WHO-EM/HEC/044/E

Report on the

Expert consultation on expanding universal health coverage to the informal sector and vulnerable groups in the Eastern Mediterranean Region

Rabat, Morocco
15–16 March 2015

World Health Organization
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1. INTRODUCTION

Universal health coverage, as a health system development goal, was articulated in the Constitution of the World Health Organization (WHO) in 1948 and was integral to the Alma-Ata Declaration of 1978. Nevertheless, it has never been higher on the international health and development agenda than now.

In 2013, the WHO Regional Committee for the Eastern Mediterranean called on Member States in the Region 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" (EM/RC60/R.2). In addition, a framework for action on advancing universal health coverage in the Region, endorsed by the Regional Committee in October 2014 (EM/RC61/R.1), asked Member States to give particular attention to the poor, the informal sector, the unemployed and the migrant or expatriate workers.

As described in the 2010 World Health Report, Health systems financing: the path to universal coverage, universal health coverage has three dimensions: financial protection, services and population. Attention has often been diverted towards the first two to the exclusion of the population dimension, which is often considered part of the other two. Nevertheless, policy-makers continue to tackle and understand universal health coverage through the lens of its population dimension. The questions of who is and who is not covered continue to surface in discussions at the national level.

In this context, an expert consultation on expanding universal health coverage to the informal sector and vulnerable groups in the Eastern Mediterranean Region was held in Rabat, Morocco, during March 15–16, 2015. The purpose of the meeting was to develop a clear understanding of the informal economy and its relations with the health sector in the context of expanding universal health coverage and to identify vulnerable groups and ways of ensuring their coverage. The meeting programme is included as Annex 1.

The specific objectives of the meeting were to:

- define the informal economy and identify its particularities, and characterize the vulnerable groups and explore their characteristics;
- identify the specific challenges in reaching out to the informal sector and vulnerable populations in the Eastern Mediterranean Region;
- discuss global experiences in advancing universal health coverage to the informal sector and vulnerable population and the relevance of these for Member States in the Region;
- discuss and seek guidance on the preparations for a Regional Meeting with Member States.

The meeting was attended by experts from academia, research institutions, health insurance agencies, national database authorities, World Bank representatives and civil society organizations. A list of participants is included as Annex 2. The meeting agenda was arranged around country experiences regarding extending coverage to the informal non-poor and the poor/vulnerable. One of the expected outcomes of the meeting was to outline a tentative agenda for a Regional meeting on expanding universal health coverage to the

informal sector and vulnerable groups in the Eastern Mediterranean Region to be organized with Member States later in 2015.

2. SUMMARY OF PRESENTATIONS AND DISCUSSIONS

2.1 Opening session

Dr Yves Souteyrand, WHO Representative, Morocco, delivered a message from Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean. Dr Alwan, emphasized the importance of this meeting as it dealt with a key element in WHO's work with Member States in reforming their health systems and acting on the social determinants of health to promote universal health coverage. It was essential to ensure that any vision, strategy or roadmap developed to pursue the goal of universal health coverage takes into consideration the right of all population groups to have access to the health services they need and to be protected financially. During the past couple of years a great deal of information had been compiled on the health financing systems of countries of the Region, including descriptions of the institutional and organizational aspects pertaining to the three functions of collection, pooling and purchasing, and their governance. An overarching challenge was the question of how to reach out to the informal sector, especially the affluent among them.

Dr Alwan noted that informality was not specific to the health sector and that economic development in itself was not amenable to limiting it. There was a need to know how other sectors were tackling the issue of informality and to derive lessons for the benefit of the health sector. The poor represented just one category among the vulnerable groups; others that could be added included children, the elderly, the unemployed, expatriates, refugees and internally displaced persons. The consultation was aimed at informing the preparations for a regional meeting on this topic later in the year.

In his welcoming remarks on behalf of the Moroccan Ministry of Health, Dr Abdelali Belghiti Alaoui, Secretary General, Ministry of Health, congratulated WHO for selecting the important but challenging topic of extending universal health coverage to informal and vulnerable populations of the Region. Countries not only had to provide opportunities for access to services but also gauge the quality of services being delivered. It was imperative, with the current move towards universal health coverage, that politicians have access to up-to-date evidence and arguments for decision-making. Reforms could not be made solely on experimentation; learning from other countries which have faced similar situations can be extremely helpful. The meeting provides an opportunity for the Region to develop a framework for action for covering the informal and vulnerable groups.

2.2 Moving towards universal health coverage in the Eastern Mediterranean Region: challenges and prospects

Dr Sameen Siddiqi, WHO Regional Office for the Eastern Mediterranean,
Dr Awad Mataria, WHO Regional Office for the Eastern Mediterranean

Dr Siddiqi presented some comparisons between health expenditure in the world and in the Eastern Mediterranean Region. In 2011, world expenditure on health was almost US$ 7

trillion, i.e. around US$ 1000 per capita. Member States in the Region spent close to US$ 125 billion on health, i.e. around US$ 200 per capita in 2011. Thus, the Eastern Mediterranean Region accounts for 1.8% of world spending on health for 8.7% of the world population.

