PDF version

Including the informal sector and vulnerable groups in universal health coverage

Universal health coverage in the Region

Every year, millions of people throughout the world are deprived of health care, and millions more experience financial hardship because of the way health services are organized, delivered and financed. The World Health Report 2010 – Health systems: the path to universal coverage, affirmed the importance of reshaping national health financing systems to pursue the goal of universal health coverage (UHC), i.e. all people having access to needed health services without risk of financial hardship.

In the Eastern Mediterranean Region (EMR), UHC has never been as high on the political agenda as it is today. However, reaching out to the informal sector and vulnerable groups remains a huge challenge for many Member States, particularly in expanding financial protection.

To focus attention on the need to reach vulnerable groups, the WHO Regional Committee for the Eastern Mediterranean in 2013 called on Member States to “progressively expand coverage to all the population, including deprived groups, rural populations and those working in the informal sector, by introducing and expanding equitable, fair and efficient prepayment arrangements”. In addition, the 2014 “Framework for action on advancing UHC in the Eastern Mediterranean Region” asked Member States to give particular attention to the poor, the informal sector, the unemployed and the migrant or expatriate workers.

Expanding universal health coverage in the Region

In order to understand the situation in the Region and support Member States to expand the UHC in their countries, an Expert Consultation on expanding UHC to the informal sector and vulnerable groups in the EMR was held in March 2015 in Rabat, Morocco. The purpose of the consultation was to develop a clear understanding of the informal economy and its relations with the health sector in the context of expanding UHC and to identify vulnerable groups and ways of ensuring their coverage.

The specific objectives were to:

define the informal economy and identify its characteristics, and differentiate the vulnerable groups and explore their characteristics;

identify the specific challenges in reaching out to the informal sector and vulnerable populations in the EMR;

discuss global experiences in advancing UHC to the informal sector and vulnerable population and the relevance of these for Member States in the Region;

discuss and seek guidance on preparations for a future regional meeting with Member States.

Participants included experts from academia, research institutions, health insurance agencies, national database authorities, World Bank representatives and civil society organizations.

Presentations were given by WHO and the World Bank on the challenges and prospects of moving towards UHC in the Region and the challenges in reaching and covering the informal sector. In addition, representatives from countries in the Region and other parts of the world gave an insight into the challenges and successes achieved in their own countries' endeavours towards introducing UHC.

Key messages for the Region

The meeting concluded with main messages for the EMR countries to work towards extending UHC to the informal sector and vulnerable groups.

Definitions and characteristics of informal sector

Countries need to look within their own context to describe and define their informal sector with respect to existing or planned health financing mechanisms.

Understanding informality

Informality is defined according to one of three criteria: size of the economic unit, non-registration, and legal status. The economy can be classified into:

public sector: formal and informal employees;

private non-agriculture sector: formal and informal enterprises;

formal enterprises have formal and informal waged-workers;

informal enterprises – all informal by nature.

Vulnerable groups

The poor represent just one category among the vulnerable groups. Several other groups are also classified as vulnerable. These include: children, the elderly, the unemployed, expatriates, refugees and internally displaced persons, and many others.

Shift to social health insurance arrangements

In the EMR, as elsewhere, there has been a strong shift to social health insurance-type arrangements, whereby the logic of social health insurance is proving to be the rationale for expanding coverage to the uninsured. Nevertheless, it is important to not absolutely equate UHC with social health insurance.

Targeting

While assessing coverage for the poor and the informal sector, there is a need to differentiate between eligibility (in accordance with the definition criteria), those being identified, and those effectively having a card through which they are covered. Countries have used two approaches to expand population coverage: bottom up and trickle down. The main challenge has been to reach out to the non-poor informal.

Governance

There is an urgent need to formulate a vision, strategy and roadmap to expand coverage. The shift to health insurance-type coverage arrangements changes the nature and role of the Ministry of Health: it will have to take on a much stronger stewardship function.

