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The International Labour Organization's measure of legal health coverage: Is it conceptually strong?

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Abstract

In 2014, the International Labour Organization (ILO) issued its annual World Social Protection Report. This report aimed to provide practical information on social protection that could be used by stakeholders for the roll-out of universal health coverage, including a new measure of legal health coverage (i.e. rights-based protection). Because this measure has estimates for 47 African countries, it potentially holds significance as a monitoring tool for the expansion of universal health coverage and the right to health across the African continent. This study examined whether the ILO's legal health coverage measure could actually be used to quantify LHC in Africa. To do this, the study assessed (i) whether the measure matched the ILO's own stated definition/concept of legal health coverage and (ii) whether the measure sufficiently reflected the concept of legal health coverage as defined in the academic literature. The findings of this investigation indicate that the ILO's measure was operationalised in a way that failed to capture key conceptual elements of legal health coverage.

1. Introduction

In September 2000, 149 world leaders from across the globe came together at the United Nations (UN) Headquarters in New York City and agreed upon eight objectives they believed the world should prioritise over the course of the next 15 years.: The Millennium Development Goals. Three of the eight goals related to health and health care: "reducing child mortality; improving maternal health; and combating HIV/AIDS, malaria and other diseases" (UN, 2016). More recently, international organisations such as the World Health Organisation (WHO) have gone further, urging every State to create policies that ultimately facilitate the realisation of "affordable universal [health] coverage" (Mills et al., 2012b; World Health Assembly, 2011). This has led to the inclusion of Goal 3 in the Sustainable Development Goals (SDGs), also known as the post-2015 Development Agenda.

The objective of SDG 3 is to "ensure healthy lives and promote well-being for all at all ages" worldwide (United Nations Development Programme, 2016). Viewed from a rights-based perspective, this objective can be characterised as the *right to*

health, which is how this study conceptualises SDG 3. Although the right to health encompasses more than just universal health coverage (UHC), UHC is a key component and an explicit target of SDG 3 (WHO, 2015b:1). Improving health is critical to countries' overall socioeconomic development, especially across the African continent (Stuckler et al., 2010).

While UHC is important in and of itself, it is also regarded as developmental in terms of its impact on improving productivity, the effectiveness of schooling, and reducing inequality (WHO, 2014:2). As a result, a number of developing countries, including African States, are implementing or planning on implementing programmes, policies, and legislation to achieve UHC (Giuffrida, Jakab & Dale, 2013:ii). UHC in Africa, and therefore SDG 3, cannot be achieved, however, if policymakers lack reliable measures for monitoring and evaluating States' progress towards each of UHC's core components, including the focus of this paper: legal health frameworks, or legal health coverage (LHC). These terms are explained in detail later, but a brief description is provided here. Put simply, legal health frameworks can be characterised as the legal policies and mandates that protect access to health services and the right to health (Clarke, Rajan & Schmets, 2016:482). For the purposes of my study, I define LHC as the *rights-based protection* that results from legal health frameworks.

In spite of this pressing need, the international community has failed to agree upon how to measure UHC and monitor it across time (Lagomarsino et al., 2012:941; Scheil-Adlung & Bonnet, 2011). To help fill this gap in knowledge, the International Labour Organization (ILO) collected and analysed data for its publication, the *World Social Protection Report* for 2014/2015. The report analyses the state of social protection schemes across the globe, including unemployment and disability benefits, but a considerable portion of its content focuses on estimating progress toward UHC. The *World Social Protection Report* accomplishes this by using several measures/indicators, each attempting to capture a different dimension of UHC. In this study, I critically examine one such measure: LHC, which is characterised in both the *World Social Protection Report* and in my study as *rights-based protection* (ILO, 2014b:100).[1]

The ILO's LHC measure was chosen as the focus of this study chiefly because it is one of the few, if any, existing measures that purports to quantify the legal aspect of the right to health for most of the world. The measure's estimates for African States are particularly noteworthy, as the literature is sparse when it comes to exploring and measuring legal aspects of UHC across Africa. The selected literature that does exist tends to focus on a few African countries rather

[1] From hereafter, these terms will be used interchangeably to refer to the concept of legal health protection.

than all of Africa. In contrast, the ILO provides estimates for 47 African States. Based on its research, the ILO concludes that fewer than 20% of Africans have LHC (ILO, 2014a:5, 11). The ILO has appealed for practitioners and other stakeholders to use this and related health information from the *World Social Protection Report* as the "basis for better informed policy-making" in social protection (Ryder, 2014: p. vi). Yet estimates of LHC should not be used for this purpose if they have been operationalised in a way that does not capture the concept of rights-based protection adequately.

To my knowledge, despite the singularity of the ILO's measure and the global prominence of the ILO in the field of social protection, researchers have yet to critically analyse its estimates. If the only widely known measure of LHC—a prerequisite for any true quantification of UHC—does not capture the concept of LHC fully, then it should not be used as a tool for monitoring progress toward SDG 3. Additionally, using the ILO's measure for any form of policymaking could pose a risk to development for some of the world's most impoverished countries.

This paper is the first of a two-part series assessing the ILO's measure and its estimates. The first paper assesses whether the measure is a good way to estimate LHC by determining if it has been operationalised in a way that fully captures the concept of LHC. The second paper assesses the measure's overall reliability by examining its metadata and determining how it quantified its estimates.

1.1 Research aims

UHC is integral to achieving the right to health, especially for those living in poverty. But accurately gauging the expansion of UHC requires conceptually strong measures. The ILO states that its LHC measure is an indicator of the legal right to health, a building block of UHC. This study asks whether the ILO's LHC measure can help monitor this in Africa and, accordingly, assist the continent in making headway on achieving SDG 3. To assess this, I pose the following, more specific, questions:

1. Does the ILO's operationalisation of LHC truly capture the concept of rights-based protections for UHC and the right to health? In other words, does the measure have conceptual integrity?
    a) This question is answered through a literature review of current academic thought on which legal components are prerequisites for UHC, and by determining whether the ILO's indicator of LHC includes these provisos.

2. Is the ILO's measure inclusive of those living in poverty?
    a) This is answered through engaging with current thinking in the literature on how health concepts and measures can be inclusive of those living in poverty and reflecting on whether the ILO's measure meets these criteria.

1.2 Significance

This two-part paper series is distinctive because, based on a search of the literature, no other study has questioned the relevance or value of the ILO's LHC measure.

The *World Social Protection Report*'s LHC estimates have, until now, most likely been considered dependable by many of its readers, principally because of the ILO's reputation as an international authority on social protection schemes. Although rights-based protection is only one component of UHC, which also includes access, quality, and other elements, it is still a "prerequisite" for UHC and therefore an important means of achieving SDG 3 (Scheil-Adlung & Bonnet, 2011:30).

Since there is a lack of standardised data and indicators for legal health frameworks and LHC, the ILO's (2015: 2) claim that it has developed "one of the few globally comparable databases" on LHC is important, especially considering that its measure has estimates for most of Africa. In my reading of the report, I found many definitional inconsistencies and conceptual limitations with the ILO's conceptualisation of what LHC actually *is*. But before critiquing, it is necessary to provide an overview of what the term means, why it is important, and how it is used in the health literature.

1.3 Paper overview

Section 2 discusses the ILO's history with social security and health coverage and familiarises the reader with the *World Social Protection Report*. Section 3 explains the relationship between LHC, UHC, and the right to health, as well the usage of the term "LHC" in academic literature. This section also explains the underwhelming global attention paid to the significance of LHC as a necessary component of UHC, the lack of available data on LHC, and considers the indicators that have been developed to monitor rights-based protection outside of the ILO.

Section 4 explains both the concepts of legal and effective health coverage according to the ILO's definitions and indicators, as well as the tables that contain the ILO's estimates. It also explains why this paper focuses on the ILO's LHC measure. Section 5 discusses the fundamentals of rights-based protection in health, specifically the characteristics of legal health frameworks that result in strong LHC, and why these include explicit protections for those living in poverty. Section 5 argues that the ILO's indicator of LHC in the *World Social Protection Report* does not capture the entire concept of rights-based protection and even disregards components of rights-based protection that the ILO itself considers to be central.

2. History of the ILO's relationship with health and introduction to the World Social Protection Report

This section offers an overview of the ILO's historical and current approach to health care; it also explains the significance of the ILO's *World Social Protection Report for 2014/2015*. This report contains the primary focus of this study: the ILO's LHC measure.

2.1 History of the ILO's relationship with health

As this paper critiques one of the ILO's health-focused measures, it is prudent to provide a brief history of the organisation and its involvement with health before moving on to issues concerning its LHC measure.