In 2012, the countries of the Region were categorized into three health system groups based on population health outcomes, health system performance and level of health expenditure. Progress towards universal health coverage has been assessed based on the three dimensions across the three groups. In respect of financial risk protection, the share of out-of-pocket payment from total health spending has been stable over the last decade but each group of countries has demonstrated diverse trends. In Group 1 countries[1], out-of-pocket payment decreased from 21% to 17%; in Group 2 countries, it fluctuated around 50%; and in Group 3 countries, it increased from 59% to 69%. It is estimated that annually up to 16.5 million individuals face financial catastrophe and up to 7.5 million are pushed into poverty in this way.

With respect to coverage with needed services, geographical access is almost 100% for Group 1 countries; it varies between 83% and 100% for Group 2 countries; and is between 44% and 97% for Group 3 countries. Among Group 1 countries, the citizens have access to a comprehensive package of health services. Several Group 2 countries have developed an essential package for primary health care as well as hospital services. The extent to which these are being implemented varies. In Group 3, four countries have developed a basic package of health services: many are no more than basic benefit packages.

In terms of population coverage, all citizens in Group 1 countries are covered for needed care. The extent and nature of coverage provided to the expatriate populations in these countries varies; expatriates are increasingly being covered under private insurance schemes. Despite high levels of eligibility, coverage in Group 2 countries suffers from fragmentation and duplication and the proportion of the eligible population varies. In the absence of well-established social health insurance schemes and the presence of underfunded public sector health services, coverage is largely restricted to civil servants and the armed forces: large segments of population remain uncovered by prepayment schemes. In Group 3 countries, while in principle governments are supposed to cover all nationals, coverage is available mostly for public sector employees. National social health insurance schemes do not exist, and private and community-based insurance arrangements cover only a very small proportion of the population.

Dr Siddiqi presented statistics on formal and informal employment, the population below the poverty line in 10 countries of the Region, the proportion of expatriates in Gulf Cooperation Council countries, and the challenges in covering refugees and internally displaced populations in multiple countries. Participants were then invited to consider ways of factoring these special groups into a strategy and roadmap for universal health coverage.

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[1] Group 1: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates; Group 2: Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, occupied Palestinian territory, Syrian Arab Republic and Tunisia; and Group 3: Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen.

Dr Mataria gave an overview of health financing and population coverage in the Region, and elaborated on expanding population coverage. Trends in heath financing policy include: the shift from general government revenues to social health insurance arrangements; social health insurance evolving into a prepayment arrangement; and financial protection evolving as a right. For coverage of the expatriate population in the countries of the Gulf Cooperation Council, a paradigm shift has been observed – from the traditional approach of exclusion to a multidimensional approach of inclusion. Most of the countries of the Region with existing social health insurance schemes have moved beyond the formal sector social health insurance – government subsidies are now considered for the social health insurance coverage/enrolment of the poor and other informal sectors. With regard to population coverage in social health insurance, multiple arrangements are in place: separate subsidized schemes for the poor/informal sector either coexist with or are part of formal social health insurance schemes. Population coverage has rapidly expanded with interventions such as Morocco's Régime d'assistance médicale (RAMED), Tunisia's Assistance médicale gratuite, Sudan's social initiative project with zakat, Egypt's coverage for schoolchildren and pre-school children, Jordan's under-6 years and Palestine's under-5 years coverage, the Islamic Republic of Iran's rural health insurance programme, and Palestine's Al Aqsa Insurance scheme.

Further enhancing the thinking about population coverage under mixed health financing arrangements, Dr Mataria described different approaches towards subsidizing the poor and vulnerable and social health insurance implementation functions. There is a need to rationalize point-of-care schemes within social health insurance and to establish clear linkages between contributions and defined rights. He also elaborated on levels of population coverage, i.e. eligibility, entitlement and actual coverage.

2.3 Challenges in covering the informal sector: views from WHO and the World Bank

Dr Inke Mathauer, WHO Headquarters,
Mr Daniel Cotlear, World Bank,

Dr Mathauer explained the challenges of expanding coverage to the informal sector and vulnerable population groups and the health financing options involved. There is strong diversity within the informal sector as there are people outside the formal sector (regular, salaried employment or employer) paying income tax, but there people in the informal sector have no regular income, and it is difficult to tax them directly. Moreover, the definition of "vulnerable" groups is country-specific. Compulsion and subsidization are two necessary and sufficient conditions for financing for universal health coverage as subsidies alone are not sufficient because rich/healthy people do not join and compulsion without subsidies imposes a heavy burden on the poor and sick. Enforcing such conditions requires a strong state role in health financing. A situation of greater informality poses critical challenges to realizing these conditions: it has been observed that low- and middle-income countries with larger informal economies have lower tax collection capacities.

Dr Mathauer described the health financing options for expanding coverage of the informal sector and vulnerable population groups and discussed what does not work and what does/can work. She elaborated on the key characteristics and limitations of full contributory

approaches for the informal sector, and non-contributory approaches and a mix of contributory and non-contributory approaches for the vulnerable groups.

