technicians	417	28,441	713	19,663	921	17,763
Midwives	2,273	5,218	2,753	5,093	3,141	5,209
Nurses	6,096	1,946	7,996	1,753	11,666	1,402
Pharmacists	n. d.	n. d.	777	18,043	1,159	14,116

Source: MoH, 2017

of a health centre and many have to travel more than 50 km to reach their nearest health facility. Access to medical care in more remote areas is further limited by the national shortage of clinical staff: some health facilities are run by unqualified staff (ACCA, 2013, p. 7).

Health expenditure represented 4.9 per cent of GDP in 2018, and government health expenditure amounted to 29.7 US dollars per capita in the same year. Out-of-pocket payments for health represented 10 per cent of total health expenditure, down from 35 per cent ten years earlier. However, while total government expenditure for health was increasing in absolute terms, the share of the Ministry of Health in the national budget keeps decreasing: 9.9 per cent in 2014, 9.6 per cent in 2015 and 8.3 per cent in 2016. According to the Strategic Plan the share of health care in total government expenditure should reach 15 per cent in 2021.

Article 112 of Zambia's Constitution of 1991 (as amended in 2009 and 2016) stipulates that »the State shall endeavour to provide (…) adequate medical and health facilities, without however conferring the *right* to medical care«. Zambia's Seventh National Development Plan (2017–2021) has prioritised health as a key economic investment, and emphasises that the successful attainment of Zambia's goal of being a prosperous, middle-income country by 2030 – as stipulated in its Vision 2030 – is dependent on having a healthy and productive population (Bakyaita & Mweemba, 2018). In this context, Zambia's National Health Strategic Plan 2017–2021 (MoH, 2017) seeks to achieve universal health coverage through a focus on primary health care at the community level. The Plan includes as a strategic goal the achievement of UHC through safe, affordable, accessible and timely hospital services by 2021. The activities associated with this goal are all related to improving the availability, timeliness and quality of medical services to the public, not to the financing of health care. However, the Plan includes a separate goal on health financing, formulated as follows: »To raise sufficient financial resources to fund the plan while ensuring equity and efficiency in resource mobilisation, allocation, and utilisation during the plan period.« Here, the main problem is linked to strong donor dependency, as some 58 per cent of total health expenditure is funded by development partners. These contributions are often disease-specific (such as HIV-Aids), and are not predictable in the medium term.

The Zambian government provides health services to all free of charge in government-owned primary level health facilities, regardless of their ability to pay. The majority of Zambians using primary health care do not incur out-of-pocket payments, so that lack of funds does not impede access for most of the population. The Zambian Ministry of Health points out, however, that the burden of out-of-pocket payments remains substantial at secondary level, mainly for hospitalisation (MoH, 2017). Primary health care in the private sector, as well as secondary and tertiary health care at both public and private health providers are either paid out-of-pocket, through private health insurance or paid by the employer. The latter two options are inaccessible to informal economy workers (Phe Goursat & Pellerano, 2016, p. 17).

The key strategy for improving the funding of Zambia's health care system, as outlined in the Health Financing Strategy 2017–2027, involves pooling all available, health-related resources, whether they are from government, donors, households or insurance companies, into a single account, so as to simplify and streamline the overall financial system by reducing fragmentation, duplication and overlap. This would require donors to move away from project funding and to agree to a sector-wide approach (a multi-donor basket fund for health care). This would be legally impossible for some donors, however, such as the United States, because it would require them to (at least partly) relinquish control over their resources.

The Financing Strategy acknowledges that Zambia currently has no social health insurance, and that only 3.9 per cent of the population has private health insurance. This means that risk pooling is almost non-existent. This is consistent with the findings of the FES-DIE-ILO opinion poll, according to which just 2.3 per cent of the informally employed are covered by health insurance. Zambia currently has no *public* health insurance system because, in principle, the government is supposed to offer health services free of charge to everyone; user fees for medical services were abolished in 2006. In practice, however, many patients do make substantial out-of-pocket payments for private medical services because government services are not available, or may be of poor quality. To improve the situation the Zambian parliament adopted National Health Insurance Act No. 2 of 2018, which led to the establishment of the National Health Insurance Scheme (NHIS) under the management of the National Health Insurance Management Authority (NHIMA). The NHIS provides a wide range of benefits (a 40-page document) for inpatient as well as outpatient services and the supply of medicines. The NHIS is a compulsory scheme for all. The following information is provided on its website:

- Employees from the informal and formal sectors will contribute according to their ability to pay; the contribution is set at one per cent of the monthly basic salary (formal economy), or one per cent of the declared average income (informal economy). In view of the data provided in Table 12, informal economy operators would therefore have to contribute 1.15 US dollars per month.

- Employers will contribute for their employees and remit contributions to the authority; they also pay one per cent of their employees' monthly basic salary.

- Government will continue to subsidise the poor and vulnerable.

Health care can be provided by both public and private institutions, as long as they are accredited with the NHIMA. Benefits will be extended to the insured person plus their registered household members. The NHIS is still at a very early stage of development, and no statistics on membership and revenue are available at present.

