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Good practice review: Extending social security coverage in Africa

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Summary

African countries face enormous challenges to extend social insurance coverage, particularly given the Continent's low incomes, high degrees of informality and constrained fiscal resources. The extent of the unmet challenges in the face of documented success stories suggest that Dynamic Social Security approaches may provide opportunities to improve coverage, strengthen social protection, support sustainability and achieve critical social security objectives. This paper highlights the key challenges of extending coverage with a broad overview on recent trends, and then focuses on two areas – income security and health protection – in which Dynamic Social Security interventions are demonstrating good practices and documenting important lessons.

The paper reports how many African countries are tackling the challenges of extending social insurance coverage with innovative approaches in line with the International Social Security Association's (ISSA) Dynamic Social Security framework. The people of Africa do not need to wait for economic growth and formalization of labour markets to enable the extension of social insurance instruments modelled on industrialized countries' systems. Creative instruments are leap-frogging conventional wisdom, developing income-security mechanisms that enable voluntary take-up by those in the informal sector. Community-based initiatives, particularly in health insurance, are mobilizing the resources of the poor and pooling risk in order to provide more effective health protection. These Dynamic Social Security innovations are providing social protection while building the productivity of human resources and supporting inclusive growth processes.

Introduction

African countries face enormous challenges to extending social insurance coverage. With some of the lowest per capita incomes in the world and a large proportion of informal sector workers, African countries must overcome significant obstacles to advance contributory social insurance systems based on formal sector employment. In the past few decades one might have postulated economic growth and formalization of the labour market as potential drivers of improved access to benefits (Barbone and Sanchez, 1999, p. 1). However, the current global financial crisis threatens years of slower economic growth. Africa's informal sector appears to be growing more rapidly than ever, at least in some countries (Sher, 2006, p. 15; see also Ikiara and Ndung'u, 1999; Xaba et al., 2002). The extent of the unmet challenges and the documented success of alternative approaches suggest that more creative directions may prove more promising.

Countries that embrace dynamic social security approaches are demonstrating the potential of innovative and forward-looking policies, programmes and processes to improve coverage, strengthen social protection, support sustainability and achieve critical social security objectives. The International Social Security Association's (ISSA's) "Dynamic Social Security" framework not only provides protection, encourages prevention and supports rehabilitation and (re)integration but also contributes to realizing more socially inclusive and economically productive societies. The lessons of African experience are beginning to document good practices that build social security mechanisms designed to maximize long-term developmental impacts, enabling this "Dynamic Social Security" approach to progressively expand coverage while reinforcing inclusive economic growth. This paper focuses on two areas – income security and health protection – in which dynamic social security interventions are demonstrating good practices and documenting important lessons.

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1. The challenge of extending coverage

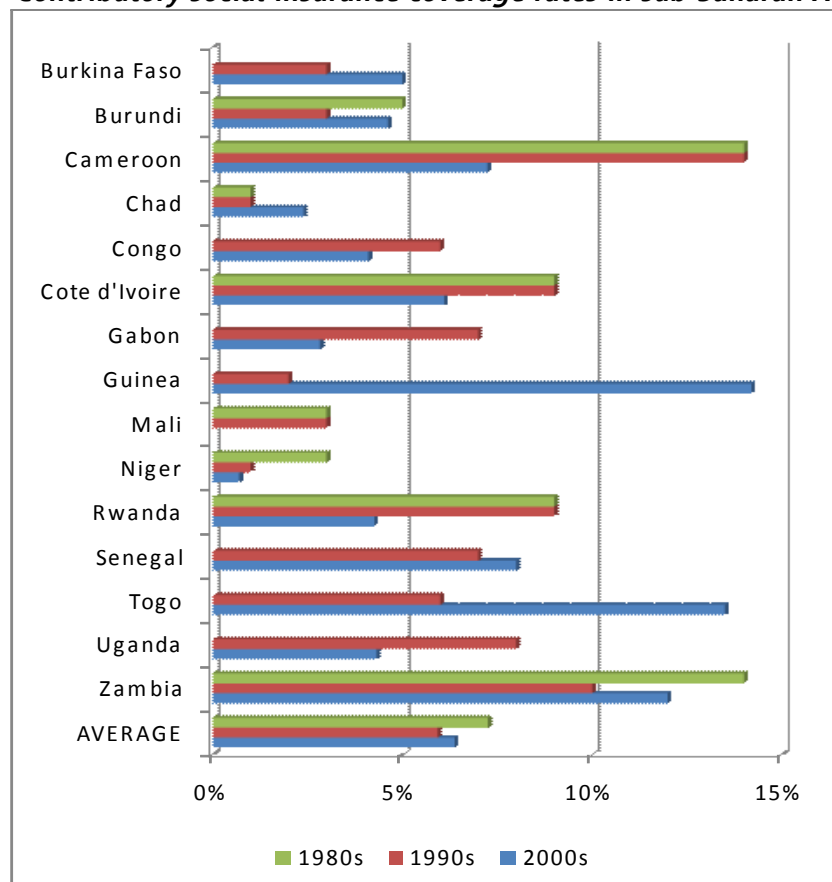
Contributory social insurance systems cover a lower proportion of the labour force in Africa than in any other region of the world for a number of reasons:

- Africa has a relatively small formal sector.
- Low incomes create affordability challenges for contributory systems.
- Constrained fiscal resources limit the options for government interventions.

Scarce data compounds the low coverage problem, making it difficult to track and analyse progress. Many African countries do not conduct regular labour force surveys, making it difficult to monitor coverage rates which are conventionally measured as the ratio of the covered population and a relevant measure of the work-force.

Figure 2.1 depicts long-term coverage trends for a sample of sub-Saharan countries. The data are drawn from different sources and studies, some with varying methodologies for calculating coverage rates. As a result, the individual trends for specific countries are not necessarily robust. More usefully, the data suggest that while some countries have experienced improvements and in others the number of covered workers has not kept up with labour force growth, the average coverage rate across countries in the sample has not changed significantly. There has been no consistent trend across countries towards worsening coverage rates – or improvements.

Figure 2.1 *Contributory social insurance coverage rates in sub-Saharan Africa*



Sources: Charlton and McKinnon (2001); World Bank (1994, p. 356, Table A.4); Palacios and Pallarès-Miralles (1999); Economic Policy Research Institute calculations (2009).

The sample in figure 2.1 is drawn from sub-Saharan Africa, which excludes the better-covered nations in North Africa. Algeria, Egypt, Libya, Morocco and Tunisia established contributory pensions in the 1950s, and social security systems in Algeria, Egypt and Tunisia include unemployment insurance schemes. Tunisia is particularly successful; having raised coverage rates substantially over the past decades it now sustains systems that protect nearly all workers in the public and private non-agricultural sectors (Bailey, 2004, p. 3).

In much of Africa, however, the greatest challenge is to extend coverage to the least-covered group – the informal sector. The past decade has demonstrated a number of approaches that document good practices, demonstrating important lessons for Africa and countries around the world facing similar predicaments. Two major types of protection required in Africa include income security and health protection. Over the past five years many social security institutions, including ISSA members, have documented significant progress in these two areas.

2. Income security

Income security constitutes one of the major objectives of social insurance – not only in terms of protecting people in their old age but also protecting workers against shocks from unemployment. While non-contributory social pensions and other forms of social assistance are becoming increasingly important in Africa, contributory social insurance systems are also expanding to cover those in the informal sector.