In regard to the global overview and current trends in institutional design features in government subsidization arrangements, the number of low- and middle-income countries with such schemes is growing. A significant share of the government budget is being transferred to such schemes, and innovative revenue-raising mechanisms are being used to finance the subsidies. Though a more systematic evaluation of the impact of individual schemes is needed, current evidence indicates that such schemes have increased population coverage, have addressed inequalities in benefits (though large differences often remain when the subsidization schemes are separate), and have increased utilization rates. Evidence on financial risk protection is more mixed.

Mr Cotlear then gave a presentation about how 24 developing countries are covering people from the bottom up. The objective of the Universal Health Coverage Studies Series (UNICO studies series) was to learn how countries are implementing universal health coverage; the series adopted a descriptive approach – researchers learning from policy-makers. Three challenges are hidden inside the universal health coverage cube: populations are segmented in their access to health care, health financing is fragmented, and there is insufficient provision with underutilized capacity. These challenges have created a provision gap and a financing gap. Evidence from the early 2000s revealed a pro-rich bias in public health spending – “trickle down”. The new wave of universal health coverage programmes seeks to reverse this trend – bottom-up expansion – and countries are confronting two key challenges: how to identify and target the poor, and how to cover the informal sector.

For targeting people, 23 of the 26 programmes described require enrolment; personal identification systems are increasingly a key to universal health coverage. The capacity to target the poor is deficient but is improving. Supply-side universal health coverage programmes often target by geography and by type of service; 19 out of the 26 programmes had access to a “targeting registry”. There is politics in targeting: countries are struggling to maintain a focus on the poor while excluding the non-poor. There are two paths to covering the informal sector,: the first (common) step is launching a poor and vulnerable programme, requiring the capacity to identify and enrol the poor population. When successful, this generates a “missing middle” but in the early stages countries suffer from “missing poor”. There are two possible second steps: i) a non-contributory informal sector programme, ii) merging into an expanded social health insurance scheme. To cover the informal sector, more progress is achieved where informality is smaller. The road to universal health coverage 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 may also be absorbed or force a tax reform. Voluntary health insurance is not a path to universal health coverage, but is useful during transition, as it brings about smoother politics and some protection.

2.4 Country experiences in covering the informal non-poor

Dr Enis Baris, Health, Nutrition and Population, World Bank
Dr Jeanette Vega, Fondo Nacional de Salud, Chile
Dr Samrit Srithamrongsawat, Health Insurance System Research Office, Thailand
Dr Sven Neelsen, Institute of Health Policy and Management, Erasmus University Rotterdam, Netherlands,

Dr Baris gave a presentation on "Expanding universal health coverage to the informal sector and vulnerable groups". Universal health coverage includes much more than just health: taking steps towards universal health coverage means moving towards equity, development priorities, social inclusion and cohesion. The informal economy refers to activities and income that are partially or fully outside government regulation, taxation and observation. A key concern with informal employment is the absence or incomplete coverage of formal social programmes and benefits such as pensions, sick pay and health insurance. Dr Baris reported that providing informal sector workers and their families with appropriate access to health services is a central preoccupation of policy-makers seeking to achieve universal health coverage in developing countries. This challenge becomes a function of the level of development, which determines both the size of the informal sector and the availability of fiscal resources that can be allocated to health services. The challenges posed by a large informal sector and limited availability of fiscal resources are compounded by the existence of segmented health systems, which often lead to problems like adverse selection, high administrative costs, low enrolment, and misrepresentation of incomes or work status to qualify as poor.

Citing country examples of expanding universal health coverage to the informal sector and vulnerable populations, Dr Baris described the design features, institutional set-up, and institutional and financial linkages with other schemes such as the Seguro Popular scheme from Mexico and BPJS Health Insurance from Indonesia. He elaborated on Turkey's experience in establishing the Social Security Institution in 2012 and the integration of all previous schemes, including that of civil servants, into a universal health insurance scheme which is now providing a comprehensive benefits package for preventive, primary and inpatient services.

Gradualism with a vision; matching demand with supply in a fiscally responsible manner; better stewardship/governance, enforcement of accountability/transparency among payers, providers and citizens; separation of functional responsibilities; economies of scale (virtual or institutional merger of payers/purchasers); and levelling the playing field between public and private providers are a few notable characteristics which can help countries enhance their effective coverage.

Dr Vega presented "Reaching out to the informal sector: the experience of Chile". She elucidated the long journey to universal health coverage in the country: currently 77% of Chileans are covered by FONASA (Fondo Nacional de Salud), with public provision of services. The rest are insured by ISAPRES (las Instituciones de Salud Previsional), with private provision of services. The Chilean government reformed the health system in 2005 with a focus on translating the right to health into enforceable guarantees; it created a model

of the progressive establishment of “explicit, enforceable guarantees” and prioritized health problems; these legally binding guarantees equalize rights for the beneficiaries in the public and private sectors. Highlighting a few unique features of the Chilean model, she pointed out that most countries which have adopted a social health insurance model for universal health coverage have taken an incremental approach, first enrolling civil servants and formal sector workers, and later covering the poor; in contrast, from the beginning, Chile offered publicly-subsidized coverage financed by general taxes for those unable to pay. It was also a pioneer in developing a national health service, prioritizing the development of a countrywide network, first through public primary health care centres and later via community, secondary and tertiary care hospitals.

