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« Transforming Challenge into Action: Expanding Health Coverage for All » at the World Bank Group and IMF Spring Meetings 2024

Two hot issues that should have been brought out of the shadows but weren't

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Most low-and middle-income countries are lagging behind in achieving the 2030 Health Sustainable Development Goals (SDGs), including the one that specifically concerns universal health coverage (UHC; SDG indicator 3.8.1). The universal health coverage index, which rose sharply between 2000 and 2021, from 45 to 68, is now in a plateau or very low-growth phase in many countries, while some 4.5 billion people are not adequately covered by essential health services.

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• • • /• • • As part of the Spring Meetings of the World Bank Group and the IMF, a public event was held on April 18 on « Turning Challenge into Action: Expanding Health Coverage for All ». In some way it was echoing the WHO's UHC Day on December 12, 2023, when the organization called on governments to urgently invest in the resilience of health systems to drive progress towards UHC and deliver health for all.

Many pressing issues have been addressed to varying degrees by the panel convened by the World Bank for this event[2]. Let's mention just a few, without attempting to do justice to all of them: strengthening cooperation, partnership, and coordination among the various players to better tackle the multi-sectoral factors on which the expansion of universal health coverage (UHC) depends; sharing with countries knowledge that is truly appropriate to their needs;[3] addressing the importance of a strong and effective political commitment by government that goes beyond mere declarations of intent; stepping up efforts in favor of quality primary healthcare, which is –and must remain, along with the first level of the healthcare system–the fundamental pillar of universal coverage; better focusing public policies on access by the poor to affordable quality care;[4] implementing more appropriate regulatory policies, including the reform of procurement systems; and–last but not least in this non-exhaustive list–strengthening the role of the private sector to make it a real player and partner of the government in the implementation of UHC.

All these questions are highly relevant « to transform challenge into action. » They were tackled in a stimulating way, but–understandably–more or less quickly, given the format of the event. Two other hot issues, however, definitely deserved to be highlighted but were not: (i) the overarching issues raised by recent studies on the contribution of health insurance to expanding health coverage for all in low-income and lower-middle income countries (LICs and L-MICs); and (ii) the compelling challenges of improving the efficiency of healthcare spending. These are the two issues discussed in this Brief Note.

The current state of health-insurance effects: What's at stake for universal health coverage policies?

The issue of the contribution of health insurance to the objectives of UHC (access to affordable quality care for all and financial protection) was not specifically addressed by the panel. It should have been, however, firstly because a reductionist vision of UHC still too often confuses it with insurance, whereas UHC is to be financed by all available sources of funding and instruments; and, secondly, because today's assessment of the effects of health insurance challenges governments and their national and external partners on the policies to be adopted to ensure that health insurance is in the position to play a greater role in the universal coverage in LICs and L-MICs, as expected.

Over the past twenty years or more, all low- and middle-income countries have introduced some form of health insurance scheme. There is more recently a trend among sub-Saharan African countries to turn to contributory public health insurance schemes alongside budgetary financing as a way of making progress toward UHC (Barasa *et al.*, 2021). Only eight of them (Benin,

2. The panelists were Ajay Banga, World Bank Group President; Tedros Ghebreyesus, Director-General, World Health Organization (WHO); Shun'ichi Suzuki, Minister of Finance, Japan; Muhammad Pate, Minister of Health, Nigeria; Mohamed Maait, Minister of Finance, Egypt; Sri Mulyani Indrawati, Minister of Finance, Indonesia; Senait Fisseha, Vice President of Global Programs, Buffett Foundation; and Lamia Tazi, CEO of Sothema, a pharmaceutical company in Morocco.
3. A. Banga (World Bank) to Th. Ghebreyesus (WHO): « You have « domain experience » beyond limit…We [World Bank] bring a diversification of knowledge. We understand water, climate, agriculture,… [and] how those connect to the intertwined health challenges we are going through… In the same way, knowledge has to be catered for the country and its stage of development. »
4. This was not mentioned, but it should be noted that, surprisingly, we don't have a comprehensive picture of who benefits from public spending on healthcare, as the issue is poorly documented. In particular, benefit-incidence analyses are fairly sparse that allow us to identify by welfare quintile or decile the beneficiaries of public health spending. It would be useful if they could be systematically included in public expenditure reviews and their results could be better exploited.