For example, Ghana's Social Security and National Insurance Trust (SSNIT), recognizing that the country's social insurance system largely excluded 80 per cent of the nation's labour force, created the Informal Sector Fund (SIS) in February 2008. This innovative institution replaces the SSNIT's scheme that previously targeted informal workers but which suffered from inadequate incentives, poor awareness and low levels of take-up. The fund started as a pilot scheme responding to the SSNIT's identification of strong demand among the informal sector for a better retirement savings scheme. The new fund's success stems not only from the resources that protect the members' retirement, but also from provisions that enable participants to use their savings as collateral, enabling access to productive microcredit and supporting more sustaining livelihoods. Members can withdraw part of their contributions when needed to cope with financial shocks, paying children's school fees, health insurance premiums or any other urgent expenses. In a similar vein, Zambia's National Pension Scheme Authority has provided for the self-employed and other categories of informal sector workers to join the contributory system on a voluntary basis. While the potential for voluntary enrolment faces significant challenges, the likelihood of success may be improved through linkages with organized groups of workers. Examples are provided in the section on social health insurance below.

Other countries are working to extend coverage more broadly by better integrating tax-financed non-contributory pensions into a multi-pillar retirement system. In Africa, Mauritius' multi-tier pension system is well developed and a model for developing countries. The first tier is a non-contributory Basic Retirement Pension (BRP) financed through tax revenue which provides a minimum income guarantee for older people. The second tier consists of two mandatory income-related pension schemes – the National Pension Fund (NPF) and the National Savings Fund (NSF). The third tier is made up by various voluntary schemes that are small-scale and targeted towards those who are not covered by the first two tiers.

As Mauritius undergoes a demographic transition with its populating ageing, the falling pensioner support ratio places increased fiscal pressure on the retirement system. The integrated multi-tier system and recent reforms, including the decision to raise the retirement age, provide effective responses to these challenges. While the universal non-contributory old-age pension covers virtually every older person, the contributory National Pension Fund covers 300,000 employees – 60 per cent of the labour force and continues to expand its coverage. Members of the National Savings Fund rose from 335,600 to 367,200 from 2002 to 2007, an increase of nearly 10 per cent. Contributions to the NPF increased by 41 per cent from 2002 to 2007, and the fund's total net assets more than doubled over this period. Contributions to the NSF rose by 50 per cent over this period. The sustainable growth in members and assets has enabled the government to steadily increase the real value of pensions since the inception of the schemes in 1978. Both South Africa and Kenya have recently begun reform processes along similar paths.

In February 2008 Kenya's Retirement Benefit Authority submitted to Cabinet a universal social pension package designed to provide all older Kenyans with a monthly minimum guaranteed benefit and to create a foundational pillar for a more far-reaching retirement savings system. Kenya's initiative is particularly important, as it represents the recognition by the institution responsible for the contributory national social security fund of the importance of extending coverage through a non-contributory pension. The pension package aims to provide all Kenyans, irrespective of income or employment history, lifetime monthly cash benefits from the age of 55. The benefit amounts to 70 per cent of the absolute poverty line (approximately Kenyan shillings (KES) 2,300 per month in 2007, implying a benefit of KES 1,600). The government plans to finance the estimated cost of KES 32 billion through a modest tax increase, either with a general levy or by charging employers and employees.

Likewise, in 2007 South Africa's Department of Social Development published a policy blueprint for a multi-pillar retirement system built on the foundation of a universal social pension with additional contributory tiers that increased the system's relevance for higher income earners (Department of Social Development, 2007). The study documented how a universal social pension better serves as a foundational pillar for a multi-pillar contributory social security system. These lessons may be increasingly relevant for countries like Ghana, whose SSNIT recently established a three-pillar pension system including a mandatory basic national social security scheme to provide monthly benefits, a mandatory privately managed occupational mechanism and a provident fund and personal pension system.

Extending unemployment insurance to the informal sector poses one of the greatest challenges. South Africa's unemployment insurance history reflects the social and political transitions of the nation. Until 2003, domestic workers constituted the largest single category of workers in the country, numbering approximately 1 million – nearly all excluded from the government's Unemployment Insurance Fund. Legislation in 2002 required domestic workers and their employers to make contributions to the Unemployment Insurance Fund starting in 2003, in order to extend this protection to the largest group of workers in South Africa's informal sector as part of the country's developing commitment to comprehensive social security. By 2008, the number of registered workers reached 633,000 with over 324,000 domestic workers actually receiving unemployment, maternity or adoption benefits as well as benefits in case of illness or death. South Africa's success shows that significant extension of coverage to the informal sector is possible if appropriate strategies are adopted that take into account the specific bottlenecks facing different groups of workers.

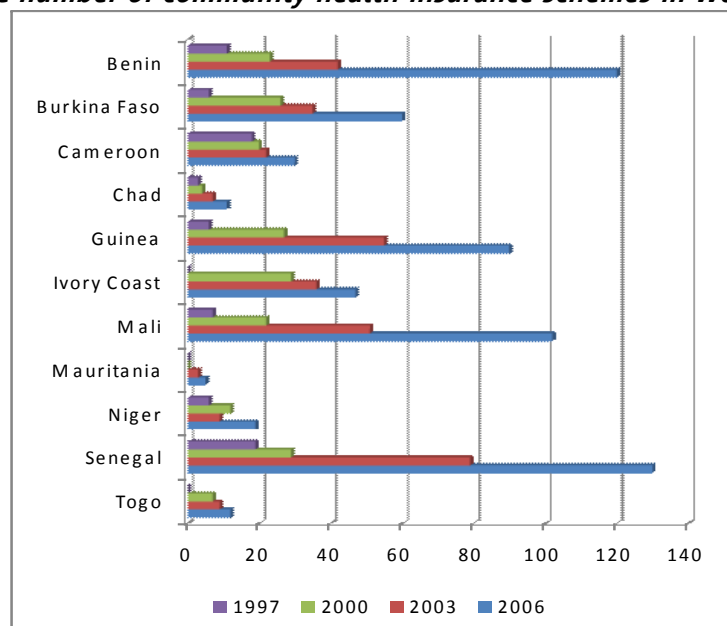
3. Health protection

Access to decent health care constitutes another of the major objectives of social insurance systems. Most African countries adopted policies providing for free health care during the 1960s, but the structural adjustment programmes of the 1980s largely abandoned this form of social protection. While formal insurance systems provided protection for a small minority of the population, health-care access deteriorated for the majority in the informal sector. The introduction of user fees created conflicting impacts – increasing resources in some areas but imposing severe access barriers for many poor households. Inspired by European social health insurance systems, African countries began developing models of Community Health Insurance (CHI) from the late 1980s, and these approaches have proven increasingly successful. "The principles are simple: on a voluntary basis individuals or households join a not-for-profit structure to share the financial risk of individual health-care expenditure; together they decide on the services covered and the contribution charged" (Ndiaye et al., 2007, p. 157; see also Brouillet et al., 1997; Criel and Van Dormael, 1998; Dror and Jacquier, 1999; Gruat, 1990; Normand and Weber, 1996).

Two major networks of community health insurance schemes now operate in Africa. The largest, referred to as La Concertation, coordinates initiatives in West and Central Africa, including activities in Senegal, Mali, Burkina Faso, Niger, Ivory Coast, Benin, Mauritania, Cameroon, Guinea, Chad, Togo, Congo, Rwanda and Burundi. In East Africa the Community Health Financing Association for Eastern Africa (ChEFA–EA) supports schemes in Kenya, Tanzania and Uganda (Ndiaye et al., 2007; <http://www.chefa.or.ug>).

Figure 2.2 depicts the consistent growth in the number of community health insurance schemes in West Africa from 1997 to 2006. In 1997 an estimated 76 schemes functioned effectively in nine West African countries. By 2006 this number had grown to 626 schemes in 11 countries, a more than 700 per cent increase in the number of schemes. The experiences of these schemes – not only in West Africa but across the continent – demonstrate good practices in terms of measured decentralization, effective community mobilization, subsidized coverage for vulnerable groups and the provision of quality care and offer important lessons for other African countries as well as developing nations around the world.

