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Report on the

Regional meeting on expanding universal health coverage to the informal sector and vulnerable groups

Cairo, Egypt
1–3 September 2015



World Health
Organization

Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

A regional meeting on expanding universal health coverage to the informal sector and vulnerable groups in the Eastern Mediterranean Region was held in Cairo, Egypt between 1 and 3 September 2015. The meeting welcomed delegates from 18 countries, in addition to a group of experts from other regions. The objectives of the meeting were:

- to share global, regional and country-specific experiences in expanding health coverage to all population groups, focusing on the informal sector (non-poor and poor) and other vulnerable groups;
- to explore the political processes and the structural and cultural factors involved in expediting coverage to the informal sector and vulnerable groups; and
- to promote a better understanding of (universal health coverage) in its three dimensions: services coverage, financial protection and population coverage.

The expected outcomes were a review of regional experiences in expanding universal health coverage to the informal sector and vulnerable groups in the Region and a roadmap for expanding health coverage for the informal sector and vulnerable groups in the Region.

The meeting was inaugurated by Dr Ala Alwan, Regional Director, World Health Organization Regional Office for the Eastern Mediterranean (WHO EMRO). After welcoming the participants and experts, Dr Alwan highlighted the critical importance of universal health coverage as an overarching priority on the agenda of WHO. Subsequently, Dr Alwan emphasized the significance of achieving coverage of the most needy and vulnerable populations as an integral step towards paving the road for universal health coverage. Dr Alwan noted the emergence of the issue of health coverage of the informal sector as a major challenge to policy makers in countries of the region. It was clarified that although informality is not limited to the health sector, it is also true that the health sector is a unique one, and solutions to tackling informality in other sectors need to be studied and adapted to better suit the health sector. The breadth of the concept of vulnerability was also underscored, whereby Dr Alwan disapproved the misconception that vulnerability is limited only to poverty. Other vulnerable groups exist, namely, children, the elderly, the unemployed, expatriates, patients suffering from chronic diseases, refugees and internally displaced persons.

Dr Alwan encouraged participants to engage actively in the discussion of experiences of different countries in reaching out to the informal sector and vulnerable groups, and to assess the viability and applicability of the solutions proposed to the Region. Attention was also pointed towards the drafting of a roadmap of potential interventions to help countries of the region achieve the goal of coverage of the informal and the vulnerable segments of the population. The roadmap, which was to be enriched and enhanced by participants of the meeting in collaboration with WHO, was set to be a major outcome of the meeting. Dr Alwan concluded his speech by emphasizing the importance of creating sustainable partnerships at the local and global levels as a means towards achieving universal health coverage. The importance of monitoring and measuring progress, as well as the undeniable significance of political commitment was also underlined.

Dr Daniel Cotlear, Lead Economist in the Health, Nutrition and Population division of the World Bank provided opening remarks on behalf of the Bank and emphasized its continued support and cooperation with WHO on its mission towards achieving universal health coverage globally and within the Region. He pointed out the divergence away from a trickle-down approach to public health spending, which entailed covering the formal sector first and the informal sector and vulnerable groups later, towards a bottom-up approach. The main challenges to this were identifying and targeting poor and vulnerable populations, and figuring out how to cover the informal sector.

Dr Awad Mataria, Regional Adviser for Health Economics and Financing took the floor to deliver the objectives and agenda of the meeting.

Dr Sameen Siddiqi, Director of Health Systems Development, then presented some comparisons between health expenditure in the world and in the Region. In 2013, world expenditure on health was US\$ 7.35 trillion or around US\$ 1043 per capita. Countries of the Region spent close to US\$ 140 billion on health, or US\$ 230 per capita in 2013. Thus, the Region accounted for only 1.9% of world spending on health for 8.6% of the world population in 2013.

Based on the 2012 categorization of the countries of the Region in accordance with their population health outcomes, level of health expenditure and health system performance, statistics denoting the progress towards universal health coverage were presented. With respect to 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, 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% during the past 10 years. It is estimated that annually, up to 16.5 million individuals face financial catastrophe and up to 7.5 million are pushed into poverty due to out-of-pocket health spending in the Region compared to 150 million and 100 million individual globally.

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 actually covered 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 9 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.

2. TECHNICAL PRESENTATIONS

2.1 Informality, vulnerability and universal health coverage in the Region

Prof Akbar Zaidi, Columbia University, New York

Dr Awad Mataria, Regional Adviser, Health Economics and Financing, WHO EMRO

Dr Davoud Danesh Jafari, Senior Adviser on Health Care Financing, Islamic Republic of Iran

The session chaired by Dr Ahmed Galal, Managing Director of the Economic Research Forum.

The session opened with a presentation by Professor Akbar Zaidi on understanding informality and vulnerability in the context of the Region, via Skype. He highlighted the vast differences between countries in the region such as differences in per capita health expenditure, urban population as a percentage of the total population, and human development ranking. A representation of the trend of higher out-of-pocket payments in group 2 and 3 countries as opposed to group 1 countries was also presented. He then proceeded to tackle the issue of defining informality, which proved to be a point of controversy throughout the 3 days of the meeting. The definition given by Professor Zaidi categorized informal workers into 7 categories in accordance with the official definition of the International Labour Organisation (ILO). The significance of the informal sector in the Region was considered and the example of Egypt was given to illustrate this point. In Egypt, 91% of youth employment is in the informal sector, and the informal sector contributes between 30% and 50% of GDP.

Important distinctions between informality and poverty were made, where it was noted that while most of poor employed persons are employed in the informal sector, not all those employed in the informal sector are poor. Often, informal sector workers are faced with poor living and working conditions and ultimately, poor health status. Professor Zaidi concluded his presentation by providing food for thought with suggestions such as questioning the ILO's definition of informality and whether it can be related to health. He also took notice of the fact that the workplace is the main focal point when defining informality and that place of residence is often overlooked. The situation of women, children and migrants was also brought to the table.

Following was a situation analysis of coverage of the informal sector and vulnerable groups in the region presented by Dr Awad Mataria. He first compared the distribution of world health expenditures by financing scheme with the same distribution for countries of the region. He highlighted the fact that the absolute amount of per capita health expenditure only provides a partial image and that knowing where the finances come from and how they are spent is required for thorough understanding of the status of health systems. Notably, social health insurance and private health insurance schemes were more abundant globally compared to the Region, and out-of-pocket expenditures represented a much larger portion of health expenditure in the Region as opposed to the world averages.

It was also made clear that in order for government spending on health to increase, it is inevitable that either health must be given a higher priority on the government's spending agenda, or total government spending must increase. While general government expenditure on health as a percentage of total government expenditure varies across the Region, it is considerably lower than the global average of 11% in most countries. A mapping of health financing arrangements in Afghanistan, Oman and Tunisia was used to provide an example for each country group. Dr Mataria provided an overview on trends in health financing policy, which include a 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.

