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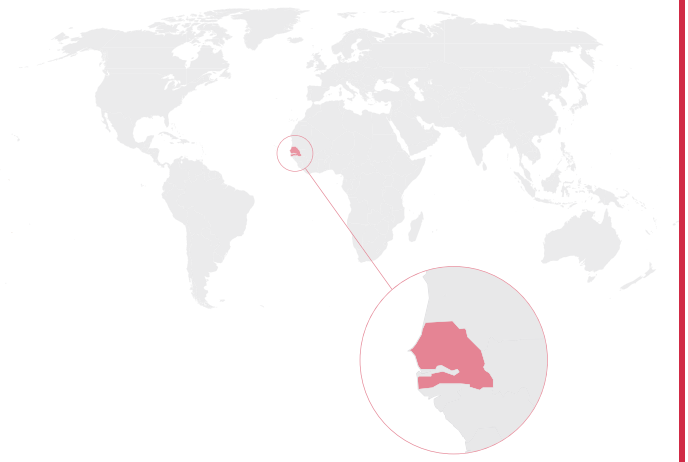
Senegal



Josefine Dehn

The Health Care System in Senegal

Global Dynamics of Social Policy CRC 1342

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The Health Care System in Senegal

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Content

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1. Country Overview

Source: On The World Map 2021

- Sub-Region: West Africa
- Capital: Dakar
- Official Language: French
- Population size: 16,296,364 (estimate, 2019)
- Share of rural population: 52.347
- GDP: US$ 23.578 billion (2019)
- Income group: Lower middle income
- Gini Index: 40.3 (2011)
- Colonial period: mid-15th century Portugal, from 1677 France
- Independence: 1960

1. Selected Health Indicators (WHOa 2020)

Indicator	Senegal	Global Average
Male life expectancy at birth in years (2018)	65.5	70.4
Female life expectancy at birth in years (2018)	69.6	74.9
Under-5 mortality rate per 1,000 live births (2018)	43.6	38.6
Maternal mortality rate per 100,000 live births (2017)	315.0*	211.0*
HIV prevalence as % of population ages 15-49 (2018)	0.4	0.8
Tuberculosis incidence per 100,000 people (2018)	118.0	132.0

Note: * modelled estimate data

2. Legal Beginning of The System

Name and type of legal act	L'arrêté du 8 février 1905[1] (Decree/Order) (Ndao 2009, 11)
Date the law was passed	08 Feb 1905
Brief summary of content	Creation of the *Assistance Médicale Indigène* (AMI, Indigenous Medical Assistance) providing free medical care and hygiene advice, promotion of vaccinations and maternal and child protection for the indigenous population (Buell 1928, 190-192; Ngalamulume 2012, 10)
Socio-political context of introduction	Senegal was a French colony affected by several severe epidemics e.g. yellow fever and the plague, especially at the beginning of the 20th century; high infant mortality (Buell 1928, 191; Snyder 1973, 130-131; Cooper 2010, 17-18, 47); at the same time the French colonial power needed a healthy indigenous labour force (Snyder 1973, 130-131; Cooper 2010, 53, 119)

3. Characteristics of The System at Introduction

a. Organizational structure

- The health care system reflected the centralized bureaucratic structure of French West Africa's[2] public health administration during the colonial period. All French colonial medical services were governed by the *Corps des Médecins de la Santé de la France d'Outre-Mer* with headquarters in the French Ministry for Overseas in Paris. The general control of colonial health services lay with the *Direction Générale* in Paris and in Senegal were more closely supervised by the two Senegalese *Directions Locales* in the towns of Saint-Louis and Dakar. In each *Direction Locale*, a French chief medical officer supervised and controlled the subordinated French medical officers and indigenous personnel in the local medical districts, the lowest hierarchical level that corresponded to that of the local administrative units (Buell 1928, 191-193; Snyder 1973, 131-132).
- Regional allocation of responsibilities for health care: Responsibility for the *AMI* lay with the colony's *Direction Locale*. For major endemic diseases responsibilities lay with the *Service Général d'Hygiène Mobile et de Prophylaxie*, which was directly supervised by the *Direction Générale* in Paris (Snyder 197, 132).
- Eligibility/entitlement: *AMI* services were aimed at the whole indigenous population regardless of status[3] (Pearson 2018, 21, 32).
- Coverage by the *AMI*: In practice, there was huge disparity in actual coverage and service provision between urban and rural areas due to a permanent lack of health care professionals and medical equipment (Pearson 2018, 21, 32).

b. Provision

- Number/density of physicians and nurses:
  - In 1910 there were 18 European doctors, 14 African doctors and medical students in Senegal (Cooper 2010, 67). From 1931 – 1946, fluctuating numbers of European medical staff were on site in French West Africa year by year as well as over the course of time; numbers of native African medical staff and doctors more than doubled or even tripled (Cooper 2010, 67, 186-187).