Figure 2.2 *The number of community health insurance schemes in West Africa*



Source: Ndiaye et al. (2007).

For example, the Government of Rwanda developed a community-based health insurance scheme in 1999 and expanded the programme to national scale in 2006. The scheme aimed to bolster financial resources for the local health-care system while improving access to health care for the poorest. The essential innovation of Rwanda's approach consists of the decentralized model that mobilizes broad-based community support. Contribution rates are kept low in order to facilitate broad coverage, creating economies of scale for the scheme and the affiliated health-care providers. By 2008, mutual funds covered over 75 per cent of the target population in all provinces, and the use of health care has increased significantly. The scheme is reported to have improved local health-care facilities by increasing the number of medical staff, facilitated the availability of medical supplies and raised community attendance.

Similarly, Ghana launched the National Health Insurance Scheme (NHIS) in 2004 to offer affordable medical coverage to the millions of uncovered poor and vulnerable citizens. Informal sector workers and others not covered by formal employment arrangements could buy into the scheme with an annual premium equivalent to approximately US\$18. The scheme includes provisions to cover the destitute, older people and children of covered members. Based on the Ministry of Health's 2007 figures, an estimated 6.8 million Ghanaians utilized the NHIS, with 8.3 million formal "card carriers" in the NHIS.¹ In the same year Ghana's Livelihoods Empowerment Against Poverty (LEAP) pilot expanded coverage to thousands of households on a pilot basis.

In similar vein, in 2007 Nigeria established the Health Insurance Fund (HIF) with financial support from the Dutch Ministry of Development Cooperation. The programme provides basic medical cover (including treatment for HIV/AIDS) for approximately 115,000 low-income Nigerians, targeting peasants, workers in the informal sector, students and working women. Linked to one of Nigeria's major health insurance companies, the programme requires income-linked contributions from participants but provides access to top-tier health-care services. With a budget of 100 million euros, the programme aims to expand to other African countries.

The same year, Uganda initiated the Social Health Insurance Scheme (SHIS) targeting employees in both the formal and informal sectors and aiming to cover the entire population over the following five years. Also in 2007 Gabon adopted a draft ordinance to create a compulsory health insurance scheme, although this has not yet been implemented. Tunisia has expanded health coverage to include some informal sector workers, fishermen, the self-employed, students, trainees, domestic servants and other categories of low-income earners. Côte d'Ivoire launched the pilot phase of a universal health insurance scheme in 2004 in two districts, but the prolonged civil war has hindered scaling up to other regions of the country.

In some countries, CHI funds are integrating with more formal systems. Tanzania created the National Health Insurance Fund (NHIF) in 1999, and it has grown to offer assistance to more than 1 million Tanzanians, and is still expanding. Today, the programme covers the majority of public servants. The private providers are increasing in numbers and the interaction of public and private providers raises the quality of health care. Recently the NHIF reported that the Ministry of Health and Social Welfare is building linkages between the fund and the Community Health Insurance Fund, which will support broader coverage, particularly for those without access to formal sector employment

4. Conclusions

Many countries in Africa are tackling the challenges of extending social insurance coverage with creative and forward-looking approaches that are yielding substantial results.

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Importantly, these innovations – in line with the Dynamic Social Security framework – are demonstrating good practices and documenting important lessons for their neighbours as well as other countries around the world. The people of Africa do not need to wait for economic growth and formalization to enable the extension of social insurance instruments modelled on industrialized countries' systems. Innovative approaches are leap-frogging the conventional wisdom, developing income security mechanisms that enable voluntary take-up by those in the informal sector. These voluntary mechanisms are likely to work best when linked to organizations of informal workers who are able to join the formal scheme as a group. Community-based initiatives, particularly in health insurance, are mobilizing the resources of the poor and pooling risk in order to provide more effective health protection. These Dynamic Social Security innovations are providing social protection while building the productivity of human resources and supporting inclusive growth processes.

Annex 1

Ghana's innovative approaches to extend social security to the informal sector

Executive summary

Prior to Ghana's Social Security and National Insurance Trust's (SSNIT) creation of the Informal Sector Fund (SIS), the country's social security system largely excluded 80 per cent of the nation's labour force. While one of SSNIT's schemes was based on voluntary contributions and provided informal workers with access to instruments providing old-age security, inadequate incentives and poor awareness contributed to low levels of take-up.

The SSNIT identified strong demand among the informal sector for a retirement savings scheme and rolled out a pilot programme in June 2005. Following its documented success the SSNIT created the Informal Sector Fund in February 2008. The fund's success stems not only from the resources that protect the members' retirement, but also provisions that enable participants to use their savings as collateral, enabling access to productive microcredit and supporting more sustaining livelihoods.

The issue addressed

Ghana's Presidential Commission on Pensions (PCP), set up in 2004, discovered after a study "that the absence of a formalized arrangement that provides retirement income security for the informal sector was inconsistent with the provisions of article 37(6)(a) of the 1992 Constitution which enjoins the State to: 'ensure that contributory schemes are instituted and maintained that will guarantee economic security for self-employed and other citizens of Ghana'".²

While informal sector workers had access to a contributory scheme, by 2003 only 6,349 of these workers contributed to the system³ – compared to 1.3 million formal sector workers.⁴ With approximately 80 per cent of Ghanaian workers employed in the informal sector,⁵ this represented a substantial challenge for Ghana's Social Security and National Insurance Trust. Part of the reason for the low informal sector coverage rate was the structure of the programme. Savings were not easily accessible to meet short-term needs, and the programme offered few additional benefits other than facilitating saving for retirement.

In addition, the targeted group – informal sector workers – lacked access to other financial services. They found it difficult to access credit, and when they did they faced very high interest rates, sometimes leading to the decapitalization of the borrowers as they had to sell their assets to repay.

Main objectives/expected outcomes

This scheme aims to help both the new participants and the economy as a whole. Informal workers face an unstable financial environment and economic insecurity and often lack income security for their old age. The scheme provides valuable financial services as well as a more attractive retirement savings option. In addition, the scheme contributes to national savings and provides participants with a collateral asset, enabling them to access productive credit at a lower interest rate. This would support the development of micro and small enterprises, and further the growth of existing small-scale firms, contributing to economic growth and employment creation. By limiting the collateral asset to half of the participant's savings, the scheme balanced the developmental aims with the social security objectives.⁶

Innovative approach

The SSNIT introduced the informal sector scheme on a pilot basis in May 2005, and based on positive evaluations established the Informal Sector Fund (SIS) in February 2008 to administer a national-scale programme.⁷ The scheme is offered to self-employed Ghanaians who are aged between 15 and 59 years, to workers in the formal sector and to Ghanaians living abroad.

The SIS is a voluntary contributory pension scheme designed principally for the workers in the informal sector which provides members with benefits that are based exclusively on their contributions. Unlike the formal sector scheme, this has no fixed-rate contributions. Contributions by members are divided into two equal parts and credited to two individual member sub-accounts, i.e. the Occupational Scheme Account, "OSA" (50 per cent of contribution), and the Retirement Account (50 per cent of contribution minus a life insurance premium).