Gabon, Ghana, Kenya, Nigeria, Rwanda, Tanzania, and Zambia; Cashin and Dossou, 2021), however, have moved away from the traditional beveridgiene-inspired system and embarked on a national contributory health insurance (NHI) system, also known as social health insurance, which makes entitlement to coverage dependent on a contribution (premium) paid by or on behalf of individuals/households. By 2021, at least seven others (Burkina Faso, Cameroon, Ethiopia, Mali, South Africa, Togo, and Uganda) were considering or had defined a legal framework for establishing NHI (Cashin and Dossou, 2021).

Taking a look at the effects–hitherto disappointing overall but not surprising–of health insurance on health outcomes in LICs and L-MICs

The literature has gathered evidence showing that health insurance in all its forms generally tends often to increase the use of health services. However this occurs to varying degrees as shown by, for example, Odipo *et al.* (2024), who studied the association between insurance status and health-care facilities use in Ethiopia, Kenya, South Africa, India, and Laos, finding highly heterogeneous results across countries. Public health insurance appears to be only weakly associated with access to health services in the countries studied. The same applies to the effects of insurance, which tends to increase financial protection by reducing the direct and indirect costs associated with illness, as well as the risk of impoverishment due to ill health. There's a positive trend, but it's not systematic.

On the other hand, the effect of health insurance on health outcomes has been mixed (Das and Do, 2023) and disappointing overall. In the small number of studies that have found a positive causal effect of insurance on health status, this is generally due to an increase in the use of better-quality services, particularly at the basic-care level. Why is there this general lack of effect of insurance on health outcomes? Das and Do (2023) consider that « the keys to understanding the uneven performance of health insurance in low and middle-income countries is the provider side of healthcare. » They identify two types of problem in addition to the well-documented fact that the quality of care is quite often mediocre or poor, including inappropriate diagnoses (Gatti *et al.*, 2021): (i) *denial of care*, which refers to a situation in which the insurance card is not honored by the healthcare facility for various reasons, and (ii) *double billing*, whereby healthcare providers levy additional and illegal top-ups from patients, both of which lead to the renunciation of care, delayed care, care that comes too late, or resorting to less-qualified providers.

Let's consider the so far unconvincing effect of health insurance on health outcomes and the fact that health insurance is largely subsidized by the budget or directly by health aid, even in countries that have opted for the NHI.[5] Won't some governments question, on grounds of efficiency and opportunity costs whether it is worthwhile, in a context of scarce resources[6], to continue to invest in health insurance for the sole reason of gains in financial protection? The question must be raised. It would be paradoxical given the broad consensus that the protean limits to a significant increase in the mobilization of public resources in LICs and L-MICs make the development of insurance indispensable. Taking the appropriate measures to ensure that health insurance has a measurable positive effect on health status should be a top public policy priority.

Low coverage rates

Another finding leads to the same kind of conclusion. After one or two decades (or even more depending on the country) of adopting health-insurance measures, the percentage of the population covered by various benefit packages of uneven quality remains very low (less than 10 %, including government staff), particularly in sub-Saharan African countries (Cashin

5. Where budget funding remains the main source of insurance financing, far ahead of premiums.
6. Especially since, as we have pointed out, the health sector is competing with other sectors for limited budget.

& Dossou, 2021; Das & Do, 2023), with a few exceptions:[7] Kenya, 16 %; Namibia, 18 %; Gabon, 54 %; Ghana, 66 %; and Rwanda, 88 %.

Why are coverage rates so low? Here, again, we need to look at both the supply and demand sides, the two being linked in a two-way relationship. The literature highlights households' low desire for health insurance and underscores that large subsidies are required to trigger a significant increase in enrollment, which often falls as soon as the subsidy contracts. Several studies have emphasized the complexity of the determinants of willingness to pay for health insurance, as they are not homogeneous across countries or household characteristics (see, e.g., Bayked *et al.*, 2024).

But *in fine*, to sum things up abruptly, the literature suggests that, in the household preference function, and considering the opportunity cost of enrollment, if an individual or household does not enroll in insurance it is because they consider *that it is not worth the money*[8]. This is the very simple but fundamental message that governments and their partners have to get across, and they need to act accordingly to make enrollment *more value for money*. A basic relevant starting approach to make households value insurance more, could be to capitalize on a demonstration effect, with a limited and subsidized package of benefits but of excellent objective and perceived quality–the two not necessarily coinciding.