1 Décret du 14 avril 1904 already authorised the governor of each colony in French West Africa (Afrique-Occidentale Française, *AOF)* to enact legislation necessary for the prevention of diseases and the improvement of public sanitation (Snyder 1973, 131-132).

2 French West Africa comprised eight countries: Mauritania, Senegal, French Sudan (now Mali), French Guinea (now Guinea), Ivory Coast, Upper Volta (now Burkina Faso), Dahomey (now Benin) and Niger.

3 Apart from a minority of African inhabitants of the *Four Communes* who possessed French citizenship with corresponding rights, the majority of Senegalese people were seen as colonial *sujets* without such rights (Cooper 2010, 11-12).

- A constant lack of medical personnel and financial resources hampered coverage and hindered an extension of the colonial health services into rural areas up until the inter-war years. To address this shortcoming, the Dakar Medical School was founded in 1918 in order to train natives as subordinated medical support personnel[4] for working mainly in rural areas and under the supervision of European doctors, reflecting a racist hierarchy of medical personnel (Snyder 1973, 134, 153; Cooper 2010, 5, 81-83, 177). After independence, the *AMI*'s existing structures were integrated into the Senegalese health care system. Over time the European health care professionals were replaced with Senegalese staff (ASNOM 2020a).

- Number/density of beds in public, for-profit, and not-for profit institutions (earliest available figures from the 1950s):
  - Public facilities located in urban areas: major hospital complexes in four big cities (among them the capital Dakar and Saint-Louis), minor hospitals in three bigger towns, 30 secondary treatment centres, six quarantine stations.
  - Public facilities in rural areas: 120 dispensaries/health posts, 42 maternity facilities and a *service mobile* (a visiting service to care for the sick, inspect the local health and sanitary conditions and deliver e.g. vaccinations) (Buell 1928, 191-192; Snyder 1973, 137; Cooper 2010, 63-64)
  - Non-governmental facilities: eleven Catholic mission dispensaries and two Red Cross dispensaries (Snyder 1973, 137; Kanté 2011: 31-34).
  - Health care was strongly segregated along racial lines and giving military personnel preferential treatment; e.g. in 1913, of the 218 beds in the Colonial Hospital in Dakar, 150 were reserved for Europeans and 68 for African patients (Cooper 2010, 131). Better equipped hospitals and the Senegalese Overseas Louis Pasteur Institute (for research and the production of vaccinations) were located in Dakar and Saint-Louis, whereas in rural areas only small health posts, rural maternity wards or even only mobile medical services existed (Pearson 2018, 21, 32).
- Importance of inpatient and outpatient sectors:
  - Free out-patient treatment was provided in dispensaries and maternity wards as well as specialized treatment in hospitals (Snyder 1973, 134; Pearson 2018, 64) with a "fee structure [...] [that] discouraged African use of hospitals for in-patient treatment and encouraged recourse to hospital out-patient treatment and [...] to local dispensaries and maternity clinics. Hospital in-patient treatment was free only to the indigent, although rates were graduated according to the income of patients" (Pearson 2018, 64).

c. Financing

- Total expenditure for health:
  - Expenditure for Medicine and Sanitation as a percentage of Colonial Ordinary Expenditures (1926) was 23.1% for Dakar and 3.6% for the whole of Senegal (Buell 1928, 209). The overall federal budget for indigenous medical assistance *(AMI)* in French West Africa increased by 150% between 1923 and 1926 from 7,977,970 Francs to 18,768,500 Francs, but still represented lower per capita spending than in British West Africa at the same point in time (Buell 1928, 37).
- Financing sources:
  - The *AMI* was mainly tax-financed by the colony's local budget as well as to a lesser extent by the federal budget of *French West Africa* (Buell 1928, 198; Huillery 2009, 181).

d. Regulation

- Actors responsible for the regulation and/or organization of health care system:
  - French Minister of Colonies: general allocation of responsibilities, decisions concerning the institutional design of responsibilities (Atlani-Duault et al. 2016, 2253)

4 For an encompassing investigation of the native medical staff's bridging role in French colonial policies see Cooper (2010).