Citing innovative contributory strategies for extending coverage to informal workers, Dr Vega listed the conditions for coverage of temporary workers: they are covered for the full year if they contribute 7% of their payroll over 3 months; they can extend their coverage for one year if they become unemployed; independent workers are covered for the full year if they contribute continuously over 4 months or discontinuously over 6 months of the year. Entitlement has been de-linked from employment status by introducing mandatory contributions for the formal sector and using general budget revenues to fund those who cannot pay (an inherently political choice). Efficiency and equity have been simultaneously pursued by pooling different revenue sources, defining a broad benefits package that is legally enforceable (Plan AUGE – Acceso Universal con Garantias Explicitas), introducing performance-related payment mechanisms, and introducing new organizations and institutional arrangements to ensure public accountability for achieving results.

Dr Srithamrongsawat described Thailand’s long march to universal health coverage – from targeting in 1975 to universality in 2002. In keeping with political promises, universal health coverage was included in the January 2001 general election manifesto; a contributory scheme was not technically feasible and not politically palatable, so to achieve universal health coverage quickly in the four-year term of the Prime Minister, the only choice was a tax-financed scheme. Financial feasibility and resource needs matched fiscal space; the Prime Minister’s leadership and capacity to mobilize the shortfall from tax funding played a key role. A tax-financed social welfare scheme now covers the lowermost layer (the poor, the elderly, and children < 12 years), comprising 15% of the population. A contributory scheme/subsidized contributory scheme/tax-financed scheme covers the middle layer (the informal sector: borderline poor and non-poor), comprising of 70% of the population.

Dr Srithamrongsawat highlighted a few key steps which have brought about successful outcomes: transforming targeting to universality and the social welfare concept to citizen’s rights and entitlement; the termination of supply-side budget allocation and the splitting of purchaser and provider functions; the dominant role of closed-ended provider payment methods in social health insurance, the Universal Coverage Scheme (UCS) and the Civil Servant Medical Benefit Scheme, which resulted in cost containments; continued commitment to the Universal Coverage Scheme regardless of the political regime; and a resilient health system with competent technocrats. He further elaborated on factors contributing to Thailand’s success by citing health system developments between the 1970s and the 2010s: there has been a significant expansion in delivery systems with the advent of

the district hospital system, the creation of a public service mandate for new medical doctors, and the initiation of a programme for technical nurses. Strong institutional capacities for information processing and policy formulation have been developed and effective research policy interfaces have also been established.

Dr Neelsen presented “Covering the ‘missing middle’: lessons from the Health Equity and Financial Protection in Asia (HEFPA) project”. He recounted the motivation for the HEFPA studies on enrolment and the rationale for experimental studies in Viet Nam and the Philippines. In both countries, enrolment in the voluntary insurance schemes for non-poor, informal workers is low, so randomized interventions were conducted to increase uptake. In Viet Nam, neither insurance information leaflets, nor premium discounts, nor the combination of the two increased enrolment substantively. In the Philippines, the combination of information leaflets, premium discounts (up to 50%), and SMS reminders increased enrolment somewhat, but at negligible levels. In contrast, using insurance agents to assist people in completing enrolment forms and sending them back to the insurer increased enrolment substantially. However, none of the interventions can be expected to raise non-poor, informal sector coverage rates above 50%. Thus the HEFPA project provides further evidence that voluntary health insurance – even if paired with additional (demand-side) interventions that reduce its costs – will not achieve universal coverage. If countries opt nevertheless to use voluntary premium-based schemes to increase health coverage, supply-side determinants of enrolment (de jure and de facto benefits) should be further explored.

Dr Neelson gave the example of Thailand, which introduced the comprehensive, taxed-financed (small co-payment initially) universal coverage scheme to insure the missing middle (and the poor) in 2001. The HEFPA study found it to be effective in terms of both raising healthcare use and bringing down out-of-pocket payments. The universal coverage scheme increased public health care spending – more than doubling it in the first 10 years after its 2001 introduction. But Thailand maintained budget control through various simultaneous supply-side reforms (and a growing economy). This example from Thailand also shows that as long as there are coverage gaps between entitlement and private care, many will opt-out, and this dampens the impact on public health care use and spending.