Several arrangements for achieving population coverage through social health insurance were discussed; namely, basic formal sector SHI schemes, formal schemes with an inclusive subsidized scheme for poor and informal populations, and formal schemes with a separate subsidized scheme for the aforementioned populations. Dr Mataria took note of several interventions across the Region which have been effective in striding towards population coverage: Morocco's Régime d'assistance médicale (RAMED); Tunisia's Assistance médicale gratuite; Sudan's social initiative project with zakat; Egypt's coverage for school children 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.

Finally, Dr Mataria concluded by considering the different approaches to subsidizing the poor and informal groups and comparing stand-alone schemes such as Morocco's RAMED to integrated schemes such as Sudan's Social Initiative Programme and the National Health Insurance Fund (NHIF). He also pointed out the need to adjust point-of-care schemes and to link contributions with coverage. It was also made clear that there was a need to distinguish between theory and practice by examining different levels of coverage including eligibility, entitlement and actual coverage.

Dr Davood Danesh Jafari presented the case of the health transformation plan of the Islamic Republic of Iran and its role in reforming the Iranian health care system for universal health coverage. Dr Jafari explained the three phases of the plan, which are expanding coverage and improving all aspects of hospital care, addressing primary care and public health and finally rationalizing tariffs and payment methods to providers. Statistics on how the plan has improved many different aspects of the service dimension of the Iranian health system

including primary, secondary and tertiary care reforms were presented. The programme has also improved the financial dimension of coverage where it has significantly reduced out-of-pocket expenditures on inpatient services for the totality of the population inclusive of the rich, the poor, those living in urban areas and those living in rural areas.

Although catastrophic health expenditures have decreased, impoverishment as a result of health expenditures increased, likely due to an increase in out-of-pocket expenditures for outpatient services. Dr Jafari discussed some of the main achievements realized by the programme such as an increase in public revenues for health through an increase of 1% VAT; putting in place a new insurance scheme for the uninsured under the Iranian Health Insurance Organization (IHIO); and the increase in tariffs by health insurance organizations to limit balance billing. Challenges were also brought to light such as the struggle of sustaining financial commitment to health and difficulties regarding monitoring levels of out of pocket payments for outpatient services.

Dr Jafari went on to classify informal and vulnerable groups in the I.R. of Iran into 4 main categories, namely, farmers and inhabitants of towns with less than 20 000 residents, those living under the poverty line, the uninsured and those residing in urban sprawl. Farmers and inhabitants of towns with less than 20 000 residents account for 29.25% of the population and are covered under the rural insurance scheme. 1.79% of the population live under the poverty line and these are covered by the Imam Khomeini Relief Committee. 15.36% of the population fell into the uninsured category prior to the start of the Health Transformation Plan and this segment was particularly given focus by the government.

2.2 Global experience in expanding coverage to the non-poor informal sector

Dr Daniel Cotlear, Lead Economist, Health, Nutrition and Population, World Bank

Dr Matthew Jowett, Senior Health Financing Specialist, Health Systems Governance and Financing, WHO/HQ

Dr Jeanette Vega, Director, Fondo Nacional de Salud (FONASA), Chile

On behalf of the World Bank, Dr Daniel Cotlear, delivered a presentation focusing on a recent study conducted by UNICO entitled “Going universal: how 24 developing countries are implementing universal health coverage reforms from the bottom up.” The study came with the objective of observing 26 programmes in 24 developing countries that have adopted a bottom-up approach to implementing universal health coverage. Dr Cotlear highlighted that the basis of the study came from the realization that these countries, despite their differences, all had a common starting point with challenges such as fragmented health financing systems, uneven access of the population to health care and inadequate provision of health care services coupled with underutilized capacity of facilities. He also noted that the issues tackled in the study are relevant globally, with over 400 million people around the world having no access to universal health coverage and 6% of the population of the world falling into extreme poverty annually as a result of catastrophic health expenditures.

Dr Cotlear pointed out the divergence away from a trickle-down approach to public health spending which entails covering the formal sector first and the informal sector and vulnerable groups later, towards a bottom-up approach. The main challenges to this are

identifying and targeting poor and vulnerable populations, and figuring out how to cover the informal sector. The issue of targeting impacts a country's ability to achieve universal health coverage significantly; and high economic and political costs are associated with narrowing the targeted population at later stages of implementation. All 24 countries began with the common step of covering the poor and vulnerable, but then countries differed with regards to their approach to the informal sector. Some countries such as Argentina and Columbia adopted a non-contributory approach by creating a separate programme for the informal sector, while others such as Viet Nam and Chile adopted a contributory approach by expanding the social health insurance scheme already in place to the informal sector either on a voluntary or mandatory basis. The former, while faster, entails a tradeoff between equity and sustainability.

An important conclusion made by the study is that the smaller the informal sector is, the easier it is for countries at hand to achieve progress towards universal health coverage. The study concluded that the bottom-up approach is feasible to achieving universal health coverage in developing countries where realistic "stepping stones" are taken. In addition, there is a need for stronger monitoring of results of universal health coverage programmes.

In terms of policy options aimed at extending health coverage to ensure that the informal sector is included, Dr Matthew Jowett explained that it is important to think from a holistic perspective and to focus on the progress of the population as a whole rather than one particular sector. Indeed, one must consider the question, "How can we reduce barriers to effective service use and improve financial protection for the poor and others persons in the informal sector?" This is in striking contrast to the question, "How do we target subsidies on the poor and get the rest of the informal sector to contribute?" The latter provides a limited approach and a restricted vision.

The experience of Georgia provides a clear example of how focusing solely on the poor proved to be an inefficient strategy, leaving 60–70% of the population with no statutory entitlements. The newly elected government in 2012 recognized the deficit and within 12 months managed to develop a comprehensive plan covering the whole Georgian population.

In discussing health system financing, it is important to define the "informal sector". This definition thus encompasses persons outside of regular, salaried employment and those characterized by irregular earnings or income and those devoid of explicit social protection. Importantly, they belong to widely diverse backgrounds, including those from urban settings, rural settings, migrants, those who are poor, or near-poor, middle-income and even some with substantial incomes. For the most part, they tend to be outside of routine data systems, so it is usually hard to get good information on them.

Public spending is key for universal health coverage. While clearly a necessity for universal health coverage, public funding is not sufficient. Indeed, extensive pooling of funds is required. It is also important to maximize redistribution of financial resources from those with low health needs to those with high health needs. Importantly, the resource pool needs to be large, diverse, compulsory, and non-fragmented. The informal sector does not pose a problem for fund pooling per se. However, setting up a separate targeted scheme for this

group would add to fragmentation and limit the potential for risk-sharing. Purchasing, which moves the system towards universal health coverage, focuses funds on priority services, controls costs, and promotes provider efficiency. Purchasing may be improved only for certain schemes, affecting a limited (and often privileged) part of population.

The main challenge presented by “informality” is the impact on public finances, i.e. it weakens fiscal capacity and the extent of risk-sharing through mandatory mechanisms. The other challenges, in particular reliance on contributory-based approaches and policies to establish separate schemes for separate population groups, often result in inequitable entitlements and coverage effectively “built into” the health system. Furthermore, the benefits being purchased are often vague, unclear, and difficult to enforce for the informal sector, leading to inequitable coverage.