- Gouverneur-Général of French West Africa (until 1939): supervision of the *AMI* and the sanitation services in the colonies, decisions on the organization of health services, creation of new medical facilities with advice by the Federal Director of Health (responsible for the administration of colonial health services within French West Africa) (Cooper 2010, 61-62; ASNOM 2020b)
- The French colonial administration decided on the numbers of European and native health care professionals as well as the amounts of medical materials and financial resources needed for health infrastructure (Huillery 2009, 182).

- Regulations for providers:
  - European health care professionals were required to have a French medical doctor's diploma from one of the medical schools in metropolitan France, and French citizenship (Cooper 2010, 65; ASNOM 2020b). By contrast, the medical training of native "auxiliary medical personnel" that took place at the Dakar Medical school was less comprehensive and shorter than in metropolitan France, and did not lead to the state diploma (Buell 1928, 38-39, Snyder 1973, 136; Cooper 2010, 127-130, 135-137).
- Public service package
  - Free services were a central principle of the *AMI*, although certain reimbursements were required from the indigenous population for specialist treatment (Buell 1928, 198). The overall focus was on preventive and prophylactic medicine such as vaccination, sanitation and hygiene measures, addressing the repeated outbreaks of epidemics at the turn of the 20th century (Snyder 1973, 133; Cooper 2010, 5, 75-76; Pearson 2018, 33-34).

4. Subsequent Historical Development of Public Policy on Health Care

a. Major reform I

Name and type of legal act	Labour Code (Overseas Territories) 1952 Act. No. 52-1322 (Legislative Act) (MOMF 1952)
Date the law was passed	15 Dec 1952 (MOMF 1952)
Brief summary of content	Art. 138-144 regulates medical services at work for formally employed workers and their dependants. It establishes requirements for a workers' medical service at workplaces with at least 100 employees and regular medical check-ups of workers (Art. 138, Labour Code (Overseas Territories) 1952), requiring employers to "provide free of charge medical care and medicaments" not only for the workers themselves but also their spouses and children in the case of illness (Art. 142, Labour Code (Overseas Territories) 1952)
Socio-political context of introduction	In light of internal pressure within African colonies, e.g. by parties and trade unions, and pressure at the international level the Labour Code was meant as a social improvement and means to justify continuing French colonialism in the Overseas Territories (Pfeffermann 1967; Pearson 2018, 139)

b. Major reform II

Name and type of legal act	» Loi cadre 75-50 du 3 avril 1975 (Framework law) (République du Sénégal 1975a) » Décret no. 75-895 du 14 août 1975 portant organisation des institutions de prévoyance maladie d'entreprise ou interentreprises et rendant obligatoire la création des dites institutions (Decree) (République du Sénégal 1975b)
Date the law was passed	Loi cadre: 18 Mar 1975 (République du Sénégal 1975a); Décret: 14 Aug 1975 (République du Sénégal 1975b)
Date of *de jure* implementation	Framework Law: 03 Apr 1975 (République du Sénégal 1975a)

Brief summary of content	» Framework law: common legal framework for different social security institutions, among them the *Institutions de Prévoyance Maladies* (IPM, enterprise-level health insurances) and mandatory, inter-company joint insurance associations for smaller companies (Art. 15, Loi cadre 75-50) » Decree: compulsory creation of *IPM*s for private sector companies with more than 100 employees; beneficiaries included apprentices and workers' dependants; regulation of the *IPM*s' operation and administrative organization by the Ministry of Public Service and Labour and administrative councils of workers and employers (Republique du Sénégal 1975b)
Socio-political context of introduction	Fifteen years after independence, the law aimed at strengthening curative medical care (Atlani-Duault et al. 2016, 2254) in the context of international economic crises (oil crises, collapse of the Bretton Woods system) on the one hand but expansionary monetary policies in Senegal on the other (Boye 1990, 10)

c. Major reform III[5]