An important aspect of Zambia's health sector strategy is the involvement of local communities. The government has elaborated a dedicated (and very detailed) Community Health Strategy 2017–2021 (MoH, 2017). Essentially, this strategy rests on two pillars:

1. The mobilisation of community-based volunteers and community-based organisations for the collection and mobile transmission of information on (i) quality of care, (ii) access to health services, and (iii) community health action planning, budgeting and implementation.

2. The formation of neighbourhood health committees which, being formed under the guidance of health personnel, shall advocate for disease prevention and control through community participation in health care management and delivery systems.

For the time being, these committees are not involved in the collection of NHIS contributions, but this may change in the future.

Zambia has made considerable progress in enhancing the availability of health services through the construction of additional facilities and the training and recruitment of additional health personnel. As health care at the primary level is provided free of charge by the government the design of a national health insurance system was less urgent than in other sub-Saharan African countries. However, the reportedly high amount of out-of-pocket payments at the secondary and tertiary levels calls for a comprehensive system of risk pooling, which has now been initiated through the launch of the NHIS (MoH, 2017, p. 17). It is not clear whether the NHIS will *replace* the current system of free health care (which would transform the current, tax-funded health care system into a contributory scheme), or *complement* it. Be that as it may, the Zambian health system is worryingly dependent on international donors, whose contributions are mostly earmarked and unpredictable, and often circumvent government delivery channels.

3

SUMMARY AND CONCLUSIONS

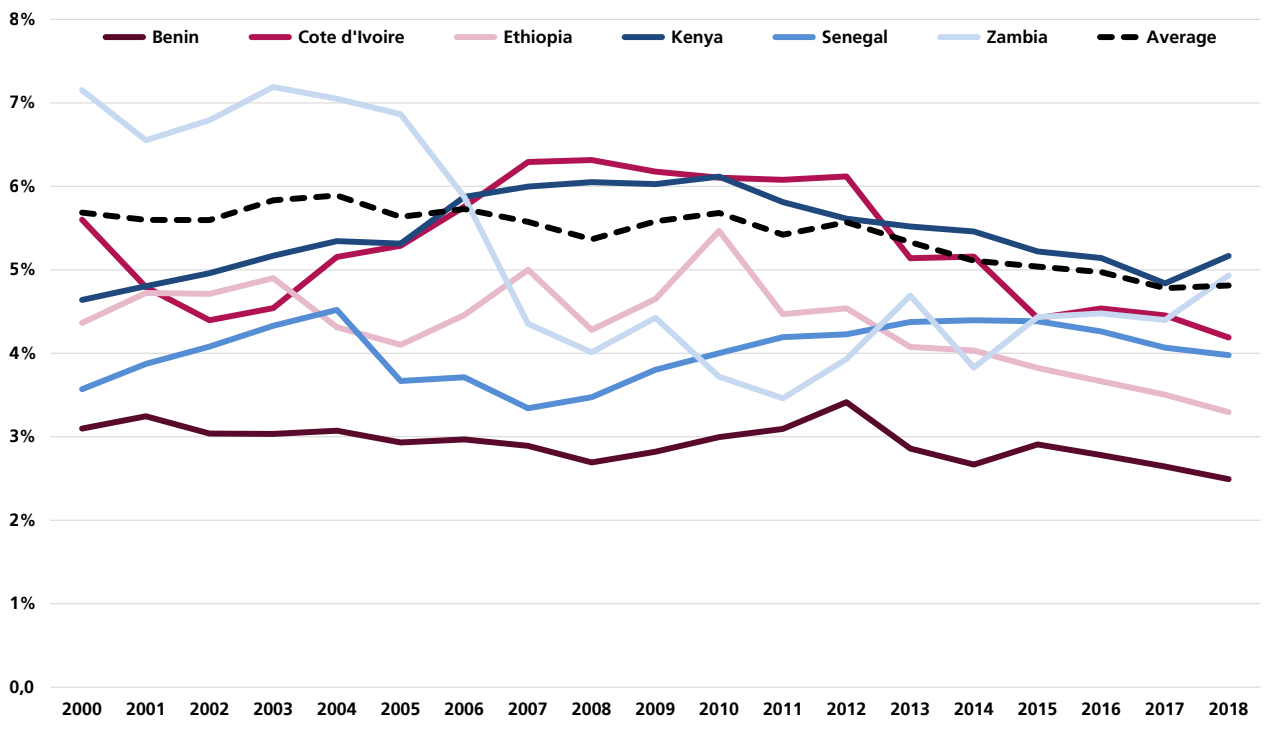
Table 15 provides an overview and comparison of the UHC-related indicators of the six countries included in this introductory paper:

Although not all indicators are fully comparable,[21] Table 15 presents very significant differences between the six countries. A medical doctor in Benin must treat more than five times as many patients as their counterpart in Kenya. Kenya spends three and a half times more on health care per capita than neighbouring Ethiopia, a difference which is partly due to different GDP-per-capita levels. A Senegalese household would have to contribute nine times more than an Ethiopian household to obtain health insurance coverage. Out-of-pocket payments for health are almost six times higher in Benin than they are Zambia.