Acknowledging the limits of voluntary mutual health insurance for UHC in the informal sector

It should be acknowledged that some approaches, while useful in their own way, are inefficient at a systemic level, although they are quiet highly prized by certain public and private donors. This is the case, with voluntary mutual health insurance in LICs, where the informal sector can account for 80 % or more of employment. Despite the external support from which they have benefited over the past two decades, they cover only a small proportion of their target population, and many of them cannot be sustained without the financial support of external partners. This is mainly because of their small membership and the resulting limits on the pool's operational capacity. While they play a fundamental role in fostering access to care for their beneficiaries and should therefore be encouraged in the absence of short-term alternatives, their position in the process of building UHC has to be questioned and reconsidered.

Three points must be borne in mind. Firstly, we know that they often miss the poorest households (first quintile). Secondly, because of their small size and the often-large number of players involved (multiple donors, NGOs, elements of civil society), they constitute a highly fragmented kaleidoscope accentuating the fragmentation of the whole healthcare system. Finally, UHC must be designed on a systemic basis. Consequently, it must be acknowledged that rapid progress towards UHC in countries with a large informal sector cannot be based on a system designed around voluntary insurance schemes to cover primary healthcare. The main role of voluntary insurance in such a context should be to finance supplementary care. It was this very observation that led Rwanda to introduce *compulsory* membership in community health insurance entities in a 2007 law. It was in response to the government's frustration at the slow uptake of voluntary schemes, weakened by the small size of their pools and by adverse selection. Compulsory enrolment then led to a considerable increase in health coverage, reaching about 90 % of the population.

7. For countries common to both studies, we report the higher figure.
8. Irrespective of whether or not this is due to the absence of an « insurance culture » for some.

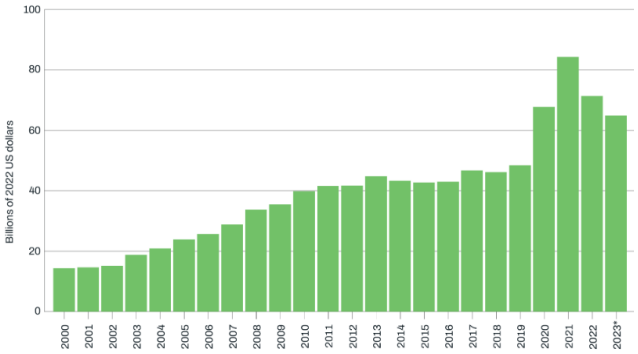
Don't forget to close the windows before turning up the air conditioning: Making more efficient healthcare spending a top priority for governments and their partners

Why?

All the panelists stressed the need to increase healthcare funding, particularly in low and lower-middle income countries[9]. They were right. In 2021, the LICs, the vast majority of which are in sub-Saharan Africa, spent an average of $45 per capita on healthcare among all sources of financing combined (WHO, 2023). This is more than in recent pre-Covid years, although slightly down from 2020 (–1.6 %). But we must bear in mind, beyond the relative imprecision of the estimates, that this amount makes it difficult to have only a first-level health system[10] that is functional and delivers quality services (McIntyre *et al.*, 2017; Watkins *et al.*, 2017), not to mention financing for the secondary and tertiary levels. The funding gap is therefore considerable in respect of Sustainable Development Goal 3: « Enable all people to live in good health and promote well-being for all at all ages. »

The overall good news for health financing is that growth continues recovering after Covid-19 in sub-Saharan Africa as a whole, with an average of 3.8 % expected in 2024 and 4 % projected for 2025, although this represents little growth per capita. The orders of magnitude are broadly comparable for the LIC group. However there is great heterogeneity between countries. In many of them, governments continue to face twin deficits (budget and current account), worrying debt situations, with debt service that, coupled with the persistently low mobilization of domestic resources, not only drastically limits the scope for enlarging the fiscal space for health but also generates pressure to cut social public spending, including health (IMF, 2024a, 2024b). This is even more the case as there are strong uncertainties over the evolution of net ODA in general and health aid in particular, the latter having declined in 2022 and 2023 after the spectacular rise in 2020 and 2021 to support the anti-covid fight (Figure 1; HIME, 2024). Finally, health is in strong competition with other sectors, such as education, agriculture and climate, particularly in recent years, which *de facto* limits the government's ability to increase health share in total public spending.

Figure 1 - Development assistance for health (HIME, 2024)



*2023 estimates are prelimary. Currency is reported in 2022 inflation-adjusted US dollars. Source: Financing Global Health 2023 Database.