Name and type of legal act	Several acts passed in 1996 (Foley 2009, 74), notably Loi no. 96-06 du 22 mars 1996 portant Code des collectivité locales; Loi no. 98-08 concerning hospital reforms (Brunner et al. 2016, 43)
Date the law was passed	5 Feb 1996 (Loi no. 96-06); 12 Feb 1998 (Loi no. 98-08)
Date of *de jure* implementation	1997 and 1998 (Foley 2009, 74; Tine et al. 2014, 3)
Brief summary of content	Commitment for local and regional governments to contribute at least 5% of public health spending and include health spending in their annual budgets; more administrative responsibilities transferred to the local level, e.g. responsibility for the management of health facilities and budgets for regional hospitals and health districts to the regions, municipalities, and rural communities (Tine et al. 2014, 3-4)
Socio-political context of introduction	Structural adjustment programs and the Bamako Initiative (1987) had led to the introduction of user fees in French-speaking African countries (Foley 2009, 59; Atlani-Duault et al. 2016, 2255).

d. Major reform IV

Name and type of legal act	Loi no. 2003-14 du 4 juin 2003 relative aux mutuelles de santé (Law) (MSPS 2003) and Décret no. 2009-423 du 27 avril 2009 (Decree) (MSPS 2009)
Date the law was passed	16 May 2003 (MSPS 2003)
Date of *de jure* implementation	27 Apr 2009 (by Décret no 2009-423 du 27 avril 2009)
Brief summary of content	Minimum legislative framework regulating conditions for the formation of mutual (social) health insurance companies (*mutuelles*), their financial organization and their structure; obligations of mutual health insurance company vis-à-vis their members and vice versa; rules for the constitution of unions and federations of mutual health unions, and for mergers, dissolution and liquidation of mutual health insurance organizations (Rapport de présentation, Décret n° 2009-423)
Socio-political context of introduction	In light of the high out-of-pocket payments for health, the extension of health insurance coverage to the large informal sector was seen as one important step towards universal health coverage (Atlani-Duault et al. 2016, 2258).

5. Description of the Current Health Care System

a. Organizational structure

» Centralization of the health care system: In theory, Senegal has a decentralized, pyramidal administration and management of the health system – with the peripheral level at the bottom with 50 *districts sanitaires*, the regional level in the middle *(region médicale)* corresponding to the administrative regions; and the

5 e.g. Foley (2009, 58-59) underlined the huge impact of this reform on the HCS's development

central level at the top (*niveau central)* with the Minister's office, directorates and related services (MSAS 2020a). In practice, however, the transfer of power from central to local governance was incomplete (Tine et al. 2014, 4-5).

» Segmentation by population group persists, with different health insurance schemes for public sector and private sector employees and medical assistance for certain vulnerable groups, e.g. elderly, young children, people suffering from certain diseases (Tine et al. 2014, 5-10).

» Eligibility/entitlement to social health insurance depends on employment status. Employees, including apprentices, seasonal workers, and temporary workers working at least three months a year for the same company are eligible if they pay at least two months' contributions. Spouses and dependent children are also covered, while the self-employed are not (SSA 2019, 223-224).
Citizens of Senegal not otherwise covered by health insurance or specific programmes for certain groups of vulnerable persons (see coverage below) are eligible for medical assistance, or AMI (Tine et al. 2014, 10; SSA 2019, 223-224).

» Coverage (Tine et al. 2014, 5-10)

Percentage of population covered by government schemes	» Mandatory scheme for public sector employees: 7.4% » Mandatory scheme for school children: 0.3% » Mandatory scheme for retired persons: 4.9% » Medical assistance and subsidized care for vulnerable/priority groups: approximately 3-8%
Percentage of population covered by social insurance schemes	Compulsory Social Insurance in *IPM*s (enterprise-level health insurance): » Private sector employees (including apprentices, seasonal workers, and temporary workers who work at least three months a year for the same company): 3.6% Voluntary Community-based Social Insurance (*Mutuelles*): » Informal sector and rural population: 3.8%
Percentage of population covered by private schemes	Voluntary Private Health Insurance: » Individual voluntary subscription: 0.2%
Percentage of population not covered	Approximately 72-77%, mostly poor, informal workers and rural population