Members are allowed to make periodic withdrawals from their OSA after five months of initial contributions provided the account has a credit balance. The funds in the Retirement Account only become accessible in the event of old age, disability or death. Members can use their contributions as partial collateral to secure credit from other regular financial institutions. They can also access small loans to start a business or help finance homes. Members of the fund may be permitted to borrow up to four times the outstanding balance on their OSA. Members are also entitled to old-age pensions as well as disability and survivor's benefits.⁸ Informal sector workers can participate as organized groups in a Group Personal Pension Scheme or as individuals in a Personal Pension Scheme.⁹

Efficient use of resources

The programme's tripartite structure supported an efficient employment of administrative and financial resources. The SIS established an agreement with two key financial institutions, the HFC Bank and Bofo Microfinance Services. The SIS maintained responsibility for recruiting members from the informal sector, opening accounts and ensuring contributions. Bofo designed, offered and serviced loan products to scheme members, using in part loan capital provided by the fund. HFC Bank provides loan capital and offers its banking network for the mobilization of contributions as well as the disbursement and repayment of loans. It is expected that the HFC "branch network will cover all the regions of the country by the end of 2009."¹⁰

This tripartite arrangement essentially enables the SSNIT's Informal Sector Fund to specialize in the long-term retirement services for members while the partner financial institutions (HFC Bank and Bofo) address the current business and personal financial needs of the participants.¹¹ The arrangement leverages HFC Bank's expertise, capital and branch network, eliminating the risk of inefficient bureaucratic expansion. Bofo's expertise in evaluating loan candidates reduces the risk to the fund's investment portfolio.

Results

By December 2006 the scheme had attracted 9,399 members,¹² and that number rose to 21,000 by late 2008. The scheme expects to reach the projected 2 million by the close of 2013 and subsequently 5 million by 2015.¹³ The innovative value-added approach promises to significantly extend social security coverage to the informal sector while supporting economic growth and job creation.

Lessons

Ghana's approach to extending coverage to the informal sector represents a model of Dynamic Social Security. The innovative approach balances cost-effective mechanisms with features that support economic productivity, building bridges between the informal and formal sectors. The scheme not only mobilizes national savings but also finances the participants' own investments. The success of this model suggests that simply enabling informal sector workers to save for their retirement may be insufficient. Providing value-added financial services and enabling participants to collateralize a portion of their savings may offer more compelling choices.

Replication value

Many other countries may find these lessons useful and at least some aspects replicable. Partnering with private sector financial institutions enables the offering of value-added services without incurring the cost of building new bureaucracies. Combining more liquid financial instruments with long-term retirement savings mechanisms broadens the appeal of the scheme. While the specific elements of Ghana's model may need to be adapted to the social and policy context of a specific country, the scheme's success suggests that other countries may benefit from consideration of the approach.

Annex 2

Contributory pension reform in Mauritius

Executive summary

Mauritius' multi-tier pension system is well developed and a model for developing countries. The first tier is a non-contributory Basic Retirement Pension (BRP) financed through tax revenue and provides a minimum income guarantee for older people. The second tier consists of two mandatory income-related pension schemes – the National Pension Fund (NPF) and the National Savings Fund (NSF). The third tier is made up by various voluntary schemes that are small scale and targeted towards those who are not covered by the first two tiers.

As Mauritius undergoes a demographic transition with its ageing population, the falling pensioner support ratio places increased fiscal pressure on the retirement system. The integrated multi-tier system and recent reforms, including the decision to raise the retirement age, provide effective responses to these challenges.

The issue addressed

In 1950 the Government of Mauritius implemented a "temporary" non-contributory pension system as an interim measure until a long-term system could be developed. The government began paying monthly pensions to poor citizens aged 65 or older. Subsequent reforms reduced the qualifying age from 65 to 60, abolished means-testing and made pensions taxable. The contributory pension system was introduced in 1978 and instead of replacing the non-contributory benefit created an increasingly integrated multi-tier retirement system.

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Like much of the rest of the world, Mauritius faces falling fertility rates and increasing life expectancy, leading to an ageing of the population. From 1980 to 2000, life expectancy in Mauritius increased from 67 years to 75 years (World Bank, 2004). Along with this transition the ratio of the people of working age to the people of pension age (the pensioner support ratio) is falling. Within a few decades there will be just two and a half workers to support each pensioner (World Bank, 2004, p. 1). This places fiscal strain on the non-contributory tier and highlights the importance of the contributory system.

Main objectives/expected outcomes

Mauritius has taken steps to solving these issues by expanding the contributory tier and changing the minimum pension age to 65 (over the next nine years). On 9 June 2006 the Minister of Finance and Economic Development announced that the non-contributory pension (Basic Retirement Pension (BRP)) and the contributory pension schemes would begin transitioning from retirement at 60 to retirement at 65.¹⁴ The reforms aim to achieve several objectives:

- maintain affordability of pension schemes despite ageing population;
- increase national saving; and
- ensure that living standards of workers do not fall in retirement.

Innovative approach

Participants in Mauritius' contributory scheme purchase points, as opposed to investing in portfolios or investing their contributions. The Minister of Social Security adjusts the points' value on a yearly basis. Participation in the NSF is mandatory for workers aged over 18 (excepting public sector employees, self-employed persons and workers with very low income) and is partially funded. The NPF "aims at a 33.3% replacement of average lifetime earnings for 40 years of employment" and requires employers to contribute 6 per cent of wages and employees 3 per cent (World Bank, 2004, p. 5). It provides monthly income based on average lifetime earnings. The National Savings Fund requires a 2.5 per cent contribution and is fully funded. It provides a lump sum at retirement based on previous contributions.

The strong link between individual contributions and personal benefits avoids the type of design features that can undermine sustainability (World Bank, 1994). Individual contributors bear the cost of early retirement, and benefits are equitably distributed. The non-contributory pension provides a minimum floor, creating a balance between the key equity objectives of the overall system and the efficient design of the contributory schemes.

The most recent reform increasing the eligibility age for retirement provides advance notice and staggers the increase over ten years. The reform adds one month to the retirement age every two months from August 2008 until the targeted age of 65 is reached in 2018. This enables participants to prepare for the change and ensures that no single age group bears a disproportionate share of the burden (World Bank, 1994).

Efficient use of resources

The National Pension Fund invests primarily in government bonds, which provides a secure portfolio while enabling the government to finance national development priorities. The fund also invests in housing loans and private companies (as of 2002 there was approximately 10 per cent of the total portfolio invested in housing loans, 10 per cent in private companies and 80 per cent in government paper and bank deposits). Investments are not legally constrained but decided by committee. The most recent reforms ensure the investment portfolio will sufficiently fund the retirement schemes to ensure their sustainability.

Sound investments and cost-effective operations have ensured an efficient use of resources. Based on the latest review of the NPF's financial performance in mid-2005, over the preceding ten-year period, the NPF earned an average nominal rate of return of 10.7 per cent and a real rate of return of 4.9 per cent.¹⁵ Additionally, the fund's operating costs have been steadily declining (World Bank, 2004, p. iv). In 2001 total operating costs were less than 0.5 per cent of total assets. This performance – both in terms of investment returns and the cost-effectiveness of operations – has proven superior to that of the average private sector pension fund over these time frames (World Bank, 2004, p. iv). More recently, due to contagion effects from the 2008 global financial crisis and the increasingly greying population, the NPF has been under considerable strain forcing it to announce in late 2008 that the retirement age would be raised from 60 to 65 for the period from August 2008 to July 2018.¹⁶ However, based on the ISSA's 2009 *Survey on social security in times of crisis*, in 2008 Mauritius still boasted a nominal rate of return of 11.2 per cent (ISSA, 2009).

Results

The National Pension Fund covers 300,000 employees – 60 per cent of the labour force – and continues to expand its coverage (World Bank, 2004, p. 5). Members of the National Savings Fund rose from 335,600 to 367,200 from 2002 to 2007, an increase of nearly 10 per cent. Contributions to the NPF increased by 41 per cent from 2002 to 2007, and the fund's total net assets more than doubled over this period. Contributions to the NSF rose by 50 per cent over this period. The sustainable growth in members and assets has enabled the government to steadily increase the real value of pensions since the inception of the schemes in 1978.

By raising the age of eligibility for pensions from 60 to 65, the Government of Mauritius is strengthening the affordability of the overall system and enabling a continued real increase in benefit levels. The reforms considerably ease the strain of the demographic transition, with a projected 3.9 working-age individuals supporting each pensioner in 2040 instead of the 2.5 projected without reforms.