2.5 Informality in economics and social sciences

Professor Alia Al-Mahdi, Faculty of Economics and Political Science, Cairo University

Professor Al-Mahdi gave a presentation on “The informal economy: definitions, scope and hindrances”. According to the International Labour Organization, the informal sector is defined irrespective of the kind of workplace, the extent of fixed capital assets, the duration of the activity of the enterprise and its operation as a main or secondary activity (comprising informal self-owned enterprises and enterprises of informal employers). An informal enterprise is either a one man show (self-employed person) or run by an employer who hires employees on a permanent or temporary basis. It may operate within or outside the establishment; the working conditions in the enterprise are usually unsuitable (e.g. lack of industrial safety, medical kits, and medical supervision in the work premises and lack of social or medical insurance for the workers). Dr Al-Mahdi explained the construct of informal employees, workers not covered by social or medical insurance and/or work contracts (wage-

workers, self-employed, and employers): they usually work an extended work day (over 8 hours) and are not granted regular paid vacation days or paid sick leave.

Reasons for informality being a widespread phenomenon in developing countries include widespread poverty; high unemployment, especially among youth; unpredictability of demand for products/services; lack of skills and modest educational attainment; micro-scale activities; difficult access to start-up finance; costly social and medical insurance subscriptions; and complex registration procedures. A few significant informality constraints in the Middle East and North Africa region are: the majority of micro/small scale enterprises are of micro size, with limited capital and limited access to finance; non-financial support services are minimal or nonexistent; females encounter specific unfavourable circumstances when they venture into business; the legal and institutional climate is inhibiting and costly and drives micro/small scale enterprises to operate and hire informally to avoid the numerous obstacles. The Egyptian experience demonstrates that lowering subscription rates, raising the insurable wage ceiling, and offering alternative health insurance packages can bring about positive results.

2.6 Country experiences in covering the poor/vulnerable

Mr El Houcine Akhnif from the Ministry of Health, Morocco, described the experience of the Régime d'assistance médicale (RAMED) in Morocco. There have been major achievements during the three years of generalization in RAMED: the number of eligible beneficiaries for the medical assistance scheme is currently 8.4 million, with an increase of 30% compared with 2013; coverage of 99% has been reached for the target population; a significant number of patients having diabetes, hypertension, cancer, and renal failure have been treated in recent years; for financing, the state, the community (beneficiaries) and local authorities are responsible for 75%, 6%, and 19% respectively. Moreover, RAMED has been able to reduce direct costs for the poor, e.g. 29.0% in Tadla Azilal and 28.2% in Grand Casablanca.

Key factors that have enabled RAMED to provide coverage for the poor were: the involvement of other sectors in the identification of the poor; the development of the information system for RAMED beneficiaries, which facilitated the follow-up and renewal of cards; commitment by head of state, which translated into availability of resources for the health sector; concomitant analysis of the health system service delivery capacity while defining the health services package; and commissioning impact studies to evaluate progress.

This was followed by a presentation from Dr Arash Rashidian, Associate Professor, School of Public Health, Tehran University of Medical Sciences, on "Expanding population coverage in the Islamic Republic of Iran". He gave a historical overview of the movement towards universal health coverage. There have been pilot projects and smaller national projects since the 1970s, but the first comprehensive programme with a mandate for implementing a national primary healthcare network started in 1985. Within 10 years the programme provided free-of-charge access to a majority of primary health care centres in rural areas. There was massive increase in vaccination, family planning and basic treatment services via community health workers (behvarz) based in rural health houses.

The second important milestone was the establishment of the Universal Medical Insurance Act of 1995, with the explicit aim of providing 100% medical insurance coverage. The act was linked with the purchasing–provision split policy and "pay for performance" payments to hospitals; this initiative resulted in increases in out-of-pocket payments. During 1985–95, specific voluntary insurance funds were created for the self-employed, certain disease groups, and urban inpatient services. Gaps and fluctuations in implementation resulted in dissatisfaction among the public and policy-makers.

Insurance coverage for the "poor" started in 1979 through means testing via the Imam Khomeini Relief Foundation. A clear programme was established in 1995 but had issues related to limited population coverage. Rural health insurance, providing coverage to all living in rural areas and towns of less than 20 000 population, was implemented in 2005; it offered free-of-charge enrolment, paid for by the government, and involved an active process of enrolment involving behvarz in rural areas. By 2010, there was extensive medical insurance coverage by social insurance organizations; coverage was increased over 80%, mainly via government-funded semi-automatic rural insurance coverage. Since April 2014, the Health Transformation Plan has been evolving; there have been remarkable achievements in mobilizing public resources for health care by implementing a 1% value added tax and the transfer of funds from public subsidy programmes to health care. Health care insurance coverage is now almost 100%, and around 10% reduction in out-of-pocket payments is expected.

Dr Soonman Kwon, Professor of Health Economics and Policy, School of Public Health, Seoul National University, gave a presentation on "Achieving universal health coverage: experience and lessons from the Republic of Korea". He described the development of health insurance in the Republic of Korea and explained the role of family-based membership and favourable political and economic environments in extending population coverage through an incremental approach. He further elaborated on the contribution-setting mechanism, the creation of a single payer system, accountability and governance, and the provider payments mechanisms now in place. The Ministry of Health and Welfare (and its Bureau of Health Insurance) has played a strong role in the reform process and has been able to avoid potential coordination problems across ministries.