One key option is the contributory approach to universal health coverage. This approach entails that individuals have to provide a contribution, whether by themselves or through their employers or through the government, to receive health services. An unsubsidized, voluntary approach will not work, even for the non-poor sector of the population. No country has ever achieved universal health coverage with this approach.

In Japan, France and Germany, the national health insurance schemes rely heavily on budget subsidies. So, this is also an important issue in richer countries. It requires a political vision that acknowledges the importance of universal health coverage, and a plan to ensure public funding should be made available. The situation in Mexico, Thailand, Rwanda and China exemplifies this. Alternatively, governments can start to build-in universal entitlements. For example, Moldova provides universal primary health care, whether or not insured in the national health insurance scheme (70%). This strengthened the link between entitlement and citizenship. Myanmar recently introduced universal (free) access to a list of generic essential medicines. In Chile, AUGE – a set of universal services (mostly elective surgery), is offered to the entire population, irrespective of their insurance scheme (public or private).

The non-contributory approach will still be incremental, given fiscal constraints, with a focus first on making high priority services universal. There will also be a need to work hard on purchasing, service delivery among other key issues.

In conclusion, the following points are the highlights of this topic.

- “Making fair choices” research is important.
- Public spending is key for universal health coverage. While clearly a necessity for universal health coverage, public funding is not sufficient. Indeed, extensive pooling of funds is required. It is also important to maximize redistribution of financial resources from those with low health needs to those with high health needs. Importantly, the resource pool needs to be large, diverse, compulsory, and non-fragmented. Sustaining a contributory-based approach requires strong political commitment and public funding.
- Non-contributory approaches rely heavily on budget, but avoid subsidy targeting issues.

- Many problems facing the progress of universal health coverage result from policies adopted, in particular complete reliance on contributory-based entitlements, establishing multiple coverage schemes.

Dr Jeanette Vega joined the discussion via Skype to explicate the experience of Chile in reaching out to the informal sector. Chile started the path towards universal health coverage in 1924 when the universal social security system was established. In 1952, a key milestone occurred with the creation of the national health services (NHS), which offered universal provision of services free of charge at the point of care, financed under a model of SHI, with 7% payroll mandatory contribution and publicly subsidized coverage for those unable to pay. The public insurance agency, FONASA, is the purchasing agency and administrator of the public health budget that includes funds from general taxes and worker contribution. In 1989 the health system was partially privatized with the establishment of ISAPRES which allowed opt-out option and the ability to transfer the 7% to private insurance companies. Currently, 77% of Chileans are covered by FONASA with public provision of services. The rest are insured by ISAPRES with private provision of services.

The model of Chile is unique in several aspects. Most countries which have adopted a social health insurance model to achieve universal health coverage have taken an incremental approach, first enrolling civil servants and formal sector workers, and later covering the poor. Chile, on the other hand, offered publicly subsidized coverage for those unable to pay financed by general taxes from the beginning. Chile 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.

The funding in Chile can therefore be summarized as follows:

- 7% payroll compulsory contribution for health for those formally employed;
- 7% compulsory contribution for independent workers with stable income (calculated from annual tax filing); and
- subsidization from general budget revenues to fund health services for informal workers with no stable work or who have income below the poverty level.

A recent study has shown that 34% of work in Chile is informal. This raises the question of how the informal sector is covered in Chile. Temporary workers are covered for the full year if they contribute 7% of their payroll during 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 during 4 months or discontinuously over 6 months of the year.

Health insurance emerged in Europe as a “condition of labour” (under Bismarck). In Chile, social (compulsory) health insurance for wage earners is deemed essential. However, the belief that “universal coverage for health is a condition of citizenship and a human constitutional right” prevails. Thus, health coverage for the entire population is guaranteed, with explicit policies to fund coverage for the non-salaried population.

Relying principally on voluntary prepayment for insurance does not achieve optimal results. Only cases of high enrolment (Rwanda, China) involve high subsidies and coordinating action by government from central to local level. All countries with universal population coverage rely on general budget revenues (in whole or in part) and the larger the informal sector, the greater the need for using general revenues. Thus Chile focused on universal health coverage, with 100% access to services with financial coverage. Furthermore, entitlement was de-linked from employment status. The system introduced mandatory contribution for the formal sector and used general budget revenues to fund those that cannot pay (an inherently political choice). In parallel, efficiency and equity were tackled by pooling together different revenue sources; defining a broad benefit package that is legally enforceable (AUGE); introducing performance-related payment mechanisms; and introducing new organizations and institutional arrangements to ensuring public accountability for achieving results.

The Chilean government reformed the health system in 2005 with a focus of translating the right to health into enforceable guarantees. It created a model of progressive establishment of “explicit, enforceable guarantees” prioritizing health problems. These legal binding guarantees equalized the rights to the beneficiaries of the public and private sectors. In addition to the conventional guarantees provided by universal health coverage, four additional, legally-enforceable guarantees for a health benefit package were added.

- Access: FONASA and ISAPRES legally bound to cover an explicit benefit package of guaranteed health interventions related to 80 priority health problems.
- Quality: Health interventions are to be delivered by properly registered and certified providers, according to standardized clinical guidelines.
- Opportunity: Health interventions must be delivered within clearly-defined maximum time periods.
- Financial protection: FONASA and ISAPRES must cover at least 80% of the guaranteed package of health benefits.

This system guarantees the coverage of diseases posing a high burden, such as schizophrenia and hypertension, diseases causing high financial burden, such as cancers, HIV/AIDS, chronic renal failure, diseases with existing high cost effective interventions, such as hip fracture and cataract, diseases with high social priority such as lower acute respiratory and oral health in children less than 6 years old.

Studies in 2015 have shown that over 85% of informal male workers and over 90% of informal female workers have enrolled in health care plans. However, it is widely recognized that enrolment does not ensure access. Therefore other indicators need to be analysed. Effective coverage has been shown by several indicators such as 100% skilled birth attendants, 96% utilization of antenatal care services, 99% utilization of family planning services and 82% success in tuberculosis treatment among other parameters.

2.3 Expanding coverage to the non-poor informal sector in the Region

Dr Hani Brosk Kurdi, Secretary General, High Health Council, Jordan

Dr Hassan Nagi, General Manager, Specialized Medical Councils and Programme of Treatment at the Expense of State, Egypt

Ms Hilda Harb, Head of the Statistics Department, Ministry of Public Health, Lebanon

This session consisted of a series of three short interventions from Jordan, Egypt and Lebanon followed by a general discussion on the material delivered by the panelists. The discussion commenced with Dr Hani Brosk Kurdi introducing the High Health Council and the purpose of its establishment, which is the formulation of general policies for the health system of Jordan. The civil insurance programme run by the Ministry of Health covered 34% of the Jordanian population, 24% was covered by Royal Medical Services, and 8% by UNRWA. The Royal Court Unit was hence developed in order to serve the remaining uninsured population. The conditionality for coverage by the Royal Court is that the individual seeking coverage must have a valid ID and cannot be covered under any of the other schemes. The Royal Court's vision is "No Jordanian left behind" and it has been working towards realizing that goal. In 2014, the Royal Court spent approximately US\$ 240 million on its beneficiaries, translating into US\$ 360 per capita of health expenditure.