Lessons

The reform process in Mauritius demonstrates the value of a multi-tiered pension system in terms of providing comprehensive social security in an efficient and equitable manner. Otherwise difficult reforms are more readily accepted if critical equity objectives are maintained throughout the reforms. The comprehensive approach demonstrates the capacity of well-designed and effectively implemented social security systems to achieve broad coverage of the entire population.

Replication value

The model of an efficient and effective multi-tiered retirement savings system may prove useful to other countries aiming to broaden the scope of their social security system. South Africa, for example, has evaluated the experience of Mauritius in designing its reformed retirement system, and Kenya's National Social Security Fund has moved in this direction. The integration of a universal non-contributory pension with interlocking contributory schemes provides a minimum floor that addresses the equity objectives of great concern in many countries, while the contributory tiers provide for a better resourced system that offers greater social security while promoting national savings. The combination is likely to prove increasingly attractive to African countries considering retirement savings reform.

Annex 3

Extending health insurance to the informal sector in Rwanda

Executive summary

Historically, many Rwandans have been unable to access adequate health care due to their inability to pay for vital services. In 1999 the Government of Rwanda developed a community-based health insurance scheme and expanded the programme to national scale in 2006. The scheme aimed to achieve two major objectives:

- *to bolster financial resources for the local health-care system; and*
- *to improve access to health care for the poorest.*

The essential innovation of Rwanda's approach consists of the decentralized model that mobilizes broad-based community support. Contribution rates are kept low in order to facilitate broad coverage, creating economies of scale for the scheme and the affiliated health-care providers.

By 2008, mutual funds covered over 75 per cent of the target population in all provinces, and the use of health care has increased significantly. The scheme is reported to have improved local health-care facilities by increasing the number of medical staff, improved the availability of medical supplies and raised community attendance.

The issue addressed

Low-income Rwandans have paid user fees for public health services since 1976. From 1996 to 1999, the average number of primary care service visits fell by approximately 17 per cent, leaving excess capacity in public health centres. Historically, many Rwandans have been unable to access adequate health care due to their inability to pay for vital services.

Main objectives/expected outcomes

In 1999 the Government of Rwanda developed a contributory community-based health insurance scheme delivered through health mutual funds. Working with local communities and with support from the Partnerships for Health Reform (PHR) project, the Government of Rwanda piloted key interventions in three rural districts. After further development and additional piloting, the Government of Rwanda expanded the programme to national scale in 2006. The scheme aimed to achieve two major objectives:

- to bolster financial resources for the health-care system at local level; and
- in particular to improve access to health care for the poorest.

Innovative approach

The essential innovation of Rwanda's approach consists of the decentralized model that mobilizes broad-based community support. Individual schemes contract with a single community-based health centre and pay this provider a monthly capitation grant for each member, and members contribute an affordable co-payment (Schneider, 2005). The Mutual Health Insurance Scheme reports the amount collected of premiums collected in order to foster greater transparency. The schemes have employed sensitization campaigns as well as public meetings in order to increase awareness and improve coverage (Tumukunde et al., n.d.).

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This community-based scheme provides a model for those not covered by the formal sector schemes implemented in 2001, when the Social Security Fund of Rwanda (SSFR) inaugurated a medical insurance scheme (RAMA) for public sector workers. Private sector workers who are members of the SSFR can also join voluntarily. A third scheme exists for military personnel, the Military Medical Insurance (MMI). The government aims to strengthen pooling between the three pillars of the Rwandan health insurance system by merging the three schemes to cover all Rwandans.

Efficient use of resources

Contribution rates are kept low in order to facilitate broad coverage, creating economies of scale for the scheme and the affiliated health-care providers. Individual contributions to the scheme cost 1,000 Rwandan francs (RWF) (approximately US\$2.00) per year, with government contributing a matching RWF 1,000 in order to cover more advanced services at the district and reference hospital level (ILO, n.d.). The scheme covers all medical services provided by health centres, including drugs as well as some limited services provided by hospitals. Specifically, the scheme covers all preventative and curative services – this includes dental services, hospitalization, surgery, radiology, laboratory services, generic pharmaceuticals and prescription glasses. The only services not covered are plastic surgery and prosthesis. (ILO, n.d.). This provides full health-care coverage for primary, secondary and tertiary medical services.

The administrative costs of the mutual funds have been kept below 8 per cent of revenue and a central reserve fund has been created for emergencies. Mutual funds have committees at district and health centre levels. Apart from providing the policy, technical assistance and monitoring, central government boosts the mutual fund system through a grant to each district. With the support of GTZ, the German development agency, Rwanda recently successfully applied to the Global Fund for a health system-strengthening grant. This support covers the cost of annual premiums for about 10 per cent of the poorest.

Results

Within a year of the pilot's commencement, about 9 per cent of the 1 million people in the three districts (a total of 88,303 individuals) had enrolled in the scheme. Insured members of the scheme paid only about a quarter of the amount uninsured members paid per health-care visit (Schneider and Hanson, 2007). By 2008, mutual funds covered over 75 per cent of the target population in all provinces, and the use of health care has increased significantly. The scheme is reported to have improved local health-care facilities by increasing the number of medical staff, improved the availability of medical supplies and raised community attendance. Eighty per cent of resources mobilized by the schemes are retained by local health facilities (Tumukunde et al., n.d.).

Lessons

Rwanda's success with this model demonstrates important lessons – most notably that community-based approaches can significantly extend health coverage to those in the informal sector who otherwise would be unable to access care.

Community health-care facilities in Rwanda historically have failed to benefit from important short-run economies of scale because of the poor's inadequate ability to pay for vital services. Accessible health insurance programmes more intensively utilize these too-often idle resources in health centres, increasing the efficiency of care delivery (Schneider and Hanson, 2007).

The community-based design and decentralized approach creates disparities across localities in the human resource base of the schemes. Additional training and capacity-building support may improve the equity of delivery across communities (Tumukunde et al., n.d.).

Replication value

Rwanda's example of community-based health insurance demonstrates a remarkable model for developing countries aiming to extend contributory health insurance coverage to those in the informal sector. While the considerable success may be attributable to Rwanda's specific social context and strong political commitment, the approach has parallels with similar initiatives in other parts of Africa – particularly the Mutual Health Organizations supported by the ILO in West African Economic and Monetary Union (WAEMU) countries, suggesting that the model may be replicable in other developing countries.

Annex 4

Pension reform in Senegal

Executive summary

Senegal has two old-age pension schemes: the Social Insurance Institute for Old-Age Pensions (IPRES), which contains private employees and one-sixth of government employees, and the National Retirement Fund (FNR), which contains the remaining government employees. Though the Senegalese system is consistently praised for its autonomy and institutional pluralism, demographic and policy factors caused the system to accumulate a significant amount of arrears.

From 2002, the schemes implemented significant reforms that expanded the contributor base, increased the eligibility age of benefits from 55 to 60, decreased the accrual rate, increased the averaging period and changed employer and employee contribution rates. The reforms succeeded in putting the schemes on a sound financial basis. To achieve long-term viability, the Senegalese government is now looking into both expanding preliminary domestic funding and diversifying investments both domestically and overseas.

The issue addressed

Senegal's social security legislation obligates all employers to offer pension plans to their employees. The Social Security Fund (CSS) supports two organizations: the Social Insurance Institute for Old-Age Pensions (IPRES),¹⁷ which contains private employees and about one-sixth of government employees, and the National Retirement Fund (FNR), which contains the remaining government employees (World Bank/IMF, 2002). Both the IPRES and FNR are currently financed by unfunded, pay-as-you-go (PAYG) schemes (IOPS, 2008a).