In 1919, the ILO was founded as a component of the Treaty of Versailles, with the aim of promoting social justice for labourers by creating a tripartite transnational forum to bridge the gap that divided "governments, employers and workers" (ILO, 2016b). Its creation was based on the international community's belief that "universal and lasting peace" could only be attained if the grievances and exploitation of workers around the world were addressed; it was understood that this required all three parties coming together to start a dialogue. Consequently, the ILO was born, and in 1946 it became an autonomous "specialised agency" of the nascent UN (ILO, 2016b).

For most of its history, the organisation focused solely on social security (including health care) for employees in the formal sector; however, toward the

end of the 1990s, the ILO became concerned with informal sector workers and other groups that had previously been excluded from social security benefits. This often included those living in poverty, as they are most likely to work in the informal economy compared to other socioeconomic groups. Currently, the ILO is "devoted to promoting social justice and internationally recognized human and labour rights" (ILO, 2016a). The ILO (2016a) enumerates four of its primary objectives for the 21st century as follows:

> a) Promote and realise standards and fundamental principles and rights at work;
> b) Create greater opportunities for women and men to decent employment and income;
> c) Enhance the coverage and effectiveness of social protection for all;
> d) Strengthen tripartism and social dialogue (ILO, 2016a).

Because this paper examines whether the ILO's LHC measure can contribute to the monitoring of SDG 3, which aims to realise the right to health for all (for which UHC is a conduit), this study is primarily concerned with the third goal (c) above. This goal of enhancing the coverage and effectiveness of social protection includes access to health care for everyone, regardless of their socioeconomic status or whether they live in the developing world. This paper asks whether the ILO's LHC measure can be used by researchers, development practitioners, and other stakeholders to help fulfil the organisation's mandate to enhance, primarily through policy monitoring and evaluation, health coverage for the world's citizens, particularly in Africa.

4.1 The ILO's World Social Protection Report for 2014/15

This section provides a brief overview of the ILO's *World Social Protection Report for 2014/15* to familiarise the reader with its content and significance. In line with the ILO's mandate, it annually publishes the *World Social Protection Report,* which examines the state of social protection globally and includes a measure on LHC. In the preface of the *World Social Protection Report* for 2014/15, the ILO's current Director-General, Guy Ryder (2014), describes the report as "an essential reference for anyone interested in social protection" (p. v). He explains that the report "provides an overview of the current organization of social protection systems, coverage, benefits and expenditures" for countries worldwide. Notably, Director-General Ryder (2014, p. v) hopes that the contents

of the report will be used by development practitioners to help inform debates surrounding social security and related policy decisions.

The findings of the *World Social Protection Report* are significant because they offer a great deal of urgently-needed data on health care, especially for African States, which generally have less reliable, standardised data available on health coverage. This type of data allows stakeholders to identify which countries most urgently need social security improvements, as well as which areas they need improvements in. In theory, stakeholders should be able to use this information in several ways. For example, if the report's findings were to state that Country A has very low health coverage, a non-governmental organisation (NGO) might take this information into consideration when determining how or where to allocate its resources. Alternatively, an academic might research why Country A is performing poorly compared to other countries in a similar stage of economic development; they may also choose to publish papers that provide innovative ideas on how best to increase health coverage for Country A's unique context. However, for the *World Social Protection Report for 2014/2015* to be used for practical purposes by relevant stakeholders, the health care measures included in the report need to be conceptually strong.

3. The importance of legal health frameworks and LHC

This section provides the context necessary for understanding the significance of the ILO's LHC measure. It first defines LHC and legal health frameworks. Thereafter, it discusses the importance of legal health as both a conduit for and a constituent of UHC, and as a reflection of the right to health. The section then explains how the term LHC is used in the academic literature and discusses several concepts related to LHC. In the last section, I explain the lack of attention paid to legal health frameworks in the global UHC agenda, the difficulty of monitoring LHC, and indicators that have been developed to do so.

3.1 Legal health frameworks and LHC defined

The first and most important concept pertains to national legal health frameworks. Comprehensive legal health frameworks are essentially structures, especially legislation, that "set the rules for how the health system functions, establish a legal mandate for access to health services and provide the means by which a national government can implement universal health coverage at a population

level" (Clarke, Rajan & Schmets, 2016:482). The ILO argues that "it is of utmost importance that governments increase efforts to extend and implement [health] legislation covering the entire population" (Scheil-Adlung, 2015:8),[2] and a large body of literature exists on which entitlements States are legally bound to provide in their legal health frameworks in order to comply with international norms and laws regarding the right to health (Sridhar et al., 2015:1). Human rights lawyers regularly collaborate with public health experts because the "development, enforcement and evaluation of laws…is integral to public health" (Marks-Sultan et al., 2016:3). In fact, "virtually all the major [global] health achievements of the last century…have depended on legal interventions" (Marks-Sultan et al., 2016:3).

Legislation can help pave the way for vulnerable members of society to access care. If a well-intended law is poorly written, it can even become a barrier to accessing health services (Marks-Sultan et al., 2016:3). The development of rights-based legal health frameworks also provides governments with the ability to legislate and mandate enforcement mechanisms for the "equity, quality[and] safety" of health care, as well as financial accessibility (ILO, 2014a:11). Accordingly, as legal health frameworks provide legal protections, this paper defines LHC as the rights-based protection that results from legal health frameworks, and not according to the percentage of a population that has health insurance.[3]

[2] The paper referenced here is called *Global evidence on inequities in rural health protection. New data on rural deficits in health coverage for 174 countries*. The paper's suggested citation lists Scheil-Adlung as its author; I have cited Scheil-Adlung in my own citation in accordance. However, I argue that the ideas presented in *Global evidence on inequities in rural health protection* are not just those of Scheil-Adlung, but those of the ILO as an organisation. This is the result of several factors. Firstly, the *World Social Protection Report* lists Scheil-Adlung as the ILO Coordinator for Social Health Protection; it also states that she helped draft the *World Social Protection Report.* Secondly, *Global evidence on inequities in rural health protection* was published by the ILO. Lastly, Isabel Ortiz (2015: 5), the Director of the Social Protection Department at the ILO, wrote the foreword for this paper, where she says that it was developed "as part of the mandate of the ILO Areas of Critical Importance (ACI) on Decent Work in the Rural Economy as well as the ACI on Creating and Extending Social Protection Floors, and has been reviewed by a significant number of experts in relevant development agencies".

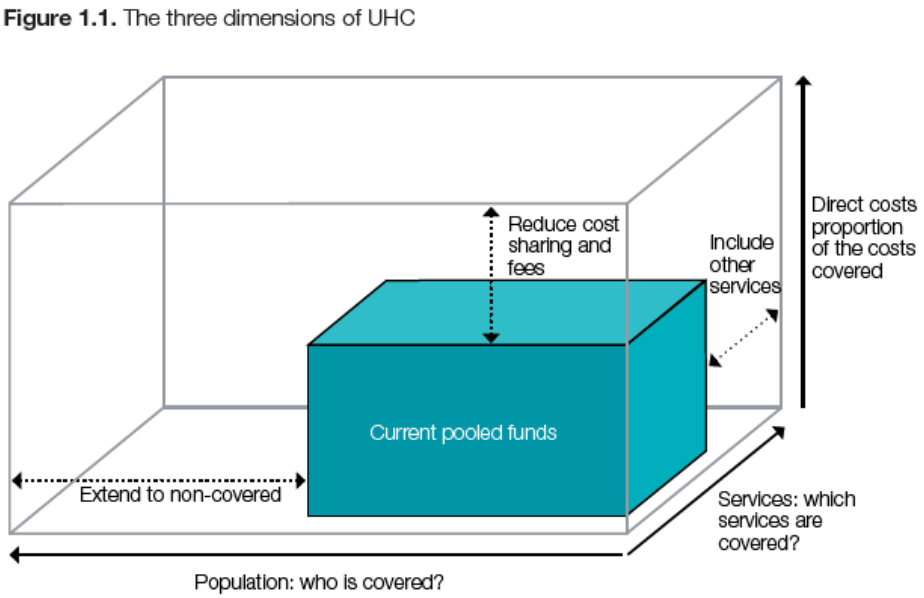
[3] Many of the ILO's LHC estimates are based on the percentage of a population with insurance, which is explained in the second paper of this series.