An overview of the Egyptian programme was elaborated by Dr Hassan Nagi, including how it functions and what it aspires to achieve. The Programme of Treatment and Expenditure Statistics (PTES) is part of a bigger goal to provide health care services to cover the entirety of the population. The programme was established to insure those who are not covered by other forms of insurance. Those covered by PTES are entitled to treatment at all public hospitals in Egypt as well as outside of Egypt in some cases. In 2014, the programme issued 2 million decrees with a budget of EGP 2.5 million. Since the launch of the programme, the population covered increased to 30%, and patient costs have decreased significantly. Despite the progress made by PTES, there is still room for improvement and there are still more opportunities for health sector reform in Egypt.

The case of Lebanon was presented by Ms Hilda Harb, who presented important statistics about the demographic structure and the health system financing of Lebanon. In Lebanon, available schemes include the National Social Security Fund (NSSF), which covers all formal employees of the private sector, contractual employees of the public sector, teachers in private schools, taxi drivers, newspaper sellers and university students; the Civil Servants Cooperative, which covers public sector staff and their dependents; insurance for military and uniformed personnel; and private health insurance. The Ministry of Health acts as an insurer of last resort.

For those who are unemployed, self-employed, informally employed or, those having undeclared income are either covered based on their affiliation with another family member; covered under NSSF and pay a contribution calculated as a function of the minimum wage; or they simply are not covered and hence they are entitled to be covered by the Ministry of Health. It is debated that certain groups covered by NSSF (16% of those covered) were already considered informal workers based upon the definition of informal employment that is characterized by irregularity of income.

2.4 Global experiences in expanding coverage to the poor informal sector

Prof Barbara McPake, Director, The Nossal Institute for Global Health, University of Melbourne, Australia

Dr Volkan Cetinkaya, Health Economist, WHO EMRO

Dr Nishant Jain, Deputy Director Indo-German Social Security Programme, GIZ, New Delhi, India

Dr John Ele-Ojo Ataguba, Senior Lecturer, University of Cape Town, South Africa

Professor Barbara McPake commenced Day 2 discussions with an overview of the global experience of reaching out to the poor and vulnerable. She began by noting health care access is multidimensional and involves several parameters including, affordability, safety, timeliness and availability of services with good quality or capacity. With lower expenditure, these parameters may be difficult to reach. For example, safety and capacity of the facilities may be compromised. Including the poorest populations in strategies towards universal health coverage requires consideration of each access step:

- financial accessibility
- safety/quality
- capacity/service availability
- physical accessibility/timeliness.

Financial accessibility is important. It involves many possible interventions including, free public health services for all, free public health services for exempted groups, free inclusion in public/social health insurance and health cards for the poor. However, failure to address the service coverage dimension could compromise effective access.

Delivering quality services, ensuring physical accessibility and service availability requires a sustainable strategy. Dimensions of this strategy include governance, economic strength, workforce, continuity, coordination, comprehensiveness, system strength.

It is questionable whether some countries (such as Luxembourg and Korea) are rich enough to have sustainable health systems without a strong primary health care. Indeed, countries that have a strong platform of primary health care show results that are associated with improved access to expanded health care networks, sustained political commitment and economic growth. Examples are seen in Oman, Portugal, Chile and Malaysia are in stark contrast with countries that invest in universal health coverage but not primary health care like China and Indonesia.

In conclusion, the following key points are critical.

- Affordability is necessary but is an insufficient condition for coverage of the poor in universal health coverage.
- Safety and quality; capacity and service availability; physical access are where health systems for the poor usually break down.
- If services for the poor are poor services, use of an unregulated private sector and catastrophic payments result.

- A sustainable system is based on primary care.
- There is a need to moderate processes by which ‘money follows facilities’.
- Managing contribution of the private sector requires regulatory and governance capacities.

The example of Turkey in expanding financial protection for the informal sector and poor was presented by Dr Volkan Cetinkaya. Before Turkey’s health transformation programme in 2003, the health system was underachieving, fragmented and inefficient. In terms of financing, health system accounted for 3.5% of the GDP. There were clear gaps in coverage, inequitable benefit, high out-of-pocket expenditures (>25%) and catastrophic expenditures. In addition, effective services were lacking and there were gaps between coverage in the east and west as well as in rural vs. urban settings.

The Green Card programme in Turkey was established in 1992. It aimed to provide health services to the poor who are not covered through formal means of health insurance. It involved voluntary enrolment. However, identification and enrolment were unfair and complicated.

Green Card entitlements changed over time. Between 1992 and 2004, only inpatient treatment costs were covered. In 2004, it expanded to cover both outpatient and inpatient service. In 2005, outpatient drugs were included. In 2012, the Green Card programme was integrated into the universal health coverage scheme. In 2003, Green Card coverage had extended to only 2.5 million people when 19 million was classified as being poor. In 2011, the number of beneficiaries expanded to 10.2 million people while 11.8 million people was classified as poor. Thus, coverage had extended to be more inclusive over time.

It was clear that if people have to pay most of the cost out of their own pockets, the poor will be unable to obtain many of the services they need and even the rich will be exposed to financial hardship in the event of severe or long-term illness. Forms of financial risk protection that pool funds (through tax, other government revenues, and/or insurance contributions) to spread the financial risks of illness across the population, and allow for cross subsidy from rich to poor and from healthy to ill, increase access to both needed services and financial risk protection.

Key policy decisions towards universal health coverage in Turkey were made, including merging all public health insurance schemes under the Social Security Institution (SSI) including the Green Card, mandatory enrollment to SHI for all citizens, SSI becoming the single purchaser of services in the public health system, merging SSI and Ministry of Health hospitals, providing a fairly comprehensive benefit package and ensuring relatively low out-of-pocket payments (16.8% in 2013). The proportion of households with catastrophic health expenditure and the proportion of impoverished households due to health expenditure decreased markedly in the period between 2003 and 2012.

Among the many lessons learned from the experience of Turkey, it is clear that long-term fiscal projections are an essential component of planning for sustainable expansions of health coverage. As countries seek to expand the coverage and benefits provided by their

health systems under a global drive for universal health coverage, decisions taken today – whether by government or individuals – will have an impact tomorrow on public spending requirements. To understand the implications of these decisions and define needed policy reforms, long-term projections for public spending on health should be calculated, analysing different scenarios related to the population, risk factors, labour market participation and technological growth. In addition, the effects of different policy options and their potential knock-on effects on health expenditure were simulated. Finally, Turkey's experience in universal health coverage demonstrates that the public is the most important power to continue a reform initiative.