Demographic and policy forces created increasing challenges for these institutions, particularly the FNR. Throughout the 1960s and 1970s, rapid growth in the civil sector increased employment, expanding the contribution base. In the late 1990s, government hiring freezes led to a rising ratio of pensioners to contributors, creating a drain on fund reserves. By 2002, the FNR had no reserves, and IPRES had only 35 billion CFA francs in reserves, just 5 per cent of total financial sector assets (World Bank/IMF, 2002; Ndiaye, 2008).

By 2003 the main challenge facing both the IPRES and FNR was the accumulated arrears from the PAYG system, totalling 26 billion CFA francs (US\$37 million), which included interest on overdue benefits and amounted to 1.3 times the annual expenditure of the programme.¹⁸ The FNR had accumulated 9 billion CFA francs in arrears. The national budget had previously financed this deficit, but budgetary agreements with Bretton Woods institutions subsequently made this arrangement infeasible. (Ndiaye, 2008).

Main objectives/expected outcomes

The reform process began in 2004 and aimed to correct systemic and institutional problems with the pension schemes. Key objectives included reforming the governance structure and formalizing an investment policy. The reforms restructured contribution and benefit rules in order to establish a more sustainable financial footing. The Cabinet adopted a draft bill to begin capitalizing voluntary retirement schemes of the IPRES in October 2006, indexed benefits for inflation and created notional accounts for defined benefit schemes (World Bank, 2006a). The Government is still in the process of gradually transitioning to partially funded pension accounts. In 2008, the Senegalese government set up an Interim Supervision Committee to oversee the Social Security Fund, and created an oversight agency for the funding process (World Bank, 2006a, 2008). Other 2006 reforms included an indexation on inflation, notional accounts for the current defined benefit schemes, and consideration for coverage and integration of the FNR and IPRES.

Innovative approach

Senegal's approach preserved the genuine autonomy and institutional pluralism of the schemes, which stand as unique features of the Senegalese pension system. In addition, key government policy-makers take an active interest in ensuring good governance and promoting institutional credibility. The Government is a key stakeholder both as an employer as well as a trustee through the Minister of Labour and the Minister of Finance. The Directorate of Labour and Social Security and the Inspectorates of Labour and Social Security both monitor Senegalese social security institutions (Diop, 2003).

While labour unions initially resisted the changes, increases in civil service salaries and a rebalancing of the structure of contributions (decreasing the contribution rate for employees while increasing it for employers) helped to build the consensus and sustain the political support needed for the success of the reforms (Diop, 2003).

Efficient use of resources

The establishment of a more sustainable financial foundation for the retirement programmes required a more conservative approach to fund resources. The reforms raised the eligibility age for benefits from 55 to 60, decreased the accrual rate, increased the averaging period, and changed employer and employee contribution rates. To achieve long-term viability, the Senegalese Government is now looking into expanding preliminary domestic funding and diversifying investments both domestically and overseas.

Results

As a result of the reforms the Social Security Fund succeeded in erasing its deficit by early 2008 (IOPS, 2008b). The system is improving its financial stability while offering a better quality of service (Diop, 2003). The schemes are examining the feasibility of creating individual accounts on both voluntary and mandatory bases. While successful in their goals, the reforms are only the first steps towards achieving long-term viability for the pension systems. Senegal is currently looking into expanding the partially funded accounts into international channels (World Bank/IMF, 2002).

The Supervisory and Regulatory Commission of Social Security Institutions of Senegal (COSRISS) is working on building popular support and gaining confidence for the IPRES and

FNR. COSRISS is also looking into whether individuals would be able to make withdrawals from personal accounts, such as for purchasing housing, and extending coverage into the informal sector (IOPS, 2008b).

Lessons

Senegal's experience documents how balanced reforms can generate the broad-based support required to re-establish financial sustainability and provide better value to contributors. Demographic and economic forces may require a reorientation of social security systems, and pragmatic reforms can improve long-term viability.

Replication value

Senegal's reform process may prove useful to other countries working to establish a solid financial foundation for their social security schemes. Good governance, prudent changes and a balance of give-and-take that broadens stakeholder support can prove a winning combination in many reform processes. While Senegal's reform process is still ongoing, the documented success may offer important lessons for schemes around the world.

Annex 5

Extending unemployment insurance to domestic workers in South Africa

Executive summary

South Africa's unemployment insurance history reflects the social and political transitions of the nation. Until 2003, domestic workers constituted the largest single category of workers in the country, numbering approximately 1 million – nearly all excluded from the government's Unemployment Insurance Fund.

Legislation in 2002 required domestic workers and their employers to make contributions to the Unemployment Insurance Fund starting in 2003, in order to extend this protection to the largest group of workers in South Africa's informal sector as part of the country's developing commitment to comprehensive social security. By 2008, the number of registered workers reached 633,000 with over 324,000 domestic workers actually receiving unemployment, maternity or adoption benefits as well as benefits in case of illness or death.

South Africa's success shows that significant extension of coverage to the informal sector is possible if appropriate strategies are adopted that take into account the specific bottlenecks facing different groups of workers.

The issue addressed

South Africa's long history of unemployment insurance reflects the social and political transitions of the nation. Protection for black workers was significantly eroded from the 1940s as the government built the apartheid system, and policy and management difficulties created a precarious financial situation for the State's Unemployment Insurance Fund (UIF) (Standing et al., 1996). The country's first democratic elections in 1994 signalled a new government commitment to social protection, but policy reforms for unemployment insurance proved challenging.

South Africa's Labour Force Survey documents that domestic workers constitute the largest single category of workers in the country, numbering approximately 1 million. Prior to 2003 almost all of these were excluded from the UIF because of the institution's inability to extend

coverage to those working in the informal sector. The objective of covering domestic workers faced many challenges:

- ensuring compliance by households who employed domestic workers;
- managing a 20 per cent increase in the number of contributors (in 2003 only approximately 5 million workers were registered with the fund);
- developing cost-effective contributions management systems, particularly in light of the low value of incremental contributions (Meth, 2001).

Main objectives/expected outcomes

South Africa's 2002 Unemployment Insurance Contributions Act required domestic workers and their employers to make contributions to the Unemployment Insurance Fund with one year's notice, commencing in April 2003. The main objective was to extend this protection to the largest group of workers in South Africa's informal sector as part of the country's developing commitment to comprehensive social security. A related objective was to ensure that one of the lowest paid categories of workers enjoyed at least some of the protection offered to the better compensated employees in the formal sector.

Innovative approach

Extending coverage to the informal sector is challenging because of the heterogeneous nature of employment. Measures useful for extending coverage to farm labourers, which focus on compelling compliance by employers, are unlikely to work for domestic workers. South Africa's Department of Labour adopted a sectoral approach adapted to the specific characteristics of the domestic work sector. Publicity, outreach and compliance mechanisms were developed in line with the challenges facing the associated employers and the targeted domestic workers.

Efficient use of resources

The UIF developed procedures to minimize the administrative hurdles for employers. For example, employers already registered with the tax agency (the South African Revenue Service (SARS)) were able to include UIF contributions with their regular tax payments. Unregistered employers contributed directly to the fund. In 2006 the UIF launched an online electronic filing system for domestic and small businesses which significantly reduces the compliance burden and lowers administrative costs to the fund.

Results

From 2003 to 2006 over half a million domestic workers registered with the UIF and approximately 15 per cent of these have actually received benefits. By 2008, the number of registered workers reached 633,000 employed by 556,000 employers. Over 324,000 domestic workers have actually received benefits. Most of the beneficiaries are women, and the fund provides unemployment, maternity and adoption benefits as well as benefits in case of illness or death.¹⁹

Lessons

South Africa's debate regarding the extension of unemployment insurance to domestic workers echoed scary predictions about mass job destruction and crippling administrative burdens. Five years later the policy innovation constitutes the fund's major success story, highlighted in the UIF's annual report to the Parliamentary Portfolio Committee on Labour (Seruwe, 2009). The fund is working with a similar model to extend unemployment insurance to informal taxi workers, another major group of vulnerable workers that generally lacks this protection.