3.2 LHC: An important conduit and constituent of UHC

LHC, UHC, and the right to health are interrelated. LHC is an important constituent of UHC, while UHC is a critical building block toward achieving the right to health for all. A country's legal health framework can be both a conduit to achieving UHC, as well as a core component of UHC in and of itself (Scheil-Adlung & Bonnet, 2011:30). However, the indicators needed to measure UHC, and even the meaning of UHC itself—who and what need to be included, as well as the minimum quality of services—are contested in the academic literature. The international community has also failed to reach a consensus on what UHC means and how to measure it, even though every UN member State has professed that UHC is critical to development (Sridhar et al., 2015; Scheil-Adlung, 2015; WHO, 2014). There are still many commonalities across definitions, however. In *Tracking universal health coverage: first global monitoring report*, the WHO and the World Bank (2015:1) define UHC as "all people receiving the health services they need, without being exposed to financial hardship".

The WHO and the World Bank (2015) commonly visualise UHC through a coverage cube, which depicts the three broad dimensions of UHC: the population covered, the services covered, and the costs covered. These dimensions relate not only to *de facto* access to health services, but also to international and national legal obligations; they are therefore related to both legal health frameworks and LHC. For example, a State is bound by international law to ensure that basic health services are accessible to everyone, while a State's domestic legislative framework may mandate that those living in poverty receive free maternity care from the government. Despite the importance of these legal mechanisms, many UHC monitoring frameworks overlook them and focus instead on monitoring health outcomes. See Figure 1 below for a visual representation of the coverage cube.

Figure 1: The three dimensions of UHC[4]



Sridhar et al. (2015:1) argue that the WHO's three dimensions need to be disaggregated further. Thus, the authors isolate "six key legal principles" of UHC that are generally accepted in the health literature: "Minimum core obligation, progressive realization, cost-effectiveness, shared responsibility, participatory decision making, and prioritizing vulnerable or marginalized groups" (2015: 1). If these principles are enshrined in national law, they become part of a country's legal health framework and thus contribute to a population's LHC. In line with the six criteria listed above, the ILO argues that all conceptions of UHC depend on "the principle of equity…guaranteeing legal entitlements", and that these entitlements must be enshrined in law at a State level (Scheil-Adlung, 2015:1, 28). The ILO also believes that legal protections provided under UHC should centre around marginalised groups, such as those living in poverty (Scheil-Adlung, 2015:1, 28).

Congruently, the WHO (2014:7-8) states that maintaining "fairness and equity" should be a primary focus during the expansion of UHC; it also says that the concerns of the poor or otherwise marginalised must take precedence over those who are better off. Strong legal health frameworks that prioritise the poor consequently become fundamental to the achievement of UHC. While the ILO emphasises the importance of legal health rights in the *World Social Protection Report for 2014/15*, its operationalisation of LHC does not incorporate most of the legal principles discussed in this section, including that of equity. This is explained in detail later in this paper.

[4] Figure obtained from the WHO and the World Bank (2015:8).

3.3 LHC as a reflection of the right to health

The ILO uses LHC as one of its indicators for overall health coverage (i.e., UHC-coverage based on legal rights *and* effective access to health services). The ILO publication, *Global evidence on inequities in rural health protection*, authored by Scheil-Adlung (2015:3),[5] explains that the ILO's LHC indicator measures one particular dimension of UHC: the right to health.[6] Before this study can examine whether this measure can help monitor the right to health and UHC, these concepts need to be defined. There is much debate in the literature regarding what the right to health means, but the body charged with monitoring this right, the UN Committee on Economic, Social and Cultural Rights (CESCR), defines it as follows:

> An inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. (WHO, 2015b:3; Committee on Economic Social and Cultural Rights, 2011)

Although this right encompasses more than just laws and policies, many scholars and intergovernmental organisations argue that UHC and associated legal aspects of health coverage are primary constituents of the right to health. At minimum, they are fundamental channels for its realisation (WHO, 2015b; Mitano et al., 2016; ILO, 2014b; Dittrich et al., 2016). Or, to look at it in reverse, the right to health helps to realise legal progress by mandating that certain "legal entitlements and obligations" be guaranteed through legislation (Backman et al., 2008:2).

Scholars such as Mitano et al. (2016:2-4) conceptualise the right to health by focusing on the significance of "legal norms that establish the rights and obligations of the State…regulating and monitoring relationships between them". Indeed, the right to health is heavily reliant on legal tools that define the scope of the government's responsibility to fulfil this right (Backman et al., 2008); it also relies on the mechanisms created to enforce it. Every State in the world has signed

[5] See Footnote 2 on page 8 for an account of why Scheil-Adlung is cited as the author in this paper (as opposed to the ILO).
[6] See Table 3 in *Global evidence on inequities in rural health protection. New data on rural deficits in health coverage for 174 countries*. Table 3 lists the "right to health" as the dimension of UHC that the ILO's legal coverage indicator measures (Scheil-Adlung, 2015).

at least one convention or treaty that spells out various commitments and responsibilities that must be fulfilled to achieve the right to health (WHO, 2014:2; Backman et al., 2008). All States therefore have international, if not necessarily national, legal obligations (though at least 100 countries have incorporated the right to health in their national constitutions). Global examples of these pledges include the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the Constitution of the WHO (WHO, 2015b; Dittrich et al., 2016). In 1981, the African continent created its own instrument, the African Charter on Human and Peoples' Rights (Mitano et al., 2016).

Importantly, the legal devices discussed above mandate the use of "mechanisms for oversight and redress" (WHO, 2014:2). This requires that measurement tools be designed for the purpose of monitoring and evaluation (WHO, 2014:2). The ILO's LHC measure can be considered one such tool, and one of the few that measures the legal component of the right to health worldwide. In addition to monitoring the expansion of the right to health, international law requires States to draft laws and policies that "ensure equal access to health care" for all, regardless of socioeconomic status. The Constitution of the WHO (2014:vii) states that "the right to health is one of the fundamental rights of every human being without distinction to race, religion, political belief, economic, or social condition".

Correspondingly, States are legally compelled to do the following, and to do so with attention to the inclusion of marginalised groups such as the poor:

> [Sufficiently recognise] the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. (Committee on Economic Social and Cultural Rights, 2011).

Additionally, States should specifically reference marginalised subpopulations in policies and legislation (Backman et al., 2008); they must outline how they plan to ensure their policies explicitly serve these vulnerable groups, particularly those living in poverty, women, and children.

3.4 Usage of the term LHC in academic literature

Outside of the ILO and its sponsored publications, the term LHC is rarely used. A 2017 Google Scholar search of this exact term for 2011-2017 yielded only 10 results, at least three of which were written by ILO-sponsored authors

(specifically, Xenia Scheil-Adlung, the ILO Coordinator for Social Health Protection) or cited the ILO itself when using the term. Instead, scholars use related terms such as legal health frameworks, the legislated right to health, the "right to health features of health systems", legal health infrastructure, and others when discussing rights-based protection grounded in the law (Clarke, Rajan & Schmets, 2016; Dittrich et al., 2016; Marks-Sultan et al., 2016; Backman et al., 2008). While these terms differ slightly in meaning, they are either mechanisms for achieving legal protection, or relate to the idea that health should be protected by legislation. For example, Marks-Sultan et al. (2016:3) define public health law as "laws that are intended as health interventions, laws that define the powers, duties, and boundaries of health agencies and systems". Public health law grounded in the right to health results in people having LHC. Legal health infrastructure is similarly defined as "the laws and policies that empower, obligate, and sometimes limit government and private action" (Marks-Sultan et al., 2016:1). When these systems and structures are well-designed and inclusive of marginalised populations, they again result in the population having LHC, though the scholars mentioned above do not use this term.

3.4.1 Lack of interest in legal health frameworks for the pursuit of UHC

Scholars such as Clarke, Rajan and Schmets (2016:482) have noted that "strengthening countries' legal and regulatory frameworks", which includes ensuring that national laws meet international norms regarding UHC and the right to health, "has been missing from the universal health coverage agenda" and has received "insufficient attention" (Backman et al., 2008:1). Globally, many stakeholders with an interest in the reform of health law have directed their attention toward improving individual laws, rather than working to create national, comprehensive legal health frameworks that "provide an enabling environment for universal health coverage" by ensuring that a State's population has sufficient rights-based protection (Clarke, Rajan & Schmets, 2016:482; Attaran & Capron, 2014). Although rights-based protections are important for a country's health system and have spearheaded a number of health accomplishments globally (Marks-Sultan et al., 2016:3; Backman et al., 2008), an individual's LHC/entitlements do not always result in effective health coverage (access).