Dr Kwon said that covering the formal sector first and extending to the informal sector creates big challenges in lower-income countries: the informal sector is too big and cross-subsidy from the formal sector may not be politically feasible. Rapid economic development resulting in shrinkage of the informal sector was a key factor for universal health coverage in the Republic of Korea. Family-based membership can more rapidly increase the population coverage in the formal sector and can reduce the size of the informal sector to be covered; family members of formal sector employees have characteristics more similar to those of the employee (member) than to those of people in the informal sector. Family-based membership promotes a culture of valuing family and contributes to overcoming the fragmented system such as separate schemes for school students and the elderly; but a potential concern in this system is free riding. With a mix of contributions and government subsidy for the self-employed, the contributions were lower than those for employees and this created an incentive for the informal sector to join. As there are potential trade-offs between population

coverage, benefit coverage, and financial protection, a priority policy was applied on the extension of population coverage. Among the few notable protection mechanisms in the country are: exemptions from co-payment for the poor; discounted co-payments for the elderly, children under 6 years, and patients with chronic conditions; 5% out-of-pocket payment for catastrophic conditions; and a ceiling on out-of-pocket payment for services covered.

The next country experience, “Monitoring and evaluating progress: universal health coverage in India”, was presented by Dr Sunil Nandraj, Advisor, Government of India and Public Health Foundation of India. In the current wake of health reforms in the country, there has been some debate regarding approaches and models to be used in progressing towards universal health coverage: the universal or the targeted approach, strengthening the supply side of public health systems or extending the health insurance model, and promoting public–private partnerships or regulating the private sector first. Two notable initiatives have already started: the National Rural Health Mission (now the National Health Mission) and Rashtriya Swasthya Bima Yojana, the national health insurance scheme. Moreover, the Planning Commission of India has suggested that each state should pilot universal health coverage in two districts and measure the extent to which populations are covered by free health services and interventions to improve coverage in a systematic manner.

Progress of the National Health Mission is being monitored through annual common review missions, periodic surveys (sample registration survey, district vigilance and monitoring committee), a web-based health management information system, quarterly progress reports, and financial audits. Dr Nandraj further noted that monitoring of universal health coverage progress is challenging in mixed health systems settings, where supply-sided public and private health systems coexist and often compete for resources with demand-sided programmes. Diversity of the population often makes agreement on proxies and measures for standardized tools to be used in baseline and follow-up surveys daunting. Attribution of outcomes is not easy when multiple pilots/interventions are being tested. Assigning weightings to parameters such as the effective coverage of benefits packages or populations needs to be carried out with care. Need versus utilization becomes an important perspective of evaluation because of the glaring inequities within small geographical boundaries. National level capacity-building is required for health systems and policy research to assess complex interventions.

Mr Usman Cheema, National Database and Registration Authority (NADRA), Pakistan, gave a presentation on “NADRA – development of a database of the underprivileged population in Pakistan”. More than 100 million Pakistani citizens have been registered on NADRA; the database has a record of 126 million faces and 720 million fingerprints. The organization has participated in multiple international projects, including: the civil registration system in Sudan, passport issuance and control system in Kenya, the national driving license system in Bangladesh, the identity card issuance system in Nigeria, and scanning and digitization for citizen registration in Sri Lanka. Over time, NADRA’s system has evolved from identification to database development and is now an enabling tool for social service delivery in Pakistan. The automated database has been used for multiple social protection programmes (financial support to indigenous displaced persons, support to flood

victims, and a nationwide income support programme) in the recent past. For the national poverty scorecard programme, a national survey was initiated in 2009. A total of 27 million households were surveyed and data were collected on 13 proxy variables. Poverty status was determined through proxy means testing; this methodology can determine the number of potential beneficiaries of any social protection programme.

Dr Faraz Khalid, doctoral student at Tulane School of Public Health, shared first-hand experience of using NADRA's poverty database for a health equity fund programme in Pakistan. An online virtual private network was established between the two databases for data security. Over the past four years, information related to nationally-agreed weighted poverty proxies was exchanged using the national identification number. This online linkage with a national poverty database has not only resulted in efficiency but has also brought transparency in targeting health equity fund programme beneficiaries. The database was also used for piloting a health insurance project aimed at protecting the poor against catastrophic expenditures in one district of the country. The Federal Government of Pakistan has recently announced the launch of a national health insurance programme covering 100 million individuals using the NADRA poverty database.

Ms Sinit Mehtsun, Program Officer, Joint Learning Network for Universal Health Coverage (JLN) explained that JLN is a global, innovative learning platform for countries moving towards universal health coverage, currently led by nine member countries and recently expanded to a group of 13 associate countries from Latin America, Europe, Africa, and Asia. It is guided by two core principles: country ownership and joint learning. The learning approach uses collaborative learning among practitioners to codevelop global knowledge on the practical "how-tos" of achieving universal health coverage. Key benefits of the JLN approach are: country ownership, relevance to country priorities, space to analyse root causes, building trust, safe spaces, and community. This results in practical tools/knowledge products that can be used and shared, and creates opportunities for responsive follow-up by partners.