One key lesson from South Africa's experience is that sectoral approaches offer significant advantages over blanket attempts to extend coverage to the informal sector. Covering the informal sector is difficult because significant bottlenecks exist – and these vary significantly from one group of workers to the next. By focusing on specific groups of workers, the responsible bureaucrats can adapt appropriate strategies for overcoming resistance and enforcing the law.

Another key lesson is the extent to which both employers and employees demand unemployment insurance. On the fifth anniversary of the extension of coverage to domestic workers, the Minister of Labour Membathisi Mdladlana recollected "the labour pains we had to go through during the early stages of the registrations of domestic workers as our officials were battling to cope with the unexpected influx of domestic employers who responded to the call to register their workers" (Department of Labour, 2005).

Replication value

The sectoral model of extending unemployment insurance to informal sector workers may prove useful to other countries aiming to broaden the reach of contributory programmes. Particularly in this time of global economic crisis, a more robust and expansive unemployment insurance system provides much-needed protection while creating counter-cyclical mechanisms. South Africa's success with this approach offers other countries useful lessons for extending coverage to the informal sector.

Annex 6

Tanzania's National Health Insurance Fund

Executive summary

Tanzania reintroduced cost sharing in the health system in the 1990s, after more than 20 years of free health care offered by government facilities and a long period of a ban on private-for-profit medical practices. A number of schemes were put in place between 1993 and 1999 to address the need for health insurance in both the formal and the informal sectors. While significant gaps exist for informal sector workers, the formal sector has benefited from better administration.

The National Health Insurance Fund (NHIF) created in 1999 has grown to offer assistance to more than 1 million Tanzanians, and is still expanding. Today, the programme covers the majority of public servants. The private providers are increasing in numbers and the interaction of public and private providers raises the quality of health care. Recently the NHIF reported that the Ministry of Health and Social Welfare is building linkages between the fund and the Community Health Insurance Fund, which will support broader coverage, particularly for those without access to formal sector employment.

The issue addressed

After obtaining its independence in 1961, Tanzania abolished user charges in government health facilities and adopted free health-care provision. In 1967 the Government banned private-for-profit medical practice and committed to providing free medical care through public health facilities. The public facilities in the following years were financed through public taxation (Mtei et al., 2007, p. 15). In 1991, private-for-profit services were re-legislated and in 1993 the Health Sector Reform programme:

- reintroduced user fees in public hospitals;

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- created the National Health Insurance Fund for government employees;
- introduced Community Health Funds (CHF) at local levels;
- introduced the Drug Revolving Fund (DRF) to assist in purchasing pharmaceuticals;
- offered drugs at half the original price;
- empowered local community supervision of health facilities; and
- allowed the private sector to operate to supplement government efforts (Humba, 2005, p. 7).

The Health Sector Reform programme redesigned the Tanzanian health-care system from scratch. Patients seeking government health-care services were required to pay a small fee at registration and contribute to the cost of medication. The task of reintroducing cost sharing for health care proved to be complex, and the Government required mechanisms to make health services affordable.

Main objectives/expected outcomes

The NHIF started operating in 2001, initially covering only the group of public employees categorized as government servants. In the first two years the programme covered only the central government employees, and then was extended to cover all public servants. Enrolment into the NHIF is compulsory for all public servants and covers the employee, the spouse and up to four children and/or dependants (Humba, 2005, p. 7). The NHIF stands out among Tanzania's social security initiatives as a dynamic project that has been well budgeted, has extended its coverage and is expected to build linkages to the informal sector. The programme's objectives include:

- To create a reliable and sustainable system for the provision of health services to formal sector employees with the possibility of extension to the informal sector as the scheme gains experience.
- To ensure easy access to good quality health services through a combination of health-care providers from the government and private health providers.
- To establish a reliable method that will enable formal sector employees to contribute towards their own health and those of their families.
- To reduce the financing gap by supplementing the government allocation to the health sector (Humba, 2005, p. 8).

Innovative approach

An important element of the NHIF's approach is its long-term objective of extending coverage to the informal sector based on the experience it builds in supporting formal sector workers, particularly through linkages to community health funds. While still being actively pursued by the Government of Tanzania, CHF rollouts have been plagued by several key barriers, including low commitment and follow through from regional and district officials, lacklustre commitment from the Ministry of Health, poor capitalization of the initiative, poor understanding of the programme's benefits amongst recipients, and high differentiation amongst various communities' willingness-to-pay estimates (Mtei and Mulligan, 2007, p. 3). In addition, the approach adopted aims to encourage revitalization of private sector provision of health-care services, and structures benefits accordingly. Given the country's previous history with public health-care provision, the NHIF had to promote awareness with both health-care providers and participants in terms of the health insurance protocols.

Efficient use of resources

The NHIF has specific limits of spending granted to the beneficiaries. Any amount exceeding the fixed expenditure is paid entirely by the beneficiary. This measure represents an attempt to counter consumer moral hazard, since members of the NHIF can choose freely what health-care facility to use (Mtei et al., 2007, p. 31).

Results

Within the first five years of operation, the NHIF covered 275,864 principal members and more than 1 million beneficiaries. The fund offers assistance to 5.1 per cent of the population (members and beneficiaries), in the context of a formal employment sector of only about 6 per cent of the total population.

In 2001 nearly all the health-care facilities included in the programme were under government administration. By 2007, 14 per cent of the facilities were privately owned and managed. With better management and more straightforward accreditation procedures, there are prospects for considerable private contribution to the health-care provision under the NHIF.

Claim processing has also improved considerably since the implementation of the programme. After the first year of the fund's existence, the reimbursement rate to health service providers was below 50 per cent. However, this rate of reimbursement had reached 70–85 per cent in 2005, in large part due to education programmes conducted throughout the country which aimed at increasing the capacity of health-care providers to lodge claim forms correctly.²⁰

Lessons

While other health insurance schemes in Tanzania (micro-insurance and community health funds) started as ambitious projects aiming for broad coverage and low contribution rates by members, the NHIF began as a small compulsory fund for government employees and has grown steadily in size and coverage ever since its inception. This suggests that cautious approaches rooted in a sustainable membership base may provide a foundation for a more expansive system. Recently, Mr Emanuel Humba, the Director-General of the NHIF, reported that the Ministry of Health and Social Welfare is building linkages between the fund and the Community Health Insurance Fund, which will support broader coverage, particularly for those without access to formal sector employment.²¹

Replication value

The model of progressively expanding coverage from a sustainably supported core programme may prove useful to other countries aiming to broaden the scope of their social security system. In addition, the NHIF has productively cultivated new relationships between public and private health facilities. While Tanzania still faces many challenges, particularly in terms of broadening coverage to the informal sector, the model's success may document an approach with important lessons for other countries.

Annex 7

Health insurance reform in Tunisia

Executive summary

Tunisia's health insurance reform provides opportunities to improve the health system coverage, equity and financing, while strengthening essential functions such as care purchase, provider control and accreditation. The detailed modalities of health insurance reform implementation are in their last phase of planning and are being discussed among the health systems main actors. Initial reforms in 2004 offered a range of health insurance options. Subsequent reforms beginning in 2007 consolidated the sickness benefit programmes of the various social security schemes into a new unified programme. This provides the same benefits to all insured persons who, consequently, all pay the same contribution rate to the same fund. The new scheme now makes it possible for all insured persons to access private health care, which was previously limited under mandatory health insurance.