Put simply, effective health coverage is the *de facto* ability to access affordable, quality health services (ILO, 2014b). LHC can fail to result in effective health coverage for a number of reasons, including resource restraints, lack of political willpower, and even corruption (ILO, 2014b). Thus, even if it were possible to

statistically measure LHC,[7] it would be very unlikely that it would have a perfect association (i.e., one-to-one relationship) with effective health coverage. Consequently, even countries with strong legal health frameworks that provide robust rights-based protection can have issues with effective coverage; however, this does not mean that LHC is unimportant. On the contrary, legal health frameworks provide "a supportive environment" for the development of UHC and the full realisation of the right to health (Clarke, Rajan & Schmets, 2016:482; Backman et al., 2008). Yet the lack of a perfect association between LHC and effective health coverage has likely contributed to stakeholders downplaying the significance of the role that legal health frameworks play in achieving UHC.

3.4.2 Lack of information on legal health frameworks/rights-based protection

Comprehensive information on legal health frameworks is not readily available for many, if not most, countries (ILO, 2015; Marks-Sultan et al., 2016; Backman et al., 2008). This is particularly true for African States, where publicly available, comprehensive information on health laws and related structures is typically minimal. A lack of data makes it difficult for scholars to develop tailored recommendations for African countries, or to see if African legal health frameworks differ from others globally. Further compounding this issue is the fact that the data that *is* available is typically not standardised or structured, making it hard for researchers to compare the right-to-health features of health systems/legal health frameworks and their resulting coverage across countries, or to monitor a particular country's changes over time (Clarke, Rajan & Schmets, 2016:482; ILO, 2015; Marks-Sultan et al., 2016; Backman et al., 2008). Since LHC is the rights-based protection that results from legal health frameworks, it follows that LHC is equally difficult to compare across countries and over time. Furthermore, a lack of standardised information "reduces transparency and nations' accountability for meeting their international obligations" (Marks-Sultan et al., 2016:2). This gap in information poses a risk to populations globally, but even more so in Africa and the rest of the developing world, where populations are most likely to suffer health crises (Marks-Sultan et al., 2016:3).

Based on this study's review of the literature, the measurement framework developed by Backman et al. (2008) in *Health systems and the right to health: an assessment of 194 countries* is the only standardised, comprehensive report available in terms of monitoring the right to health components of health systems,

[7] This paper argues that it is not possible to measure the entire concept of LHC using statistical measures, explained in the next section.

and LHC in particular (the authors do not use this term). As mentioned earlier, the ILO's LHC measure is considered to reflect the dimension of the right to health in UHC. In contrast to the ILO's single quantitative indicator for LHC (explained in detail in Section 3), Backman et al. (2008) argue that dozens of indicators, including qualitative indicators, are needed to assess the right-to-health features of health systems. Although not all the authors' 72 proposed indicators relate to legal protections, at least 22 of them do. These indicators address multiple areas of rights-based protection, including "recognition of the right to the highest attainable standard of health"; principles of non-discrimination; the right to health information; national health plans; inclusive participation; medicines; "health promotion"; and "monitoring, assessment, accountability, and redress" (Backman et al., 2008:11-12).

Indicator 2, for example, asks whether a State's "constitution, bill of rights, or other statute recognise[s] the right to health" (Backman et al., 2008:11); Indicator 22 asks whether "the state's national health plan include[s] explicit commitment to universal access to health services". Although Backman et al.'s (2008) study developed many indicators that would help assess whether a population has legal health protections, the authors highlight the fact that data is not available for many of its indicators for a worryingly large number of countries. In comparison, the ILO's legal coverage measure has data for most countries, including 47 African countries.

4. Legal Health Coverage according to the ILO

This section explains the definitions and indicators for both LHC and effective health coverage used by the ILO to measure progress toward UHC. Although this study focuses on LHC (as opposed to effective coverage), it is necessary to explain how the ILO understands both concepts. This is important because there is some slippage between these terms. The ILO goes to great lengths to explain the differences between legal and effective coverage, yet its approach to measuring UHC is still essentially anchored in legal coverage. This can easily result in confusion about the nature of the data and what they represent. Some of the writing in the following section may sound somewhat convoluted. This is unfortunately unavoidable, as the ILO uses different terms to reference the same concepts, and even the same measures, in different places, tables, and so forth. A great deal of explication is required as a result.

4.2 Definitions used by the ILO for legal coverage versus effective coverage

In the *World Social Report*, the ILO argues that UHC is composed of two "dimensions" of coverage: effective access/coverage, which includes three components (affordability, availability, and the financial protection of quality benefits), and LHC. Both types of coverage are equally important and together comprise UHC (Scheil-Adlung & Bonnet, 2011). Effective coverage is defined as "the scope of quality medical benefits that is available, given e.g. the existence of a sufficient number of skilled health workers that can be accessed when in need without involving financial hardship or impoverishment" (ILO, 2014b:168). In contrast, LHC is defined as the "*proportion of the population that is protected by legislation* ***or*** [emphasis added] otherwise affiliated to a health system or scheme" (ILO, 2014b:168).

4.2.1 Scope, extent, and level of coverage

The ILO (2014b:168) states that a country's progress toward UHC cannot be measured without assessing both legal and effective health coverage; this also requires measuring the distinct scope, extent, and level for each type of coverage. Legal coverage and effective coverage "are distinct and must be measured separately" (ILO, 2014b:170). Each coverage type has three primary components that can be measured: *scope*, or the number and forms of health benefits available to a country's population; *extent*, or "the percentage of persons covered within the whole population"; and *level*, which refers to the "adequacy of coverage" (ILO, 2014b:165). Although both legal and effective coverage have these three dimensions, the dimensions themselves differ depending on whether one is measuring legal or effective coverage. For example, one indicator that could be used to assess the scope of LHC would be to determine what type of health benefits a State's population is legally entitled to, such as maternity care. The scope of effective coverage would be whether women are actually able to access the care they are entitled to by law. The differences between the extent, scope, and level of effective versus legal coverage can be seen in Figure 2.

Figure 2: The ILO's dimensions of effective and legal coverage[8]

Table AII.1 Multiple dimensions of coverage: Examples of questions and indicators

Dimension of coverage	Legal coverage	Effective coverage
Scope	Which social security areas are addressed by the national legislation?	Which social security areas are actually covered (actual implementation)?
	For a given group of the population: for which social security area(s) is this group covered according to the national legislation?	For a given group of the population: for which social security areas is this group effectively covered (benefits are actually available)?
Extent	For a given social security area (branch): which categories of the population are covered according to the national legislation? What percentage of the population or labour force is covered according to the national legislation?	For a given social security area (branch): which categories of the population are effectively covered, that is, enjoy actual access to benefits in case of need (currently or in the future)?
		The "beneficiary coverage ratio": for a given social security area, what percentage of the population affected by the contingency receives benefits or services (e.g. percentage of older persons receiving an old-age pension; percentage of unemployed receiving unemployment benefits)?
		The "contributor coverage ratio": for a given social security area, what percentage of the population contributes to the scheme, or is otherwise affiliated to the scheme, and can thus expect to receive benefits when needed (e.g. percentage of working-age population or of the labour force contributing to a pension scheme)? By extension, the "protected person coverage ratio" includes people potentially entitled to non-contributory benefits.
Level	For a given social security area: what is the level of protection provided according to the national legislation? For cash benefits: what is the prescribed amount or replacement rate according to the national legislation?	For a given social security area: what is the level of protection actually provided (e.g. for cash benefits, average level of benefit as a proportion of median income, minimum wage or poverty line)?

4.2.2 Indicators used for coverage

The ILO uses five proxy indicators to gauge UHC (one for legal coverage, and four for effective coverage). It states that "progress towards UHC [can only be assessed] when data are considered from all five indicators *together"* (ILO, 2014b:168-169). Effective coverage has four proxy indicators:

1. Extent of OOP [out of pocket payments] as a percentage of total health expenditure;
2. Coverage gap due to health professional staff deficit;
3. Financial deficit, calculated as per capita expenditure (except OOP) using the relative threshold of the median expenditure in low vulnerability countries (US$239 per capita);
4. Maternal mortality ratio per 10,000 live births (ILO, 2014b:168-169).

[8] Table obtained from ILO (2014b:166).

The ILO does not aggregate its effective coverage indicators to create a composite measure of total effective coverage (i.e., it does not have a single measure that incorporates all four effective coverage indicators). For measuring legal coverage, the ILO uses the following indicator:[9]

> The share of a population or its specific groups effectively affiliated to or registered in a public or private health system or scheme…it is usually measured as a deficit compared to 100% of the population and provides information on the current status and progress of population coverage in term of affiliation. (ILO, 2014b:168)

One issue with this indicator is that it only measures scope while failing to measure the extent or level of legal coverage. Problems with the ILO's conception of LHC are discussed further in the next section.