In this context, improving the efficiency of healthcare spending (i.e., in short, achieving more results with the same volume of resources, or producing the same results with fewer resources[11]) is of cardinal importance. It's an issue that would have deserved to be highlighted directly and forcefully by the World Bank panel. But it was not,[12] while all participants insisted–rightly, as we have seen–on the need to increase the domestic and external resources allocated to health. The point is then

9. A. Banga pointed out that the World Bank is « talking about putting to work 50 % more money per year [until 2030] than what we used to spend in healthcare pre the pandemic ».
10. Those who provide basic healthcare, playing a fundamental role in achieving the health SDG in LICs and L-MICs.
11. And without compromising the quality of services provided, if one considers indicators that are not health-status indicators but, for example, activity indicators (e.g., the number of consultations, etc.).
12. That said, the issue of efficiency was mentioned very briefly by Mohamed Maait, Egypt's finance minister and former health minister, who presented his government's reform plan to promote progress toward UHC: « The [previous] system had become financially unsustainable, inefficient, and also it didn't achieve its objective. »

that the effort to increase health financing will be partly wasted if, in parallel, improving the efficiency of health spending doesn't turn out to be a core priority for governments and their external partners. In a nutshell, deploying considerable efforts to increase healthcare financing without also tackling the issue of improving efficiency head-on is like turning up the air conditioning in a room while leaving the door and windows open.

There is scope for maneuvering, and it is often quite substantial

Numerous studies show that in all countries there is (very) large scope for increasing the efficiency of healthcare spending, not only without altering the quality of care but even while improving it.[13] Today, it's clear where the main efficiency problems lie. But defining and implementing appropriate operational strategies depend fundamentally on local contexts, as there is no such thing as « one size fits all. » Broadly speaking, there are four main approaches to increasing the efficiency of healthcare spending. We need to act on each of them: developing the use of cost-effectiveness (or extended cost-effectiveness) analyses to select priority interventions in health policies, notably to build up the benefit package for UHC; strengthening the strategic purchasing of services, a strategy that remains very little used in low- and middle-income countries; improving the efficiency of healthcare facilities by starting to measure them; and strengthening coordination among stakeholders.

Improving efficiency is one of the main areas of FERDI's policy-oriented research in the health field. Research carried out on the efficiency of district hospitals in several African LICs (including Burkina Faso, Niger, and Zimbabwe) showed a wide disparity in efficiency levels.[14] As a result, there is large potential to increase healthcare output (frequently by more than 20 %) with the resources available, if in each country the efficiency of each district hospital came close to that of the most efficient (Mathonnat *et al.*, 2023; Guillon *et al.*, 2022; and Guillon, Mathonnat *et al.*, 2022, for Mongolia). In another approach, Banerjee *et al.* (2023) found for a selection of primary care facilities in India, China and Kenya that between 70 % and 90 % of expenditures are medically unnecessary. The authors point out that « This contrasts sharply with the fraction of medically avoidable expenditures attributed to overtreatment » (p. 10).

Staffing and procurement: Promising grounds for improving efficiency, but demanding and politically sensitive

In each of the FERDI studies, there appears to be no significant relationship between district hospital efficiency and staffing levels. Medical staff productivity is low in most cases, suggesting that it would be beneficial to the overall efficiency of the healthcare system to reconsider staff allocation criteria.

According to the WHO, 90 % of LICs, particularly in sub-Saharan Africa, have a deficit in human resources for health, with levels well below the threshold of 4.4 qualified personnel per 1,000 inhabitants (WHO, 2016). It is widely understood that this results in an excessive workload, negatively affecting the quality of care. Still, various studies, including those by Das and Do (2023) and Kovacs and Lagarde (2022), highlight a workload of between five and ten patients per day per medical staff in primary care facilities in a sample of African countries.[15] They also show, as do Kwan *et al.* (2019), the absence of a relationship between patient workload and quality of care. Banerjee *et al.* (2023) find that clinics are operating at substantial excess capacity. In the two sub-samples where they observed providers for a full day, providers spend four to eight hours in their clinics but less than one hour actively seeing patients.

This means that there is significant slack capacity in first-level facilities, and seeing more patients would not require any real additional effort on the part of medical staff. Looking at WHO standards,

13. This also applies to high-income countries.
14. As in Cambodia and China (Shandong province).
15. This is in line with what was said in the above-mentioned efficiency studies.

there is indeed a shortage of medical staff, but the current available personnel could do more, which is precisely an efficiency issue that, as is generally the case in efficiency, challenges both the supply and demand sides. The issue is even more important given that the cost of healthcare staff absorbs on average around 55 % of government healthcare expenditure in LICs, with a range of 40 % to 65 % (Toure *et al.*, 2023).