Ms Marilyn Heymann, Senior Program Coordinator, Joint Learning Network for Universal Health Coverage explained JLN's population coverage technical initiative, which is supporting peer-to-peer learning for member countries on topics related to extending health coverage to population groups by focusing on the poor and near-poor, informal sector workers, and other disadvantaged or underserved groups. It is promoting learning through multiple flexible modalities such as coproduction of knowledge and tools, adaptation of knowledge in-country, a joint learning fund, intense collaborative learning, and knowledge management. Past activities of JLN's population coverage initiative have been on policy development, targeting and identification, premium collection, and equity measurement. Through its population coverage initiative, JLN will undertake the following activities in the near future: i) 12 country profiles on defining, identifying, and enrolling populations, ii) user experience maps for enrolment, iii) short case studies on country experiences covering the informal sector, and iv) a synthesis paper on the global experience of covering the informal sector.

2.7 Regional meeting on expanding universal health coverage to the informal sector and vulnerable groups in the Eastern Mediterranean Region

Dr Awad Mataria, Regional Adviser, WHO Regional Office for the Eastern Mediterranean

Dr Mataria presented a tentative outline of the forthcoming regional meeting to be held in September 2015 in Cairo, Egypt and garnered suggestions from the participants on agenda, structure, expected outcomes, potential participants, and timing of the event.

The preliminary objectives are: to share global, regional and country-specific experiences in advancing universal health coverage to all population groups, and discuss their relevance to Member States in the Region; to explore the political processes and the structural and cultural factors involved in facilitating and expediting the move towards universal health coverage by covering the informal sector and vulnerable groups; and to promote a better understanding of universal health coverage monitoring across its three dimensions (services, financial protection and population).

The approach to be adopted will encompass: the finalization of seven OASIS (organizational assessment for improving and strengthening health financing) country studies and extraction of those parts relating to population coverage of the informal and vulnerable groups, compilation of a background paper on population coverage in the Eastern Mediterranean Region, preparation of a lexicon of terms related to universal health coverage of the informal sector and vulnerable groups, and the development of a policy brief on demand-side financing experiences and their relevance to Member States.

Expected deliverables from the meeting are: i) a review of experiences in expanding universal health coverage to the informal sector and vulnerable groups in the Region, ii) a population coverage framework that can be integrated as part of the regional attempts to monitor universal health coverage in its three dimensions, and iii) a validated framework for assessing the bottlenecks to pursue universal health coverage in the Eastern Mediterranean Region.

It is anticipated that the experts and participants will include: 44 participants from ministries of health (director-general of health level) and health financing experts from all countries in the Region, experts from Eastern Mediterranean Region countries and from other regions, representatives of development partners (World Bank, African Development Bank, Asian Development Bank, Islamic Development Bank, International Labour Organization, etc.), and staff from WHO country offices actively involved in pursuing universal health coverage in their countries.

3. KEY MESSAGES

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. Informality is not a

problem in itself, but it limits fiscal capacity, and challenges arise as a result of past policy choices.

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, as well as many others.

Shift to social health insurance arrangements

In the Eastern Mediterranean Region, 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. In this regard, social health insurance has evolved as a prepayment arrangement with specific characteristics or elements, including having a separate fund, autonomy, compulsion and subsidization. Nevertheless, it is important to keep the discussion of options open and not absolutely equate universal health coverage with social health insurance. Despite the recent shift to the health insurance-type coverage mechanism, substantial supply-side financing remains in place: defining who pays for what is crucial.

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. In several cases, progressive population coverage has gone through adding slices of the population: the formal, the poor/vulnerable and then the informal. 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 as

power issues arise. Alignment of reforms is essential and rigorous regulation is required for the integration of private sector health services and to get services from autonomous public hospitals.

Voluntary vs compulsory health insurance schemes

Voluntary insurance schemes do not bring about universal health coverage, 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.

Incentivizing health workers for appropriate productivity

Lessons can be learnt from Turkey and Chile about minimizing the service provision gap by altering existing health workforce behaviour through appropriate incentives.

A parallel focus on financing and purchasing lends positive results

Thailand made simultaneous reforms at both the financing and the purchasing ends; the adoption of a closed-ended provider payment mechanism is an example. 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. The lack of interest in enrolling in health

insurance schemes by the non-poor informal population in the Philippines and Viet Nam serve as examples of this.

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 universal health coverage 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 universal health coverage 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 universal health coverage 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 universal health coverage 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

Noncontributory 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 universal health coverage 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 (other than in Rwanda and China, with specific success factors). 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.