Voluntary vs compulsory health insurance schemes

Voluntary insurance schemes do not bring about UHC, as they lead to adverse selection, fragmentation and inequitable access. Governments may not be willing to initiate compulsory schemes due to: poor policy-making capacity/understanding, inability to enforce contributions, and a reluctance among people to pay on behalf of those unable or too poor to contribute.

Fragmentation

Multiple pools/schemes are a reality, though this is not desirable. The political economy within countries might not allow for radical mergers. Consequently, exploring harmonization among existing arrangements might lead to better results.

Sustained political commitment – a key factor for success

The importance of this factor is not limited to the Eastern Mediterranean Region: Turkey and Thailand are successful examples of the gradual approach and sustained commitment.

Provide incentives for health workers for appropriate productivity:

The health workforce behaviour has been altered through appropriate incentives as a way to minimize the service provision gap.

A parallel focus on financing and purchasing lends positive results

Thailand made simultaneous reforms at both the financing and the purchasing ends. There is an immense potential for resource mobilization through innovative revenue-raising mechanisms and countries can further explore this in line with their own context.

Missing middle

The term “missing middle” should be used cautiously, especially in countries adopting the bottom-up approach. In cases where the poor are not covered, this term may be misleading if it

draws more attention to the non-poor informal.

Valuing health insurance

The value of health insurance is linked to the comprehensibility of the benefit package and the associated out-of-pocket payments.

Performance

How to reach the “unreached” still remains an important policy challenge. Evaluation of the impact of health financing arrangements for the unreached is difficult due to the lack of available data or monitoring programmes.

Lessons from country examples

The rapid expansion in population coverage has been possible largely through non-contributory arrangements. Administrative procedures are key factors for the success of a UHC programme; thus, future studies need to give more attention to the assessment of administrative procedures, especially the roles of the authorities and individuals. Identification of whom to cover is important for budget transfer arrangements.

Rapid economic growth has played a pivotal role in extending coverage to the informal sector and population coverage expansion can be accelerated with public financing and private provision. Personal identification systems and poverty databases are increasingly becoming key factors in expanding coverage to the poor. The population dimension alone is, however, not enough as it could lead to high out-of-pocket expenditures and inadequate service coverage.

Family-based membership can be a good starting point for the countries in the initial stages of UHC expansion. This approach brought about positive results for the Republic of Korea in the earlier stages; now it is moving towards individual-based membership so as to avoid free-riding.

The bottom-up path to UHC is viable in developing countries – programmes are converging towards policies that seem sound by expert consensus but still require the development of operational dashboards and the monitoring of results. The road to UHC often requires that countries take transitional steps: programmes targeted only to the poor are eventually absorbed and separate informal-sector programmes with fewer benefits than those for the formal sector lead to inequity in benefits; these may also be absorbed or force tax reform.

Co-contributions from the informal sector

Non-contributory arrangements can lead to faster expansion of population coverage, while contributory arrangements have proven to be slower and more challenging. Nevertheless, both require effective supply-side policies and good UHC skills. In practice, countries apply both non-contributory and contributory approaches within one scheme/arrangement, so the two should not be treated as distinct approaches. The use of the flat fee is easier to implement than income-related contributions, however equity considerations still need attention.

Approaches adopted to cover the vulnerable

Various approaches have been adopted to cover vulnerable groups; the single common factor in all the experiences has been the need for expanded public investment through general government revenues. Subsidization must be high enough for enrolment to be attractive, so as to reach significant population coverage rates. The share of budget transfers to social health insurance schemes is significant, above 50% in many countries

Policy lessons on institutional design features

Integrated schemes for both the subsidized and the contributors are more effective in enhancing equity of access (package and utilization). Merging a separate scheme set up for the subsidized with a formal sector scheme at a later stage is difficult, but nevertheless possible (examples include schemes in Turkey and Indonesia). Overall, semi-contributive schemes have not been successful in enrolling significant parts of the population. Exemption from cost-sharing is important for the poor and vulnerable population groups. Pooled and integrated health financing arrangements are more likely to provide the same benefit package to the subsidized as to contributors.

Thursday 11th of July 2024 09:16:54 AM