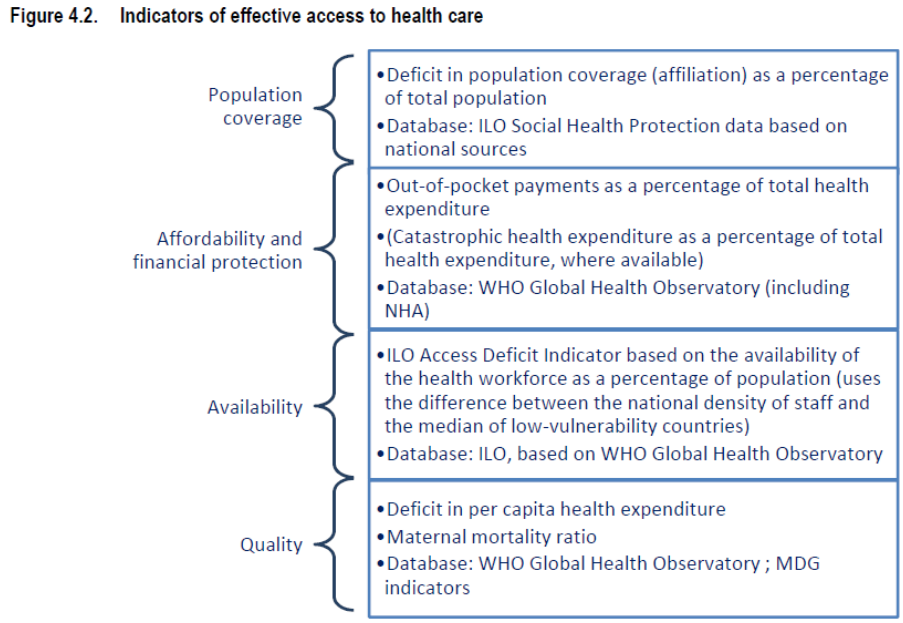
4.2.3 Tables B.11 and B.11b

ILO African country data for all five of these indicators is provided in Table B.11 in the *World Social Protection Report*. Although the ILO has data on the four indicators for effective coverage in Table B.11, it does not combine them into any sort of aggregate measure to assess total effective coverage. The only column in Table B.11 that appears to provide estimates for countries' "total" health coverage is labelled "estimate of health coverage as a percentage of the population". The footnote for this column refers readers to an external table, available online in a Microsoft Excel spreadsheet format, if they wish to obtain detailed information on the ILO's data sources for these estimates: Table B.11b,[10] entitled *The multiple dimensions of health coverage: percentage of the population covered (members of health insurance or free access to health care services provided by the State).*[11] The column labelled "total coverage" in Table B.11b is synonymous with the column labelled "estimate of health coverage as a percentage of the population" in Table B.11; their country estimates are the same. After examining the sources cited in Table B.11b for the "total coverage" estimates, it becomes apparent that these estimates quantify LHC only. Hence the label "total coverage" is misleading.

[9] This study analyses African country estimates for this indicator during the metadata investigation, which is explained in Paper 2's methodology section.
[10] Available at the following URL: http://www.socialprotection.org/gimi/gess/RessFileDownload.do?ressourceId=37218.
[11] Table B.11b does not provide data on the four effective coverage indicators explained earlier (only Table B.11 has estimates for these).

Thus, despite the many distinctions that the ILO makes between legal and effective coverage, in Table B.11b, where the ILO only lists its estimates for LHC, the spreadsheet tab name is "*effective coverage"*, and the column where the ILO lists its LHC estimates is called *"total coverage"*. Additionally, Table B.11b is called "The *multiple* dimensions of health coverage [emphasis added]", even though only one dimension (LHC) is presented. Thus, although the ILO says that there are different dimensions of coverage, when presenting the data, it essentially conflates "total coverage" with "legal coverage" and then describes the data set as "effective coverage". This mistake occurs in another ILO publication as well, when the ILO includes its indicator of LHC in a table of effective access indicators (See Figure 3 below).

Figure 3: Conflating legal coverage with effective coverage[12]



This is one of the primary reasons this study focuses on the LHC measure. Henceforth, when this paper discusses the ILO's LHC measure, it is referring to what the ILO calls "total coverage" in Table B.11b, as this essentially measures legal coverage only. In addition to the issues discussed, there are several conceptual problems with the ILO's definitions of LHC, explained in the section below.

[12] Figure obtained from *Universal health protection: progress to date and the way forward* (ILO, 2014a:48).

5. The fundamentals of rights-based protection in health

This section reviews related literature to identify several essential characteristics of legal health frameworks that result in strong rights-based protection. It also discusses why the ILO's indicator of LHC in the *World Social Protection Report* fails to capture key components of rights-based protection that the ILO itself states are important. This segment of the paper focuses on concepts and definitions and so does not discuss problems with the measure's metadata and estimates. These are discussed in the results and discussion sections.

5.1 ILO Recommendation No. 202 and a rights-based approach

In *Universal health protection: progress to date and the way forward*, the ILO (2014a:48) asserts that "deficits in LHC should be used as a proxy for the extent to which rights-based approaches are used". Yet, a rights-based approach includes much more than a measure of whether an individual has insurance, or even legislation stipulating that people have a right to health. The guidelines provided in ILO (2012) Recommendation No. 202 illustrate this point well. Recommendation No. 202 instructs States to adopt a number of guidelines for "building comprehensive social security systems and extending social security coverage by prioritizing the establishment of national floors of social protection accessible to all in need" (ILO, 2017). The implementation of these legal guidelines are preconditions for employing rights-based approaches in health. As mentioned earlier, the ILO believes that 'deficits in legal coverage' are synonymous with 'deficits in rights-based approaches'.

If implemented, these guidelines would safeguard a "social floor" of bare minimum rights and entitlements for health coverage and other forms of social protection; this is particularly useful for safeguarding the rights of "the poor and the most vulnerable" (ILO, 2017). Recommendation No. 202 stipulates that countries' national legislation should explicitly outline the following: "the population covered; a defined set of essential health services including prevention and maternity care; progressive realization, including by setting targets and time frames; and complaint and appeal procedures" (ILO, 2012; ILO, 2015). Most of these legal guidelines are not reflected in the ILO's operationalisation of legal coverage, which means that its estimates do not take these guidelines into account.

As discussed earlier, the ILO's indicator for LHC ("The share of a population or its specific groups effectively affiliated to or registered in a public or private health system or scheme" [ILO, 2014b: 168]), is used to calculate its estimates of "total coverage" in Tables B.11 and B.11b. This indicator essentially measures coverage by quantifying insurance. Although insurance can certainly be considered part of rights-based protection, it is by no means the only legal protection that a population would need to have for full legal coverage; comprehensive legal health frameworks address several key factors other than insurance, or even government health schemes. Whether an individual has health insurance is meaningless if there are no laws in place mandating that providers adhere to certain standards and regulations, such as providing basic health services like maternity care. Additionally, simply having a law or constitutional amendment that states that everyone has the right to health is not enough; an effective legislative framework must have modern, comprehensive laws appropriate for that particular country's context (Marks-Sultan et al., 2016). Without such a framework, a national right to health is functionally non-existent.

5.2 A strong legal health framework: Key components

This section outlines the building blocks needed to achieve strong rights-based protection by expanding upon Clarke et al.'s (2016) definition of comprehensive legal frameworks, and by considering the works by other scholars/intergovernmental organisations commenting on the right to health and rights-based protection (Dittrich et al., 2016; ILO, 2012; ILO, 2015; Scheil-Adlung, 2015; ILO, 2014b; Backman et al., 2008; Clarke, Rajan & Schmets, 2016). It is important to note that this section discusses just a few of the fundamental components of rights-based health protection that the ILO's legal coverage indicator neglects to consider. To include more would require a separate, in-depth study similar to the one conducted by Backman et al. (2008), discussed in detail earlier.

5.2.1 Basic components of rights-based protection

The list below has been adapted from both academic literature and the recommendations of intergovernmental organisations such as the WHO. The list outlines some of the preconditions that need to exist before a population can be

considered legally covered.[13] The list often references the ILO or Scheil-Adlung (the ILO Social Protection Coordinator) and is not meant to be exclusive.