Annex 1

PROGRAMME

Sunday, 15 March 2015

Opening session

08:30–08:40	Opening remarks on behalf of the Ministry of Health, Morocco	
08:40–08:50	Opening remarks on behalf of WHO Regional Office for the Eastern Mediterranean	
08:50–09:00	Introduction and objectives	Dr Awad Mataria, Regional Adviser, Health Economics and Financing, WHO/EMRO

Session 1: Moving towards universal health coverage in the Eastern Mediterranean Region: challenges and prospects

09:00–09:15	Moving towards universal health coverage in the Eastern Mediterranean Region: commitments and framework for action	Dr Sameen Siddiqi, Director, Health Systems Development, WHO/EMRO
09:15–09:30	General discussion	
09:30–09:50	Ensuring health coverage to the informal and poor in the Eastern Mediterranean Region: how does it look, what can countries do? Overview and lessons learned	Dr Awad Mataria, Regional Adviser, Health Economics and Financing, WHO/EMRO
09:50–10:30	General Discussion	

Session 2: Challenges in covering the informal sector – views from WHO and the World Bank

11:00–11:20	Challenges facing extending universal health coverage to the informal sector and options for addressing them: an overview of the global experience	Dr Inke Mathauer, Health Financing Expert, Health Systems Governance and Financing, WHO/HQ
11:20–11:40	Reaching out to the informal sector: findings from the World Bank UNICO Study	Mr Daniel Cotlear, Lead Economist, Health, Nutrition and Population, World Bank
11:40–13:00	General discussion	

Session 3: Country experiences in covering the informal non-poor

14:00–14:20	Establishing an integrated health financing system to cover the informal sector in Turkey Overview and lessons learnt	Dr Enis Baris, Sector Manager, Health, Nutrition and Population, World Bank
14:20–14:40	Reaching out to the informal sector: the experience of the Fondo Nacional de Salud in Chile Overview and lessons learnt	Dr Jeanette Vega, Director, Fondo Nacional de Salud, Chile
14:40–15:30	Discussion	
16:00–16:15	Reaching out to the informal sector: the experience of the universal coverage scheme in Thailand	Dr Samrit Srithamrongsawat, Deputy Secretary General,

	Overview and lessons learnt	National Health Security Office and Director of Health Insurance System Research Office (HISRO), Thailand
16:15–16:30	Covering the 'missing middle': Lessons from Health Equity and Financial Protection in Asia (HEFPA) project Overview and lessons learnt	Dr Sven Neelsen, Academic Researcher, Institute of Health Policy and Management, Erasmus University Rotterdam, Netherlands
16:30–17:30	Discussion	
17:30–17:40	Synthesis of the messages from Day 1 on covering the informal non-poor	Dr Sameen Siddiqi, Director, Health System Development, WHO/EMRO

Monday, 16 March 2015

Session 4: Informality in economics and social sciences

08:30–08:50	Understanding informality: definition and classifications	Prof Alia Al-Mahdi, Faculty of Economics and Political Science, Cairo University
08:50–09:30	Discussion	

Session 5: Country experiences in covering the poor/vulnerable

09:30–09:45	Reaching out to the poor: the experience of RAMED in Morocco Overview and lessons learnt	Dr Abdelali Belghiti Alaoui, Secretary General, Ministry of Health, Morocco
09:45–10:00	Expanding population coverage: the experience of the Islamic Republic of Iran Overview and lessons learnt	Dr Arash Rashidian, Associate Professor, School of Public Health, Tehran University of Medical Sciences, Islamic Republic of Iran
10:00–10:30	Discussion	
11:00–11:15	Achieving universal health coverage: how did the Republic of Korea do it? Overview and lessons learnt	Dr Soonman Kwon, Professor of Health Economics and Policy, School of Public Health, Seoul National University, Republic of Korea
11:15–11:30	Monitoring and evaluating progress towards universal health coverage in India: a population coverage perspective Overview and lessons learnt	Dr Sunil Nandraj, Advisor, Government of India, Public Health Foundation of India, India
11:30–11:45	Covering the poor under a low-income setting: The experience of Ghana Overview and lessons learnt	Dr Chris Atim, Health Systems and Equity Adviser, Maternal and Child Survival Program (MCSP-USAID), R4D
11:45–12:30	Discussion	
13:30–13:45	Developing a database of population below the poverty line in a low-income setting: the experience of NADRA	Mr Usman Cheema, National Database and Registration Authority (NADRA), Pakistan

14:00–14:30	Ensuring health coverage to other vulnerable groups in the Eastern Mediterranean Region: the case of expatriate population, refugees and internally displaced people Moderated discussion	Dr Sameen Siddiqi, Director, Health System Development, WHO/EMRO
14:30–15:30	Main messages for the Eastern Mediterranean Region on extending universal health coverage to the informal sector and vulnerable groups in the Eastern Mediterranean Region Presentation followed by general discussion	Dr Awad Mataria, Regional Adviser, Health Economics and Financing, WHO/EMRO

Session 6: Regional meeting on expanding universal health coverage to the informal sector and vulnerable groups in the Eastern Mediterranean Region

16:00–17:00	General discussion on the preparations for the "Regional meeting on expanding universal health coverage to the informal sector and vulnerable groups in the Eastern Mediterranean Region"	

Closing session

17:00–17:10	Closing remarks	Dr Sameen Siddiqi, Director, Health Systems Development, WHO/EMRO

Annex 2

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