The experience of India in launching a health insurance scheme for the poor and the informal sector was presented by Dr Nishant Jain. In India, the government is both the financial and service provider in the health sector. The government spends only 1% of GDP on health. It is supposed to provide free health care to the population across India. However, the real case scenario is very different. People spend on average the equivalent of US\$ 100 even when they are hospitalized in a government hospital. Though the facilities are free per se, a lot of the expenditure is related to the medicines, diagnostic tests, food, transportation, etc. To take care of these expenditures people often have to borrow money or sell assets. Therefore, the government decided to launch a health insurance scheme: Rashtriya Swasthya Bima Yojana-Benefit Package.

It was decided that only hospitalization benefits would be provided, which meant that outpatient care would not be included. In addition, the hospitalization cover was defined with a ceiling per family per annum on a family floater basis. A family was also defined to consist of up to five family members. Maternity and newborn care were also covered. Furthermore, all pre-existing conditions were to be covered. Pre and post hospitalization expenses were covered and transport allowance was provided.

Since this scheme was to be fully subsidized by the government, the categories selected for coverage were also decided by the government and informal workers would be the target segment. However, due to data issues, the scheme initially started with Below Poverty Line (BPL) families as the target segment. Later on it was expanded to informal workers and many categories were also included in the scheme.

Since the scheme initially was only for poor, the government will fully fund the scheme. The premium per family would be shared between the federal and provincial government (75% federal, 25% provincial) and the equivalent of US\$ 0.5 would be charged every year per family as a registration/renewal fee. This would bring a sense of ownership among the families and simultaneously provide feedback. Government funding was fully tax-funded with no new taxes imposed on the population for health insurance.

In terms of governance, the federal government designed the scheme and prepared all the main guidelines and policies but implementation responsibility would be with the state government. Every state had to set up an autonomous body that would be responsible for implementation of the scheme. However, for implementation in the field, private insurance companies were hired through an open tendering process based on the lowest premium. Once

selected, the insurance company would be responsible for implementing the scheme with supervision of the government. Performance of the insurance company would be measured based on defined parameters and their contract could be renewed up to three years based on performance.

A strategy was put in place to target poor families. The number of poor families was identified through a means testing method. However, in some provinces, the government did a separate process of data collection to identify poor families. In the process of developing a BPL list, many challenges are faced. Central and state (province) governments differ on the number of poor families in the State. There are cases of wrong exclusion and inclusion. In addition, the list of poor families is not updated regularly. Migration of families poses a problem. In addition, family composition changes and is not usually updated.

A strategy was also placed to target informal families. The biggest challenge for the scheme was that a lot of poor families were left out due to issues in the BPL list. Furthermore, there were many other vulnerable families just above poverty line. Therefore such categories of workers that are vulnerable were added. This task was difficult because there was no list of various categories of workers available. Creating the list was also a challenge due to lack of documents. There was tremendous pressure for more categories to be included.

The state government set up an independent nodal agency to implement the scheme. In this case, the insurance company is selected through an open tendering process. A list of potential beneficiaries is prepared based on defined criteria for different categories. Insurance companies need to go to the field and enrol beneficiaries in the village after taking fingerprints and photos. A smart card is printed and given on the spot and a government representative authenticates it with fingerprint. A beneficiary can go to any public and private empanelled hospital and get cashless treatment through the smart card. Data flow every day from each hospital to the insurer and the government. There is a paperless claim settlement process for the hospitals. For enrolment, every beneficiary family that needs to get benefits under RSBY is required to enrol themselves in the scheme. The primary responsibility of the enrolment is of the insurance company. The insurance company is paid a premium based on the number of families enrolled so they have a business interest to enrol. A team goes to each village as per pre-defined schedule to take the photographs, biometrics and correct the data.

Regarding the purchasing of services, the insurance company is responsible for purchasing of services; both public and private hospitals are eligible. They are empanelled based on the defined criteria. For rural and interior areas criteria can be more flexible. A software system is installed in each empanelled hospital. Hospitals are paid based on package rates that are fixed by the government in advance. Every day, the claim data are sent electronically to a government server connected with hospitals. The insurance company pays claims electronically to the hospitals after verification.

As for service utilization, a sick family member would visit an empanelled hospital. The smart card and fingerprint is verified to ensure that beneficiary is eligible and they have money in their smart card. After verification, the beneficiary is admitted in the hospital if necessary. Treatment is provided free of cost and no money is charged from the patient.

Hospitals send the electronic claims data to insurance companies which then pay the hospital directly. To reach its objectives, RSBY takes advantage of many technologic advances such as biometric technology, smart card technology, and mobile technology among others.

The current status of RSBY implementation in India demonstrates that approximately 37.1 million cards have been issued, 119 million people are enrolled, 8.0 million people received benefits, 10 000 hospitals are enrolled and 17 insurance companies are involved. Beneficiaries have experienced several advantages. These include improved quality of services, reduction in out-of-pocket expenditure, improved access to health care and providing social identity. There is a state of healthy competition between public and private hospitals. Incentives have been put in place for staff of public hospitals from insurance money. Furthermore, there is an increase in the capacity of private hospitals and improvement in quality of services provided at the hospitals.

Many challenges remain. These include, beneficiary data preparation, improving enrollment, information dissemination, capacity building, early detection of fraud and abuse, improving health care quality, linking primary health care with inpatient benefits.

Key messages from the Indian experience are that if a country develops a reasonably good universal health coverage plan, it is better to start than to keep waiting for a “perfect” design. The private sector must be leveraged to complement government efforts. It is critical for the government to target poor and informal workers for whom cost will need to be borne by the government. Focus should be on ease of access for beneficiary rather than ease of implementation.

Dr John Ele-Ojo Ataguba then took the floor to introduce the tiered health system in South Africa. The public sector is funded largely through general tax revenues. Over 80% of the population is totally dependent on the sector. There is a three tier public hospital structure (tertiary, regional and district) in addition to a primary health care system. The public sector accounts for about 40% of total health care expenditure and less than 50% of both financial and human resources.

The private sector is largely financed through a private medical scheme (i.e. private health insurance). It serves (mainly) less than 20% of the population with private health insurance. It comprises a range of providers (general practitioners, specialists, pharmacies, private hospitals, etc.) It accounts for about 60% of total health care expenditure and more than 50% of both financial and human resources. Over 8% of GDP is spent on health services.

Since 1994, public health sector resourcing has been fairly stagnant. Expenditure in the private sector has increased substantially. Per capita private health expenditure is approximately 6 times that of public health expenditure. Historically, the apartheid era (1948–1994) witnessed a fragmented health system. There were different health departments and administration for different population groups.

In fact, there were separate public health facilities for the black and white populations. Health services for the black majority were heavily underfunded. Rural areas and homelands

were neglected. There were high levels of inequalities and inequities, the vulnerable population groups bearing a heavy burden. In the post-apartheid era, a formal constitution was adopted in 1996. One national and nine provincial health departments were developed. A decentralized system was established with public health sector restructuring. Primary health care received considerable significance. Official moves to address issues for the vulnerable population (and in fact for all South African residents) were made. Some initiatives were developed for the vulnerable groups, such as free maternal and child health care (1994), abolishing user fees for these services, development of a national school nutrition programme (1994), establishment of quintiles 1–3 public schools (primary and secondary) and free primary health care for all using the public health sector (1996).