1. Enshrines the right to health in national law, whether this be through legislation or its Constitution (Clarke, Rajan & Schmets, 2016; Backman et al., 2008). International commitments are important but not sufficient.
2. Legislation includes "a defined set of essential health care services including prevention and maternity care" (ILO, 2015; ILO, 2012; WHO, 2014).
3. Legislation specifies the range, qualifying conditions, and basic entitlements required (including a list of essential medicines) as part of any scheme, whether it be public or private (ILO, 2014a; WHO, 2014; Backman et al., 2008; ILO, 2012).
4. Anyone unable to afford services included as part of this basic package is legally guaranteed access through the State (ILO, 2014b; ILO, 2012; WHO, 2014).
5. Legislation stipulates clear complaint, appeal, judicialisation, and enforcement mechanisms for health care/schemes (Dittrich et al., 2016; ILO, 2012). Although the ILO mentions that legal coverage is often lower than effective coverage because of government failure to enforce existing legislation (ILO, 2014b:170), its measure does not take into account the fact that legislation also needs to include enforcement mechanisms if it is to result in comprehensive legal protections.
6. Legislation contains transparent, mandated mechanisms for priority setting (Dittrich et al., 2016).
7. Legislation is based on a participatory framework, inclusive of marginalised groups, especially the poor (Scheil-Adlung, 2015; WHO, 2014), and does not discriminate according to any characteristics protected under the Universal Declaration of Human Rights (Backman et al., 2008).
8. Legislative framework commits to the reduction of socioeconomic inequities in health (Scheil-Adlung, 2015; Backman et al., 2008).
9. Legislation outlines specific mechanisms for the expansion of coverage and conditions listed above – for example, through a national health plan (Backman et al., 2008; ILO, 2012).

[13] The sources cited in this list do not necessarily talk about "legal health frameworks"; rather, they discuss the importance of the identified legal mechanism/characteristic (e.g., priority setting) that I consider to be critical to a strong legal health framework.

If comprehensive legal health frameworks need to incorporate these components, it follows that any attempt to measure LHC must address at least some of them. It is beyond the scope of this paper to develop indicators to monitor these components; however, the significance of several of these components, and therefore the importance of including them in any measure that claims to estimate LHC, are detailed below.

5.2.2 A legislated right to health: Range, qualifying conditions, and basic entitlements

Although the ILO does not claim that its measure captures every aspect of LHC, by definition, any measure of LHC obviously needs to consider countries' laws. Countries that have no national legislation stipulating range, qualifying conditions, and basic entitlements that meet the ILO (1952) *Social Security (Minimum Standards) Convention (No. 102)* should be considered to have 0% legal coverage, regardless of whether a small percent of that country's population has decided to purchase private health insurance (the ILO's measure calculates private insurance into its estimates, regardless of whether national legislation or an inadequate government scheme exists). Additionally, the laws must mandate that health schemes, whether they be government-sponsored, social, or private, be "operated in line with certain conditions" for their beneficiaries to be considered legally covered (ILO, 2014b:100).

5.2.3 Qualifying conditions

Legislation should include which qualifying conditions entitle an individual to receive care. ILO (2012:para. 6) Recommendation No. 202 indicates that "at least all residents and children" should qualify for the baseline guarantees written in the Recommendation. Additionally, legislation must not permit loopholes for providers to exclude individuals based on their sex, socioeconomic circumstances, age, health status, and so forth. A population cannot be said to have less than 100% legal coverage/protection if it is lawful for schemes to exclude people based on characteristics such as those described above. The previous health insurance model used by the United States is a good example. Women were frequently charged higher health insurance premiums than men, and many insurance companies considered pregnancy and situations of domestic violence as "pre-existing conditions" (Kertscher, 2013; Parker-Pope, 2010). They often refused to cover these "conditions" or charged all women higher rates than men (Kertscher, 2013; Parker-Pope, 2010). In this example, legislation would not meet the minimum standards for "qualifying conditions" because it did not

prohibit the disqualification of individuals based on protected characteristics; not all residents and children necessarily qualified.

5.2.4 Basic entitlements

By publicly specifying which benefits/services insurance companies, public health schemes, and other providers are legally required to offer, legislation promotes "democratic accountability, social learning, and the prevention of corruption" (WHO, 2014:12). Accordingly, legislation should explicitly include which entitlements the government is required to provide if it is going to ensure that the population is protected adequately. The availability of information that clearly lists the basic entitlements schemes are required to provide "is critical to the full use of services and for citizens' ability to claim their rights and entitlements" (WHO, 2014:45). This is especially true for those living in poverty, "who often lack information about policies that are vital to their lives" (WHO, 2014:45).

The ILO clarifies which benefits States are legally required to provide, at least as far as their capacity allows, as set out by the *Social Security (Minimum Standards) Convention* in 1952, though they are not included in the operationalisation of legal coverage. These include the following:

- General practitioner care, including domiciliary visiting;
- Specialist care at hospitals for inpatients and outpatients, and such specialist care as may be available outside hospitals;
- Essential pharmaceutical supplies, as prescribed by medical or other qualified practitioners;
- Hospitalization where necessary; and
- Pre- and post-natal care for pregnancy and childbirth and their consequences, either by medical practitioners or by qualified midwives, and hospitalization where necessary. (ILO, 2014b:101; ILO, 1952).

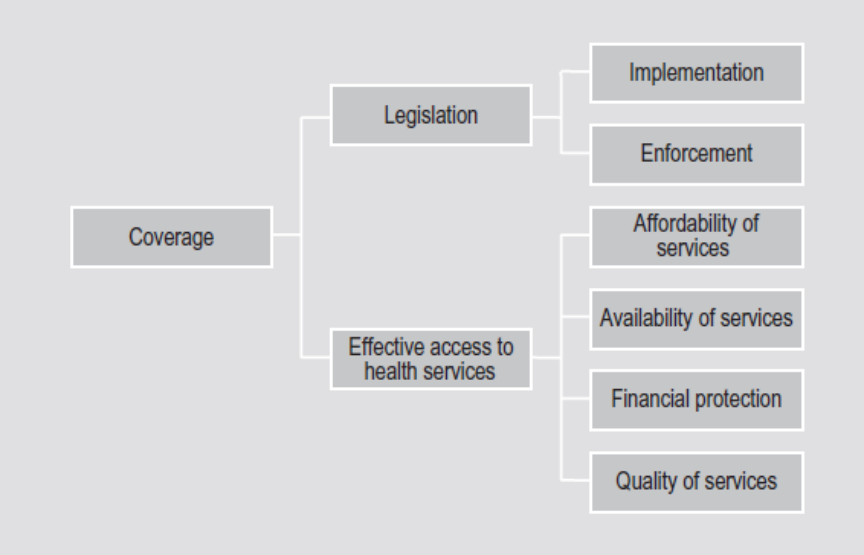
5.2.5 Judicialisation and enforcement mechanisms

The operationalisation of legal coverage given in the *World Social Protection Report* considers legislation but does not pay attention to whether these rights are

implemented or enforced. Comprehensive rights-based protection needs to incorporate the "judicialization of the right to health" (Dittrich et al., 2016:24), which includes implementation and enforcement mechanisms. Health laws have significantly less impact without legally embedded enforcement mechanisms that give power to the courts, which are "often critical for granting access to the health care products citizens are entitled to under a state's universal coverage system" (Dittrich et al., 2016:24). For example, the Treatment Action campaign in South Africa was able to use the court systems to force the government to implement public sector provision of mother-to-child transmission prevention (Dittrich et al., 2016).

Enforcement mechanisms are considered to be essential elements of rights-based protection in several ILO documents, including both Recommendation No. 202 and *Beyond legal coverage: assessing the performance of social health protection* (Scheil-Adlung & Bonnet, 2011). The latter publication states that "LHC requires the *implementation* and *enforcement* of legislation with a view to providing universal access to health services" (Scheil-Adlung & Bonnet, 2011:23).[14]

Figure 4: The ILO's concept of coverage[15]



[14] Although Xenia Scheil-Adlung and Florence Bonnet are named as the authors of this paper (as opposed to the ILO itself), the paper lists the International Labour Office beneath their names. Footnote 2 explains Scheil-Adlung's position within the ILO. Bonnet also works for the ILO. Additionally, although *Beyond Legal Coverage: Assessing the Performance of Social Health Protection* was published by Wiley-Blackwell in a peer-reviewed journal on social security (the International Social Security Review), the journal itself is printed "on behalf of the International Social Security Association (ISSA)" (Wiley-Blackwell, 2017). The ISSA was "founded under the auspices of the International Labour Organization" and "maintains [a] close partnership" with the ILO (International Social Security Association, 2016).