Added to this is the fact that absenteeism of frontline health workers in public sector facilities is widespread in LICs and L-MICs (Gatti *et al.*, 2021; Zhang *et al.*, 2021), with heterogeneity depending on the country and the position of care facilities in the health pyramid. In Uganda, for example, Di Giorgio *et al.* (2021) found high rates of health worker absenteeism at public sector health facilities, with most of the absenteeism occurring at lower level public health clinics. They pointed out that « on average, no health worker was present in 42 % of all days monitored in lowest level public health clinics[16] » (op. cit.), level which is of primary importance for the health SDG.

As another source of inefficiency, Chalkidou *et al.* (2020) showed, based on simulations of three approaches to reforming the public procurement of healthcare products, that 50 of the poorest low- and middle-income countries could save between $10 and $26 billion a year with an appropriate reform policy. These orders of magnitude are to be compared with the $46 billion in health aid excluding Covid for 2021.

States and their partners should therefore make improving the efficiency of healthcare spending a « great cause », and donors should convince governments that this is an economic imperative (and also something of a moral imperative, given the magnitude of the unmet healthcare needs) and that buoyant appropriate initiatives and programs should be put in place, as has been the case, for example, with essential generic medicines and maternal and child healthcare. Increasing funding–domestic, total net external, public, and private–without pushing efficiency improvement to the top of the agenda of governments and their partners contributes to creating or maintaining a moral-hazard situation that can only be detrimental to achieving the health SDG.

16. Whereas this number was less than 5 % in high level public hospitals and private facilities.

Not to overlook the issue of private-sector efficiency

The scope considered for efficiency-improvement strategies should not be restricted to the efficiency of public spending or facilities. It should also include that of private providers,[17] who deliver a large, sometimes overwhelming, share of first-level healthcare in LICs, notably for most basic healthcare services for mothers, children, and malaria treatment (Grepin, 2016; Sriram *et al.*, 2024). But for-profit providers appear frequently (although not systematically) to deliver care at higher cost than public ones, and they are mainly financed out of pocket. The central role of profit and the uneven quality of care from private providers (ranging from excellent to dangerous) fuel a divisive, sometimes with ideational considerations, debate,[18] on its potential contribution to UHC. But it would be odd in a UHC development strategy to disregard the issue of providers efficiency to whom a very large proportion of households turns. The true question is not whether to consider the private sector in efficiency-enhancing strategies but what regulatory policies are relevant to harness the private sector to the production of key quality services at a reasonable price within the benefits package targeted by the government as part of the implementation of UHC. There is no one-size-fits all policy, and it's a hugely complex task, all the more so as there is a widespread lack of information and data to tackle the problem.

17. The main bulk of the strategy should primarily focus on the formal private sector, along with pressing specific operations in the informal sector, such as the fight against « pharmacies on the ground » (street vendors of generally dubious quality medicines).
18. Although, contrary to widespread belief, the literature does not allow us to consider that quality is better or worse than in the public sector.

References

• **Banerjee A., Chowdhury A., Das J., Hammer J., Hussam R., Mohpal A.** (2023) The Market for Healthcare in Low Income Countries, Harvard Business School Working Paper, July.

• **Barasa E., Kazungu J., Nguhiu P., Ravishankar N.** (2021) Examining the level and inequality in health insurance coverage in 36 sub-Saharan African countries, *BMJ Global Health*, 6(4), e004712.

• **Bayked E.-M., Assfaw A.-K., Toleha H.-N., Zewdie S., Biset G., Ibirongbe D.-O., Kahissay M.-H.** (2024) Willingness to pay for National Health Insurance Services and Associated Factors in Africa and Asia: A systematic review and meta-analysis, *Frontiers in Public Health*, 12, 1390937.

• **Chalkikou C., Keller J., Over M., Jones A.** (2020) Can Better Procurement be the Key to Financing UHC? Potential Savings from Health Sector Procurement Reforms in Low- and Middle-Income Countries, CGD Policy Paper 192, Center for Global Development.

• **Das J., Do Q.-T.** (2023) The Prices in the Crises: What We Are Learning from 20 Years of Health Insurance in Low- and Middle-Income Countries, Journal of Economic Perspectives, vol. 37, no. 2, Spring, 123-52.