In addition, public hospitals were heavily subsidized, and were basically free for the poor and vulnerable groups. A government employee medical scheme was established (2005) and was restricted to public sector employees. Government commitment to a national health insurance (NHI) was achieved in 2007.

A national health insurance plan was proposed. A plan with three 5-year phases was developed, creating a condition for efficient and equitable delivery of quality services, involving primary health care re-engineering, improving quality of health services delivered, addressing infrastructure deficiencies and availability of essential medicines etc., and improving management deficiencies while ensuring an efficient purchaser-provider split and establishing a NHI fund that is funded largely through general taxes. There were some concerns around national health insurance. For example, resource constraints were an outstanding issue, financial sustainability (affordability) and human resource shortages along with opposition from certain groups.

Currently, public primary health services are free for all in South Africa. Public hospital services are heavily subsidized for the poor and vulnerable. Consequently, public primary health services benefit the poor more in South Africa (i.e. pro-poor). Both inpatient and outpatient services are available. However, higher level public health services benefit the rich more than the poor and vulnerable. The burden of diseases is still higher among the poor than among the non-poor in South Africa. Health inequalities are to the disadvantage of the poor and there is a need for increased public health funding and commitment to the ideals of universal health coverage.

2.5 Using social health insurance to expand coverage to the poor informal sector

Mr Mostafa Chouitar, Chief, Division of Planning & Studies, Ministry of Health, Morocco

Dr Sofiene Manaii, Ministry of Health Tunisia, Tunisia

Dr Mahgoub Abd Elrahim, Director of UC, National Health Insurance Fund, Sudan

Mr Mostafa Chouitar outlined the road towards inclusion of the poor and needy in Morocco, and the country's experience in implementing RAMED (Le Régime d'Assistance Médicale).

There are five axes for the plan in 2015:

- improving the management of the beneficiaries;
- establishing National Integrated Management Information System and dedicated to RAMED (SNIGI-RAMED);
- introducing a priori control to ensure reliable statements and the fight against fraud;
- identifying prerequisites and accompanying measures for the establishment of the agency manager RAMED; and
- other actions to improve the governance of the scheme.

RAMED is a social development tool. It provides easy access to care for more than 8.5 million disadvantaged. It is an opportunity for the public health sector to improve its funding and the best way to fight against poverty and social exclusion.

Tunisia's AMG (L'assistance medicale gratuite en Tunisie) was then introduced and elaborated on by Dr Sofiene Manaii. The objective of the programme is to provide access to health care for needy and low-income families who cannot afford health insurance. There are two benefit packages involved, one of which is totally free (AMG I) and another that entails reduced fees (AMG II); benefits provided by both packages are provided through public facilities. Eligibility for AMG I is based either on the economic criterion of individual income not exceeding the poverty line (approximately US\$ 300 per person per year), or social criteria such as an individual's inability to work, poor living conditions, lack of family support, disabilities and chronic illnesses. On the other hand, AMG II requires that individuals be non-affiliated and ineligible for social security, and that annual family income must be less than or equal to the minimum wage for a family of 1 to 2 persons, less than or equal to 1.5 times the minimum wage for a family of 3 to 5 persons, and less than or equal to 2 times the minimum wage for a family of 5 persons or more.

Those covered by the scheme are the beneficiary, their spouse and their dependent children. To apply for AMG, the candidate must submit a request to local services for social assistance, who will then look into the candidate's economic and social positions and relay the information to a regional commission. If eligible, the participant will then be granted a health card that is valid for 5 years of care under either AMG I or AMG II. The programme is largely financed through the Ministry of Social Affairs in conjunction with the Ministry of Finance. In 2014, 2 508 000 were covered by AMG, a 4.5% increase from 2013. Nevertheless, most of the population (68%) is covered by CNAM (Caisse nationale d'assurance-maladie), 16% is covered by AMG II, 8% is covered by AMG I while 8% of the population remains uncovered. Despite the success of the programme, certain limitations exist. With regards to the rationing of health care cards, the use of quotas does not necessarily reflect the needs and profile of poverty in a region and there is a lack of regular monitoring and ongoing evolution of the economic situation of households. With regards to the rationing of care in public hospitals, there is a lack of access to certain drugs and implantable devices such as knee prostheses and ocular implants.

The experience of Sudan in using the Zakat fund to expand health insurance coverage to the informal poor families was shared by Dr Mahgoub Abdel Rahim. NHIF is a solidarity organization committed to securing good quality of health services to beneficiaries with fairness and sustainability.

In Sudan, the unemployment rate for individuals aged 15 years and above is 24.5%. Also, 46 % of the population live below the poverty line (baseline survey 2009) and two-thirds of the population aged 10 years or above is literate. Secession of South Sudan marked a watershed in the economy. Sudan lost 75% of its oil production capacity. Furthermore, there are economic sanctions, a large international debt, ongoing conflict in Darfur with an effect on inflation and difficulties that have reflected on the health care system.

The health system in Sudan has three tiers consistent with the political structure of the country: federal, state and locality. The health delivery system is based on the district approach that emphasizes the role of the primary health care. There is a general tendency towards the use of public health facilities when seeking health care.

Financing of the health system in Sudan evolved gradually over time. Since independence in 1956, the health care was provided free of charge and was financed through government revenues and taxes. To alleviate the negative effect of user fees, the country introduced compulsory health insurance for public and private formal sector in 1995. SHI in Sudan (now called NHIF) was launched in 1994 with the aim of increasing revenues, helping to target public sector subsidies for the poor, promoting equitable and sustainable access to health services and improving the quality of curative medical services. It was important to safeguard health service users, people and households, especially the poor, against the implication of the market liberation policy embarked on by the Sudanese government to reform the national economy of the country.

The national health insurance system is mandatory for public and private sectors and pensioners (government subsidization). The unit of enrollment is the family regardless of the family size or health status (solidarity). The insurance card gives the privilege to receive treatment across the borders of the different states of the country (national card). There is a unified benefit package for all categories of subscribers. The NHIF beneficiaries are only charged 25% of the cost of any prescribed drugs and the medicine list includes 602 items.

The zakat is one of the five pillars of Islam. It means purity and development, it is obligatory for every sane, mature and financially capable Muslim. Since the first era of Islam and until the collapse of the Ottoman Empire, zakat management was basically state responsibility. The Zakat Chamber of Sudan (SZC) Supreme Council of Trustees sets zakat collection and distribution policies, monitors and holds accountable the executive departments of SZC. A Fatwa Committee monitors and ensures all SZC operations are in accordance with *sharia*. It comprises distinguished scholars. The SZC administrative and executive body (State branches) works to implement the policies, plans and programmes approved by SZC Supreme Council of Trustees. There are 167 zakat offices with grass-root zakat committees, spread in all villages and neighbourhoods. There are 20 000 committees, and members of each committee are well known for *taqwa* (piety). It is normally headed by the imam of the neighbourhood or village mosque.