[15] Figure obtained from Scheil-Adlung and Bonnet (2011) in *Beyond legal coverage.*

5.2.6 Inclusivity for those living in poverty and a participatory approach

Many African leaders have become interested in pursuing UHC because, "at the heart of UHC is a commitment to equity" (WHO & the World Bank, 2013:6). Correspondingly, ILO Recommendation No. 202 "requires that inequities be addressed both across and within countries" (Scheil-Adlung, 2015). Marginalised groups, especially the poor, often have "low levels of legal coverage [due] to the absence or insufficiency of inclusive legislation" (Scheil-Adlung, 2015:30). In order "for UHC to be(come) the practical expression of the right to health, any effort to measure UHC should start from an assessment of all the excluded people" (WHO (2015b:13), including (but not limited to) those living in poverty. The ILO (2014a) puts forth both of these points in several of its publications, including *Universal health protection: progress to date and the way forward*, and *Global evidence on inequities in rural health protection* (Scheil-Adlung, 2015). In the former, the ILO writes that "legislative…failures [can cause] inequities in LHC", especially for marginalised groups (ILO, 2014a:2). In the latter, ILO-sponsored scholar Scheil-Adlung (2015) argues that the unique challenges of marginalised rural populations need to be considered when crafting policies, including legislation, lest the end result have a significant "urban bias". Like rural populations, if the poor's needs are not explicitly considered when drafting a country's national health legislation, its LHC will have a significant "wealth bias". The ILO's table below demonstrates that the quality and extent of legislation have significant effects on rural populations' right to health (Scheil-Adlung, 2015:40), but I argue that the same case can be made for those living in poverty.

Figure 5: Components of effective access affected by legislation and other issues[16]

	Components of effective access affected by the issue				
Issue	**Rights to social security and health**	**Availability of health care**	**Quality of health care**	**Financial protection and affordability**	**Monitoring health system outcomes**
Issues within the health sector					
Fragmented legislation implicitly or explicitly excluding rural populations	✓			✓	
Lack of or poor implementation of legislation for guaranteeing access to essential health care	✓	✓		✓	
High OOP for rural populations				✓	
Overall shortage of human resources for health		✓	✓		
Lack of decent working conditions for rural health workers		✓	✓		
Poor rural health infrastructure		✓	✓		
Health system inefficiency including lack of evidence-based decision-making		✓	✓	✓	
Maldistribution of health spending/poor financing mechanisms	✓	✓	✓	✓	
Lack of social/national dialogue	✓	✓	✓	✓	✓
Lack of accountability	✓	✓	✓	✓	✓

There are many ways for health coverage legislation to exclude the poor. Health laws that mandate that employers provide coverage but lack provisions for those working in the informal economy, usually comprised of those living in poverty, are a clear example (Scheil-Adlung, 2015). There are many other ways for legislation to omit the poor that are less apparent, and some occur inadvertently. For example, if a poor individual has health insurance through the State, and the State's insurance does not cover an ailment commonly found in those living in poverty but *does* cover highly specialised treatment at the tertiary level, which mainly benefits the rich, this would not be consistent with inclusivity. Incorporating priority setting mechanisms into a country's legal health framework is one way to address this.

[16] Table obtained from Scheil-Adlung (2015:40).

5.2.7 Priority setting

Priority setting is closely related to inclusivity and may even be considered a branch of inclusivity of marginalised populations. It is a tool used to answer the question of which services to provide and whom to provide them for. Because the capacity and resources of every State are limited, thus preventing governments from providing every medical service/intervention/medication to every resident, States that want to roll-out UHC must engage in priority setting. This is particularly crucial for countries with high inequality, or severely limited resources, as is the case for most of Africa.

Priority setting rooted in the right to health requires that policymakers decide which health services the State will pay for over others (or legislate that other service providers must cover). For example, when using a rights-based approach, it would not be appropriate for a government to prioritise expensive and highly specialised tertiary care for a rare disease over sexual health and reproductive services for the entire population. Additionally, to maintain consistency with the right to health, "countries should primarily first expand coverage for low-income groups, rural populations, and other groups disadvantaged in terms of service coverage, health, or both" (WHO, 2014:xi). Many countries have already included this approach in their legal frameworks, "including those in the Netherlands, Norway, and Sweden" (WHO, 2014:15). States should not only follow this approach but should also include these policies in their health coverage laws.

5.2.8 The importance of disaggregated coverage data

In addition to incorporating the full concept of LHC, data should also be disaggregated, where possible or applicable. The WHO (2015b:6) argues that making disaggregated data available would help "identify gaps in coverage that arise from multiple types of discrimination" and even goes so far as to say that disaggregation is required for most indicators of UHC, which should also be designed in line with a commitment to equity (WHO, 2014:47). Similarly, the CESCR's guidelines also state that "[r]ight to health indicators require disaggregation on the prohibited grounds of discrimination" (WHO, 2015b:13).
Almost all of the health-related data made available over the years by international organisations, governments, and research groups has been limited to indicators that use country averages (Gwatkin, 2000) – this includes the ILO's LHC measure. The lack of disaggregated data globally has resulted in a general "[disregard for] equity in coverage and access to health care of large parts of the

population…at national, regional and global levels" (Scheil-Adlung, 2015:v). The issue with using aggregated coverage data (i.e., country averages) is that they usually obscure the reality of the poor's lived experiences (Gwatkin, 2000; WHO, 2015a).

African birth coverage data (i.e., estimates for the percentage of births covered by a skilled medical practitioner) obtained from the WHO (2016a) illustrates this idea well. In

Figure 6 below, the Y-axis shows birth coverage of the poorest 20% (quintile 1, or Q1) of a country's population. The X-axis shows the percentage of the total population covered. For every African country with data available from the last 10 years, Q1 has substantially lower birth coverage than the total population. The yellow dotted line represents the line of equality; all countries fall below this line. If one were to look at the aggregate coverage data on its own, they would likely analyse countries' coverage percentages very differently. Thus, when data is not disaggregated, it is difficult to assess whether legal health frameworks are successful in their goal of helping the most vulnerable members of society: the poor (Mills et al., 2012a:126).

Figure 6: Aggregate birth coverage and birth coverage of the poorest quintile

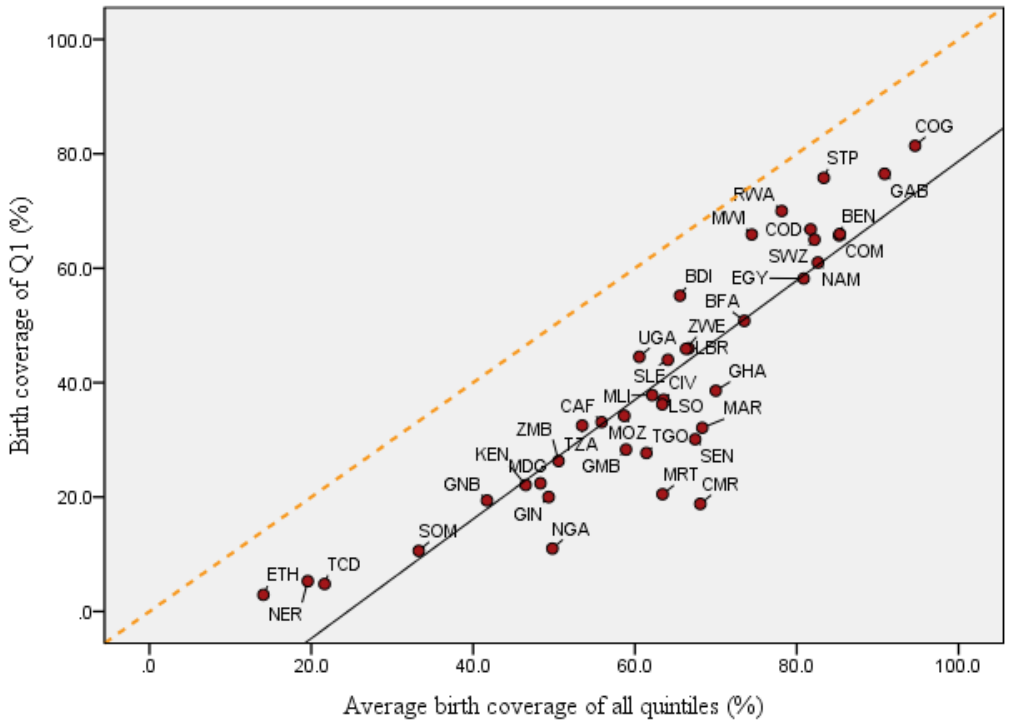
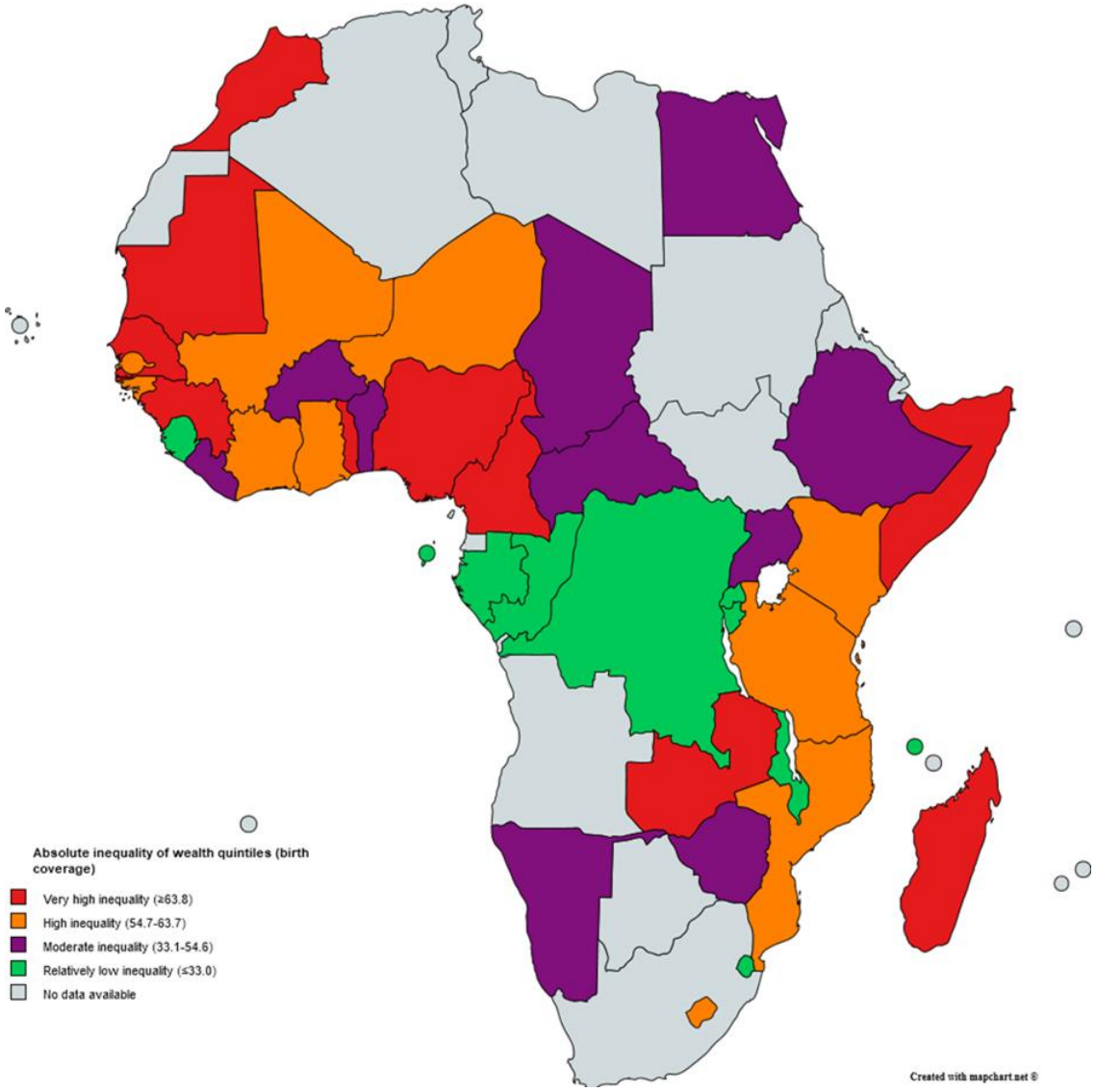