Indicator	Value	Source
Physicians (per 1,000 inhabitants)	0.068	(WHO 2018)
Nurses and midwives (per 1,000 inhabitants)	0.309	(WB)
Hospital beds (per 1,000 inhabitants)	0.3	(WB)

b. Financing

Total expenditure on health (% of GDP)	4.1	(WHO 2020c)
Domestic general government health expenditure (% of current health expenditure)	21.0	(WHO 2020c)
Private expenditure on health (% of total expenditure on health)	62.3	(WHO 2020c)
Out-of-pocket expenditure (% of current health expenditure)	52.4	(WHO 2020c)
External health expenditure (% of current health expenditure)	16.7	(WHO 2020c)

c. Regulation of the dominant system

» Mandatory schemes for public sector employees and retired persons are overseen by the Ministry of Finance; *IPM* for private sector employees is overseen by the Ministry of Labour; and a scheme for students by the Ministry of Education; *Mutuelles* are overseen by the Ministry of Health and coordinated by *Agence de la Couverture Maladie Universelle* (Tine et al. 2014, 5).

» Regulations of providers: extensive and sometimes conflicting regulation for private providers exist, most of them regulating private providers and insurers (Brunner et al. 2016, 43-45).

- Public service package:
  - Schemes for public sector employees and their dependants: 80% of hospitalization, consultation and exam costs at public health providers, excluding costs for drugs or medicines (Tine et al. 2014, 5-8).
  - Mandatory Social Health Insurance for private sector employees and their dependants: 40-80% of costs incurred for medical care, hospitalization, exams, analyses, drugs depending on the employee's financial capacity. However, in practice, service packages vary across IPMs (Tine et al. 2014, 5-6, 8-9).
  - Medical assistance and subsidized care for vulnerable or priority groups: 100% of the costs for medical care in public health care facilities. Additionally, government regulations exempt such groups from selected health payments (Tine et al. 2014, 6, 10), but in practice, the availability of the services included – especially at municipal health care facilities – is limited (Foley 2009, 78)
  - Responsibility for inclusion of services in medical assistance programmes lie with the Ministry of Health. Decisions on services covered by health Insurance for public sector employees are made by the Ministry of Finance, while for IPMs for private sector employees the respective company decides (Tine et al. 2014, 6-7, 8, 10).

Besides the above there are also voluntary, community-based health insurance schemes for residents of Senegal aged 18 or older, provided by mutual insurance institutions (*Mutuelles*), supervised by the Ministry of Health (Art. 2, Décret no. 2009-423), and managed by community participation.

6. Role of Global Actors

After World War II, Senegal's colonial power France had to rely on financial and material resources from UNICEF and the WHO in order to be able to continue providing certain health services in French West Africa. However, due to fears concerning the increased activity of IOs in its colonial territories, France only reluctantly accepted their support (Pearson 2018, 142, 148-149, 152). After independence, international donors provided financial and technical support for the Senegalese health care system via bilateral and multilateral projects, pooled funding arrangements, and direct grants to community-based organizations (Tine et al. 2014, 5).

Structural adjustment programmes in the 1980s by the World Bank and International Monetary Fund and the Bamako Initiative (1987) resulted in decentralization and led to the "institutionalization of community financing of the health system through user fees and a generic drug plan" as well as further shifts of responsibilities for health system organization and management to the local level (Foley 2009, 59-61, 80-81). The development of health financing strategies and community health programmes were financially and technically supported by USAID. Technical support was provided by the WHO in financing universal health coverage projects (Cali et al. 2018, 137-138; UHC Partnership 2020).

The Catholic and the Protestant Church and three NGOs, Action and Development, *Association Sénégalaise pour le Bien-Etre de la Famille* (an International Planned Parenthood Federation affiliate), and Marie Stopes International's Bluestar Network act as health care providers at health posts and private clinics (Brunner et al. 2016, 11-12).

7. List of Additional Relevant Legal Acts

- 1906: Arrêté du 25 mai 1906 du Gouverneur-General sur l'exercice de la pharmacie en AOF (Order of the General Gouverneur on the practice of pharmacy in French West Africa).
- 1918: establishment of the Medical School in Dakar by Décret du 14 janvier 1918 establishment of l'École de médecine de l'AOF (Medical School of French West Africa), the first medical higher education school in Africa, to train doctors, pharmacists, nurses and midwives working in the AMI.
- 2008 Décret no. 2008-381 du 7 Avril 2008 Instituant un Système d'Assistance "Sésame" en Faveur des Personnes Âgées de 60 Ans et Plus (creation of the medical assistance programme for the elderly above 60 years of age).

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