Zakat has social and economic dimensions. Its legislation is associated with the achievement of social justice, economic development and poverty alleviation, whereby the rich spend part of their money on the poor and the needy to secure food and treat their illness

and provide tools for increasing their productivity. This enables the poor and needy families to settle and improve their productivity to move out of the poverty trap. The payer feels satisfaction and pleasure because he or she does a religious duty voluntarily. One knows that the amount of zakat is decided by *sharia*, so there are no doubts in one's mind as to how his or her zakat is calculated. This generally strengthens the social fabric and the redistribution of wealth.

The zakat system meets the criteria laid down for social security programmes. It provides a regular income to meet the needs of specific poor groups provides aggregated and stable resources have with less susceptibility to swing in conditions of adverse economic changes because zakat is based on a broad base of funds. The income redistribution through zakat makes the financial burden on the zakat-payer less than in the case of taxes because zakat covers a broader kind of property than taxes. Zakat is used to pay the medical expenses for the poor through an office located in big hospitals. It is also used to provide health insurance for poor families and to fund major health projects. In 2004, attention was given to health insurance as a mechanism to provide the service to poor families and 54 926 of the poor families were covered by medical insurance.

A frame protocol was signed in Khartoum in March 2009 between the General Secretariat of Zakat Chamber and the National Fund of Medical Insurance, providing medical services for the families and individuals in all states of Sudan. The number of families to be covered reached to 469 780 households. The participating amount started from SDG 8 in 2004 until it reached SDG 35 in 2014 for each family. Surveillance was done by zakat and through the grass-root committees to identify the poor families (2.3 million families). Various mechanisms to mitigate poverty were implemented, including cash transfer, micro finance and health insurance cards. 1.4 million poor families were covered by the end of June 2015. NHIF agreed upon a strategic plan to reach universal health coverage by health insurance by the end of 2020. Accordingly, the number of poor families to be covered annually starting from 2015 is 272 019.

2.6 Closing the gap in population coverage in the Region: addressing special groups

Dr Mariam Aljahma, Assistant Undersecretary for Primary Care & Public Health, Ministry of Health, Bahrain

Mr Jan Schmitz-Huebsch, Director, Business Development and Projects, Munich Health Daman Holding, Abu Dhabi, United Arab Emirates

Dr Haidar Saeed Al Yousuf, Director, Health Funding Department, Dubai Health Authority, United Arab Emirates

Dr Abdulwahab Alkhamis, Saudi Arabia

Dr Mariam Aljahma started the session with some demographics on Bahrain's population. The percentage of Bahrainis was 49% and non-Bahraini 51%. The crude birth rate was 15.6 per 1000 population and the population growth rate was 5.8% (Central Informatics Organization, 2011 and 2012). GDP per capita is US\$ 24 763.3 and health expenditure accounts for 4.9% of GDP. Similar to other GCC countries, Bahrain has a relatively young population with two thirds of its residents being in the age group of 15–64 years; a noticeable increase in this category has been in the working-age group of non-Bahrainis.

The Government of Bahrain is fully committed to the policy that all residents in the country should enjoy the right to access comprehensive health care.

This implies a determination to provide integrated preventive and curative health services through a network of primary, secondary and tertiary health care facilities. The technical and financial responsibility for providing this care lies mainly with the Ministry of Health with coordination of other ministries, private sector facilities and the community. Comprehensive health services are provided to the whole population in line with WHO global objectives. The Ministry of Health took all the burden of planning; providing free health services for all population (national and residents) in the country and ensuring that everyone has access to a high quality, responsive health service throughout their lifetime; with a very limited but growing participation from the private sectors. The Minister of Health is a member of the Council of Ministers chaired by the Prime Minister, as well as a member of the Health Supreme Council. The council is responsible for developing a national health strategy, following up on its implementation and setting health care policies in the country. A royal decree formulated the national health regulatory authority in 2009. Its main responsibility is licensing and regulation of health care professionals, health care facilities and drugs in Bahrain.

Investment in human resources has been always considered important in the Ministry of Health. The training budgets over the past 5 years have been in excess of US\$ 10 million per year. Furthermore, Bahrain boasts a modern, technologically advanced and comprehensive health care system with an adequate number of qualified Bahraini doctors many of whom have studied abroad and returned home to practice. Bahrain has four medical universities: the Arabian Gulf University, the Royal College of Surgeons of Ireland, the College of Health Science at University of Bahrain and AMA International University.

The Health Information Directorate was established with the main focus of developing an automated system that will enable the management of various support functions and all socio-medical information related to patients. In addition to organizing information in a database for availability when and where required, the Health Information Directorate also has responsibility for statistical analysis and reporting of health data in the country. It has explored several possible approaches in the development of automated patient care and support services for the Ministry of Health.

On February 2011 Ministry of Health signed a contract for the implementation of Health Information Systems (I-SEHA). The success of this initiative is a crucial and strategic step toward an effective and an efficient work environment that will create a national electronic health record and lead to an improvement in the health services.

The journey of expanding coverage to expatriates started in a phase from 1976–2011. Household workers paid US\$ 4–8 per visit to a primary health care centre. The fees included consultation, investigation and medicines. Workers in companies with less than 50 employees paid US\$ 4–8 per visit to a primary health care centre. Expatriates working in the government were exempted from the fees. Only Companies with more than 50 employees were enrolled in the social health insurance provided by the ministry of health, with annual fees of US\$ 159 for

non-Bahrainis and US\$ 47.6 for Bahrainis. These fees included primary health care only. The disadvantage of this scheme was that there was no financial protection and the lack of access to the same range of high quality health services. From 2012–2015, household workers still paid 8 US\$ per visit to primary health care centres. Expatriates working in the government are exempted from the fees. The cabinet has raised the fees of social health insurance from US\$ 152 to US\$ 190 and from US\$ 47.6 to US\$ 58 for Bahrainis. Under the new labour law, the employer undertakes to provide the basic health care for his workers, regardless of their number, in accordance with the regulation issued by virtue of a decision of the Minister of Health in agreement with the Minister of Labour.

Several challenges face health care financing in Bahrain. These include high cost of human resources, high cost of medicines, aging and increase in noncommunicable diseases, improper utilization and a general increase in the cost of health care. The current health scheme offers several advantages, ensures financial protection and access to the same range of essential health services and additionally reduces out-of-pocket expenditure. Its disadvantages, however, include that it does not include all expatriates, covers only primary care, does not include Bahraini labours in the private sector and does not provide immediate coverage for all employees equal because it is linked to the time of renewal.

In an attempt to move towards universal health coverage, Bahrain is examining options to initiate reforms in the health sector. Options include the introduction of a new mandatory national health insurance scheme, a redesigned and integrated HMIS, a phased plan to implement provider autonomy in the public sector health facilities. The goal is to improve the fiscal sustainability, efficiency, equity, service quality, transparency, and accountability of the Bahraini health system. Three categories of reform options were modelled: one that maintains the status quo and adds some reforms, a second where more social health insurance models are introduced and a third where private health insurance models are emphasized. Social and economic impacts of each model are studied.