An indicator which is increasingly used is the amount a country spends in terms of public spending on health as a percentage of GDP. The World Health Report 2010 noted that it would be »difficult to get close to universal health coverage at less than 4–5 per cent of GDP« (Jowett, et al., 2016). Figure 5 shows that this indicator (as an average for the six countries) has declined slightly in recent years, from 5.68 in per cent 2000 to 4.81 per cent in 2018 (World Bank, 2021). This decline can be explained partly by the strong economic growth in most of sub-Saharan Africa during the same period of time. In 2018, three countries (Côte d'Ivoire, Kenya, Zambia) exceeded the four per cent threshold of health expenditure as a percentage of GDP, whereas Senegal fell just below.

21 For example, the health insurance scheme guarantees completely free care in some countries, but only partial coverage in others. This must be taken into account when comparing financial contributions to those schemes.

Figure 5
Current health expenditures in % of GDP



Source: World Bank, 2021. Health expenditure indicators. [Online] Available at: https://data.worldbank.org/indicator/SH.XPD.GHED.CH.ZS?locations=KE [Accessed 29 January 2021].

Table 15
UHC indicators for six sub-Saharan African countries (latest available figures, as indicated in the country reports)

		Benin	Côte d'Ivoire	Ethiopia	Kenya	Senegal	Zambia	SSA average or WHO standard
Share of informal employment		92.6%	86.7%	86.0%	82.7%	93.4%	87.5%	**89.0%**
Ratification of ILO Convention 102		Yes	No	No	No	Yes	No	N.A.
Population per unit	**Health posts equivalent**	12,191	10,164	4,172	4,927	4,032	18,206	**10,000**
	Health centre equivalent			5,568	22,730	41,571	9,434	
	Hospitals	200,020	213,522	258,868	65,228	217,280	123,050	**150,000**
Population per health worker	**Medical doctors**	21,137	7,534	10,335	3,930	14,464	10,806	**10,000**
	Nurses	4,441	2,259	1,194	557	5,779	1,402	**5,000**
	Midwives (per women of reproductive age)	3,202	1,104	3,238	n.d.	1,925	1,302	**3,000**
Health expenditures	**As a percentage of GDP**	2.5%	4.2%	3.3%	5.17%	3.98%	4.90%	**5.08%**
	Per capita (US dollars)	30.90	71.90	24.23	88.39	58.90	75.99	**83.25**
	Out-of-pocket health expenditures (US dollars)	44.60	28.30	23.64	20.90	32.90	7.59	**33.34**
Health financing	**Health insurance coverage (percentage of total population)***	9%	7.1%	35.3%	60.3%	Between 5 and 52%	3.9%	**20.0%**
	Health insurance coverage of the informally employed**	2.3%	10.3%	34.9%	25.6%	8.2%	2.3%	**n.d.**
	Annual insurance contribution per household (US dollars)	15.6	21.96	6.86	60.0	76.9	13.8	n.d.
	Annual contribution as a percentage of minimum wage	1.8%	1.7%	0.6%	7.2%	4.7%	1.1%	n.a.
Covid-19 situation	**Cases**	8,100	47,600	273,900	175,200	41,900	110,300	5,016,511
	Deaths (total)	102	306	4,200	3,400	1,100	1,400	134,295

Notes: * Public and private schemes, both formal and informal employment.
** According to the FES-DIE-ILO opinion poll.
Source: AU CDC (2021)

We conclude this study by confirming that all six countries have made universal health coverage a national priority. We see a convergence between universal goals (SDGs, WHO strategies, ILO instruments), regional priorities (African Union health strategy), national commitments and donor support. UHC is progressing in all six countries, albeit at a slower pace in some than in others.

The lessons learned from the six country papers seem to indicate that a hybrid model of health insurance would have the greatest potential to achieve universal health coverage. The »hybridity« covers two dimensions:

– A hybrid management and delivery system, whereby essential functions are delegated to local communities, yet under the guidance and supervision of a central authority that sets standard rules and regulations, monitors financial flows, and pools risks.

– A hybrid funding scheme, whereby household contributions are complemented by government subsidies and, for a temporary period, by donor support.

It has also become clear that the poorest households must be exempt from paying any financial contributions, because this would exclude them from UHC. Moreover, health insurance schemes must be mandatory for everyone, whether formally employed or not, because otherwise the healthier households would opt out.

Finally, the findings from the country reports point to the importance of intra-African South-South cooperation in the area of health care and health financing. As already mentioned, the Ethiopian CBHI was inspired by the Rwandan model – both seem effective and successful. Benin's health insurance scheme, in contrast, has apparently not incorporated the lessons learned from the Senegalese CBHI, in particular with regard to standardised rules and centralised oversight. The FES, the ILO and other partners could play a useful role in initiating, facilitating and supporting such South-South partnerships in the field of universal health coverage.

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