Figure 7 below shows a map of continental inequalities in birth coverage. Inequalities were determined by subtracting the poorest quintile's birth coverage (Q1) from the wealthiest (Q5). For African countries with very high inequality (the bottom, or worst-performing, fourth of countries with data available), the gap in coverage was equal to or higher than 63.8 percentage points. This map therefore highlights the fact that using averages conceals significant equity problems.

Figure 7: Absolute inequality in birth coverage across Africa



5.2.9 Conclusion

This paper rejects the idea that LHC can be measured solely by quantifying affiliation to health schemes (as assumed, *de facto*, by the ILO). The ILO acknowledges that the mere existence of affiliation does not result in substantive legal protections, yet, in practice, this qualification is not operationalised. Any accurate measure of legal coverage needs to include many key components, including those described above. At least one study has developed much more comprehensive, globally comparable indicators. Backman et al.'s (2008:1) publication, "Health systems and the right to health: an assessment of 194 countries", is probably the only existing study with a near-comprehensive set of indicators (72) that measure "the right-to-health features of health systems" (Backman et al., 2008).

Importantly, many of these indicators focus on rights-based protection in health systems. Indicators related to legal coverage span many areas, including the following:

1. Recognition of the right to the highest attainable standard of health.
2. Non-discrimination.
3. Health information.
4. National health plan.
5. Participation.
6. Medicines.
7. Health promotion.
8. Health workers.
9. International assistance and cooperation.
10. Other safeguards.
11. Awareness raising about the right to the highest attainable standard of health.
12. Monitoring, assessment, accountability, and redress. (Backman et al., 2008)

To illustrate, Indicator 21 is listed under the "National health plan" area (the third bullet point above). The criteria for Indicator 21 is met if a country's "national health plan includes an explicit commitment to universal access to health services, defined as access to primary, secondary, and tertiary physical and mental care" (Backman et al., 2008:15). For African countries with available information, Botswana, Libya, Mauritius, Mozambique, and Seychelles meet this benchmark. Egypt, Lesotho, Malawi, and Tanzania do not (Backman et al., 2008). Another example is Indicator 30, which assesses whether "a published national list of essential medicines" exists (Backman et al., 2008). All African countries

with data available for this indicator meet this requirement, though many Western countries do not (Backman et al., 2008). Backman et al's study developed indicators without regard to data availability. Thus, for 18 indicators, the authors were unable to obtain data for *any* of the 194 countries included in the study. Consequently, they conclude that "organisations that obtain such data give insufficient attention to the right-to-health features of health systems" (Backman et al., 2008:1).

Although the ILO claims to measure rights-based protection with its LHC measure, I argue that the ILO falls short of paying sufficient attention to "the right-to-health features of health systems", as described by Backman et al. (2008:1) above. The organisation neglects to incorporate any of the indicators included in the study, even though many of the study's indicators measure what it argues are the bare minimum legal commitments required to pursue full LHC (even if it does not use the term LHC). As the WHO (2014:50) recommends, international organisations such as the ILO should put more effort into developing "comprehensive, high-quality data collection systems" that incorporate "a broad set of indicators that goes beyond the data currently available". Additionally, the ILO should develop indicators that can be disaggregated by socioeconomic class and other characteristics that indicate marginalisation.

5.3 Recommendations for future studies on legal health coverage

Whether the concept of legal health coverage can or should be quantified at all is debatable – qualitative methods that analyse legal texts and public records may be more appropriate for the majority of indicators needed to capture "the full range of the construct", a requirement for a reliable operationalisation of a concept (Field, 2013:12). Although a lack of data certainly makes it difficult for the ILO to find pre-existing estimates that incorporate the entire construct, especially in Africa, the ILO could still conduct its own in-depth case studies of African countries' legal health frameworks. This would allow them to assess the extent of legal health coverage, since it is achieved only once strong legal health frameworks are in place. One way to do this would be to create a repository for countries' international and national legal obligations to the right to health.

The ILO may not actually be the best intergovernmental organisation to collect information on legal health coverage globally. In *National public health law: a role for WHO in capacity-building and promoting transparency*, Marks-Sultan et al. (2016:1) argue that the WHO "has the authority and capability to support capacity-building in the area of health law within Member States, and to make

national laws easier to access, understand, monitor and evaluate". States that hold membership in the WHO, which includes every African State (WHO, 2016b), are required to monitor and report on "their national health laws and regulations to the WHO" (Marks-Sultan et al., 2016:1). The WHO is therefore in a good position to assist countries with improving their legal health frameworks, despite never having had its own legal centre. Marks-Sultan et al. (2016) make a persuasive argument for the creation of a legal health repository, manned by legal experts from the WHO. They further argue that this repository needs to include analysis, rather than a simple list of laws and policies that relate to health. Having a list in an "unstructured format can be a hindrance to the task of comparing laws across countries, identifying country-level strengths and deficiencies, or monitoring changes over time" (Marks-Sultan et al., 2016:4).

The measurement framework developed by Backman et al. (2008), which has more than 20 indicators for the legal aspects of the right to health, would be a good starting point for a WHO or ILO legal health repository. This would require an extended effort to collect country data for these indicators, as even Backman et al.'s study was unable to collect country data for all of its indicators. Although many of the indicators that should be used to assess rights-based protection will not be quantitative, for indicators where disaggregation is possible, researchers should ideally disaggregate them based on characteristics protected by international law, especially socioeconomic class. Ultimately, for UHC to be achieved both in Africa and internationally, researchers and intergovernmental organisations will need to work together to develop more comprehensive indicators to measure legal health coverage, and States will need to make data publicly available.

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