• **Di Giorgio L., Evans D.-K., Lindelow M., Nguyen S.-N., Svensson J., Wane W., Welander Tärneberg A.** (2020) Analysis of clinical knowledge, absenteeism and availability of resources for maternal and child health: A cross-sectional quality of care study in 10 African countries, *BMJ Global Health*, 5(12), e003377.

• **Gatti V., Gilman A., Ciro A., Orion R., Jigyasa S., Andres Y.** (2021) *The Quality of Health and Education Systems Across Africa: Evidence from a Decade of Service Delivery Indicators Surveys*, Washington, D.C.: World Bank.

• **Grépin K.-A.** (2016) Private Sector An Important But Not Dominant Provider Of Key Health Services In Low- And Middle-Income Countries, Health Affairs, 35(7), 1214-1221.

• **Guillon M., Audibert M., Mathonnat J.** (2022) Efficiency of district hospitals in Zimbabwe: Assessment, drivers and policy implications, *International Journal of Health Planning and Management*, vol 37(1), January.

• **Guillon M., Mathonnat J., Narantuya B., Dorjmyagmar B., Enkhtsetseg E.** (2022) Exploring the efficiency of primary health care provision in rural and sparsely populated areas: a case study from Mongolia, *Health Policy and Planning*, vol. 37(7), August, pp. 822–835.

• **IHME** (2024) *Financing Global Health 2023: The Future of Health Financing in the Post-Pandemic Era*, Seattle, WA: Institute for Health Metrics and Evaluation, Seattle, WA.

• **IMF a.** (2024) Regional economic outlook, Sub-Saharan Africa: a tepid and pricey recovery, Washington D.C., April.

• I**MF b.** (2024) Macroeconomic developments and prospects for low-income countries, Policy Paper, Washigton D.C., April.

• **Kovacs R., Lagarde M.** (2022) Does high workload reduce the quality of healthcare?, Evidence from rural Senegal, *Journal of Health Economics*, 82, 102600.

• **Kwan A., Daniels B., Bergkvist S., Das V., Pai M., Das J.** (2019) Use of standardised patients for healthcare quality research in low and middle income countries, BMJ Global Health 4 (5).

• **Mathonnat J., Guillon M., Kergall P., Morillon G.** (2023) « Effets de la pandémie de Covid-19 sur l'efficience des hôpitaux de district au Burkina

Faso et au Niger », Papier de recherche n°300, Agence française de développement, Paris.

• **Mcintyre D., Meheus F., Røttingen J.-A.** (2017) What level of domestic government health expenditure should we aspire to for universal health coverage?, *Health Economics*, Policy and Law, 12(2), 125-137.

• **Odipo E., Jarhyan P., Nzinga J., Prabhakaran D., Aryal A., Clarke-Deelder E., Mohan S., Mosa M., Eshetu M.-K., Lewis T.-P., Kapoor N.-R., Kruk M.-E., Fink G., Okiro E.-A.** (2024) The path to universal health coverage in five African and Asian countries: Examining the association between insurance status and health-care use, *The Lancet Global Health*, 12(1), e123-e133.

• **Sriram V., Yilmaz V., Kaur S., Andres C., Cheng M., Meessen B.** (2024) The role of private healthcare sector actors in health service delivery and financing policy processes in low-and middle-income countries: A scoping review, *BMJ Global Health,* 8(Suppl 5), e013408.

• **Toure H., Aranguren Garcia M., Bustamante Izquierdo J. P., Coulibaly S., Nganda B., Zurn P.** (2023) Health expenditure: How much is spent on health and care worker remuneration? An analysis of 33 low- and middle-income African countries, *Human Resources for Health,* 21(1), Article 1.

• **Watkins D.-A., Norheim O.-F., Jha P., Jamison D.-T.** (2017) Mortality Impact of Achieving Essential Universal Health Coverage in Low- and Lower-Middle-Income Countries, Working Paper 21 for Disease Control Priorities (third edition), Department of Global Health, University of Washington, Seattle.

• **WHO** (2016) Health workforce requirements for universal health coverage and sustainable development goals, *Human Resources for Health Observer Series* No 17, Geneva.

• **WHO** (2023) Global spending on health: coping with the pandemic, Geneva.

• **Zhang H., Fink G., Cohen J.** (2021) The impact of health worker absenteeism on patient health care seeking behavior, testing and treatment: A longitudinal analysis in Uganda, *PLOS ONE*, 16(8), e0256437.

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