The issue addressed

Tunisia's health-care system substantially out-performs other countries with similar income levels (Arfa and Achouri, 2008). With annual health expenditures lower than US\$150 per capita, Tunisians enjoy a high life expectancy (estimated at 73 years in 2004), a low infant mortality rate (19 deaths per 1,000 live births) and a low maternal mortality rate (70 deaths per 100,000 live births) (World Bank, 2006b).

Health insurance was introduced in Tunisia in the 1950s and comprises a number of private and public schemes (ISSA, 2008). Initially, the schemes were managed mainly – and later, exclusively – by two social security funds providing public and private sector coverage, respectively. The recent reforms of the late 2000s are only an additional link in a long chain of reforms that began in the 1980s. Gradually, the Government has attempted to move towards universal health-care coverage. This has taken place in five stages. In the 1980s reform efforts focused on improving primary care provision. From the late 1980s to late 1990s, management methods were of central importance – this included creating a "legal arsenal" to incorporate the private health-care sector. The early 2000s featured a modernization drive to upgrade facilities and better organize the entire health-care system. The revamp of the industry included the establishment of the National Health Insurance Fund, which had the mandate to create and manage a social security health insurance scheme for both the private and public sectors (Arfa and Achouri, 2008, p. 427).

Previously, there were two separate government schemes: the Caisse Nationale de Retraite et de Prévoyance Sociale for civil servants and the Caisse Nationale de Sécurité Sociale for private sector employees. The final period of reforms occurred in 2007, with the formal launch of the Caisse Nationale d'Assurance Maladie (CNAM), which is said to be based on France's health-care system.²² Despite having serious obstacles to overcome, the introduction and ongoing roll-out of the CNAM brings Tunisia closer to its goal of providing universal health care (ISSA, 2008). Most of the Tunisian population has health coverage that allows access to medical care either through social health insurance or the public medical assistance programme (World Bank, 2006b), and health infrastructure and human resources are reasonably distributed throughout the country. An estimated 95 per cent of the population has access to a health structure less than 5 km away.²³ Supplementary insurance schemes (group insurance and mutual insurance companies) have also developed in response to the insufficiencies of the Social Security Fund health insurance schemes.

These wide-ranging forms of coverage belie the extent to which out-of-pocket expenditures constitute a burden on household budgets, comprising nearly half of all health expenditures (WHO, n.d.). The percentage of private expenditures in Tunisia has risen in the past two decades. Benefit incidence analysis documents the significance of the economic burden of health expenditures on the poor, and the poor are likely to spend a substantial proportion of their income on private health care even though public services for the poor are available and provided free of charge.

Main objectives/expected outcomes

In 2004 Tunisia's Parliament enacted legislation establishing a new national health insurance fund (CNAM). The following year the Government passed decrees to determine the organization of the national Health Insurance Council and standardize contracting procedures between the CNAM and providers. The reforms aimed to achieve three key objectives:

- To establish and implement a sole mandatory basic regime managed by a single health insurance body, the national health insurance fund (CNAM).

- To implement optional complementary regimes in order to cover the costs that remained unmet by the basic regime.
- To involve all health-care providers, both public and private, through contracts addressing quality standards of care delivery, mechanisms of cost containment, tariffs and provider payment methods.

Innovative approach

The initial reformed model enabled beneficiaries – both civil sector and private sector employees – to select from the following insurance schemes, each associated with a set of benefits as well as cost control measures (El-Saharty, 2006). Each year beneficiaries have the opportunity to review and adjust their choice if desired (Jeffreys, 2008, p. 204).

- A public sector scheme offers access to all services provided in the public system, and caps the required annual co-payment at the equivalent of about two months' salary.
- A private sector scheme enables beneficiaries to obtain care in the private sector. Beneficiaries are required to choose a primary care provider, who will serve as a gatekeeper to specialist care in order to provide a measure of cost control. Participating doctors agree to the fees and co-payments established by the CNAM and are not able to bill their patients for additional fees, but the required co-payment for services received under this scheme is greater than those for the public sector scheme.
- A reimbursement scheme allows the patient to consult any provider of care, regardless of specialty or sector. In return, the patient must pay for the care received and then request reimbursement from the CNAM. Fees and co-payments are also established by the CNAM according to the service provided and no balance billing is allowed. Annual reimbursements are capped at lower levels than that for the private sector scheme.

Subsequent reforms beginning in 2007 consolidated the sickness benefit programmes of the various social security schemes into a new unified programme. This provides the same benefits to all insured persons who all pay the same contribution rate to the same fund. The new scheme now makes it possible for all insured persons to access private health care, which was previously limited under mandatory health insurance.

Efficient use of resources

Active workers and the self-employed covered by the fund make contributions through a tax of 6.75 per cent on their income, split between the employer and the employee (i.e. 67 per cent paid by employer, 33 per cent paid by the employee). An additional tax is levied for those individuals who also receive pensions at a rate of 4 per cent (ISSA, 2008). Eventually, all social security beneficiaries (presently 2,700,000, roughly 26 per cent of the population based on 2008 estimates; see CIA, 2008) and their dependants will be covered by at least the mandatory scheme. Progressive extension of coverage will encompass public sector beneficiaries and non-agricultural salaried workers. The second year of implementation extends coverage to the non-salaried workers and salaried workers of the improved agricultural sector. In the third year, the plan will also reach the salaried agricultural workers. The new law has also created a national Health Insurance Council to oversee the functioning of the health insurance scheme and propose the necessary means to ensure its financial viability.

Results

Despite the impressive reforms adopted by Tunisia, there is very little evaluative analysis literature available on the plan's outcomes. According to a World Bank survey, "within its efforts to improve health-care quality, Tunisia focused on improving inputs (human resources, rehabilitation of facilities, care process), before focusing on process improvement and results monitoring" (World Bank, 2006b). However, health indicators and qualitative assessments do point to the potential benefits of the programme adjustments – reflecting improved health-care coverage, improved equity and strengthened financial sustainability of

the scheme. The main areas of success include the purchase of care services, accreditation and provider control (World Bank, 2006b). The reform effort has successfully mobilized key stakeholders with disparate interests and approaches, and is beginning to yield positive results.²⁴ In terms of health indicators, life expectancy has increased from 67.4 years in 1984 to 74.2 years in 2007 and child mortality rates have dropped from 51.4 per cent in 1984 to 17 per cent in 2006.²⁵ There are also some (tentative) indicators that link more directly with the reforms: the number of hospitals has increased from 156 in 1990 to 172 in 2006 and the ratio of inhabitants to doctors has dropped from 2,110 in 1987 to 930 in 2007.²⁶ One particularly telling indicator of how much progress has been made more recently is the absolute number of doctors, which increased from 9,805 in 2004 to 70,184 in 2006, a 616 per cent increase in a period of two years.²⁷

Lessons

Tunisia's reform experience provides important lessons. In particular, despite moving towards universal health-care coverage, the issue of adverse selection is still present because of the balancing act between promoting the private health-care sector and providing affordable care of all its citizens: "private health providers could be tempted to accept only richest patients, particularly if they estimate that tariffs of responsibility have been set at a too low level. Poor patients would thus tend to remain in the public sector" (World Bank, 2006b). Thus, as other developing markets move towards dynamic approaches to health insurance provision, it is crucial to recall that there is a delicate balance at play. Additionally, it is important to include all key stakeholders in the consultation process, particularly when disparate interests and perspectives create significant challenges. Careful and comprehensive financial analysis increases the likelihood of the reform efforts promoting long-term sustainability. Finally, lessons from international experience can enrich the options from which policy-makers can choose, while nevertheless keeping the alternatives grounded in the country's social and policy context.

Replication value

Tunisia's experience offers an important model that other countries may find attractive and even replicable. Offering effective choices within a reform framework can broaden the stakeholder appeal of a new social security system. Tunisia's experience reflects the country's unique historical context yet nevertheless provides an approach from which other countries may draw useful lessons.

Notes

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