Mr Jan Schmitz-Huebsch delivered a presentation on the experience of Daman in building resilient national health finance systems in Abu Dhabi. It was noted that funding health budgets and paying for health care services are central to any health care system. Questions as to where money to fund the health care system comes from, through which contribution mechanisms and which organizations are involved in the pooling of funds and distributing them to providers via payment mechanisms are fundamental to the health systems framework. Dr Schmitz-Huebsch indicated that mandatory health insurance is an important enabler for universal health coverage, which is a main driver for economic development and political stability. Daman in Abu Dhabi is a successful example for achieving universal health coverage through a public–private partnership (PPP). Munich Health owns a 20% share in the programme while the government of Abu Dhabi owns 80%.

As the national health insurance company, Daman is a core element in Abu Dhabi's health system. The vision of the Health Authority of Abu Dhabi encompasses a patient dimension, whereby everyone has access to health care and freedom to choose their provider; a provider dimension in which there exists an open system for all certified providers of health services delivers world-class quality care and outcomes in compliance with the highest

international standards; and a payer dimension, whereby the health system finances itself through mandatory health insurance for all citizens and residents, with Daman being the national health insurance company. The rollout of the partnership happened over several phases and took 3 years until full implementation. Ensuring the right capabilities, expertise and alignment of stakeholders have been essential for Abu Dhabi's mandatory insurance plan. Key success factors in Abu Dhabi's mandatory insurance plan include a clear regulatory strategy and vision, political support and leadership, governance in the PPP model and aspiration to innovate technology and processes in the health system.

The involvement of the private sector in partnerships in developing countries can be exhibited in different roles ranging from analysis, concept development, formation of a detailed operating model, implementation and steady state operations.

In Dubai, the implementation of health insurance does not relate only to health coverage, but rather it entails a restructuring of the health system through the restructuring of health system financing and the introduction of performance, quality and reliability indicators to reduce waste within the system, increase efficiency and guarantee optimum utilization of resources.

Dr Haidar Saeed Al Yousuf briefly touched upon the general objectives of the health insurance law and system which include:

- provisioning an integrated high quality health care service and responding to the aspirations of the beneficiary system;
- creating a niche in the field of health and enhancing their competitiveness both locally and internationally;
- ensuring health security for citizens and residents to bring happiness to the members of the community and enhancing productivity; and
- attracting investment and best international expertise to the health sector in Dubai

The portal for health insurance claims for Dubai is a platform that utilizes medical uniform language for all health transactions in the emirate. It is a unified communication mechanism through which all data is addressed in a uniform manner through a single system. There are 23 smart specialized services to support the health insurance system. Electronic claims are the infrastructure of the health insurance system in Dubai. Since 2012, all health care providers and providers of health insurance services have been trained to deal with electronic claims, and all health insurance transactions in the emirate have been converted from paper to electronic and standardized global language. This integrated electronic system puts Dubai at the forefront of health insurance systems globally in terms of method of administration, organization and the availability of necessary health information for planning on scientific grounds.

The "Sa'ada" programme is a health insurance programme serving citizens in the Emirate of Dubai and emphasizing the need to work towards bringing happiness to people through the provision of all health choices for citizens and the prioritization of their health and happiness. The programme is the first programme that uses the national identity card as a

health insurance card used to register for the programme through the smart application, and then allows beneficiaries to take advantage of all the services provided by the programme within a large network of outstanding health services providers; those who committed themselves to the standards and requirements of the programme. The programme has been designed to cover the citizens who do not currently benefit from any insurance coverage of the Government of Dubai and the programme will be launched in several stages, expected to cover 130 000 people.

Dr Abdul Wahab Khamis commenced his presentation on expanding coverage to the expatriate population in Saudi Arabia with an overview of statistics and characteristics about the country and its demographic structure, which is characterized by an expatriate population of 33% of the total population. Saudi Arabia's Compulsory Employment Based Health Insurance (CEBHI) was introduced to all expatriate employees in November 2008, after strains on the health care system arose due to the increase in demand for health care, the shift in disease patterns from curable diseases to chronic ones such as diabetes, hypertension and high cholesterol, increased awareness on the importance of health care, and an increase in the demand and utilization of Ministry of Health hospitals particularly by the expatriate population.

CEBHI was designed to increase expatriates' access to private health care services, to mitigate demand on government health care services and to help the government guarantee equitable access to health care for all residents. It is mandatory, covers all employees and their families and entails a unified basic health package. Approximately 11 million Saudi nationals and non-Saudis (38% of the population) are covered by CEBHI. As of 2013, the Ministry of Health owns 60%, the private sector owns 22% while other governmental sectors own 18% of hospital beds. The government encourages initiatives to increase investment in private health care sector by providing loans without interest up to US\$ 66.7 million. The private health care sector is expected to add more than 11 000 beds between 2012 and 2016. Nonetheless, CEBHI continues to face certain challenges, particularly in the realm of limited private health care providers as well as the underdevelopment of the insurance industry.

2.7 Ensuring equity in expanding population coverage – going beyond health financing

Prof Rita Giacaman, Birzeit University, Palestine

Prof Orielle Solar, Researcher, Flasco Chile, Chile

Prof Ali Ghufron Mukti, former vice Minister for Health, Indonesia

Dr Akihiro Seita, Special Representative and Director of Health, UNRWA

Dr Hany Fares, Public Health Officer, UNHCR

Dr Zeinab Khadr, Director, Cairo Demographic Center, Egypt

Dr Shakil Ahmed, Senior Technical Advisor, Nossal Institute for Global Health, Univ. of Melbourne, Australia

2.7.1 Palestinian Refugees: the work of UNRWA

Palestinian refugees account for a total of 5 million. Providing universal health coverage for this highly vulnerable population is a major challenge. UNRWA (United Nations Relief and Works Agency for Palestine Refugees in the Near East) is probably the largest UN agency

providing services for Palestinian refugees. Various services provided include services in education, health infrastructure, administrative support as well as relief. Based completely on voluntary contribution, UNRWA strives to compensate for budget gaps with the assistance of Member States. The health budget in 2015 amounted to US\$ 111 million and the per capita health expenditure was US \$36. Striving towards achieving universal health coverage for its beneficiaries located in Jordan, Lebanon, Palestine and the Syrian Arab Republic, UNRWA took several steps including, identifying the major health burden for Palestinian refugees, and following the burden of noncommunicable diseases as well as infant mortality rate over time. In addition, UNRWA initiated modifying the service delivery pattern at primary health care level, with a focus on family medicine and a family team approach. In the past, primary health care was disease-specific. UNRWA has also focused on improving quality of services, with a patient satisfaction rate reaching 80–90%, reflecting such improvement. This involved training of doctors overseas and introduction of e-health and electronic medical record systems. While initial results are encouraging, it is recognized that there is yet a long way to go in this regard. UNRWA has also strengthened partnerships with countries and international organizations, bought supplies from India to meet the defect and addressed health insurance and health care financing for this population. UNRWA has addressed hospital care needs, with a focus on improving efficiency of care delivery. It has also succeeded in providing donor-funded, free-of-charge primary health care.

2.7.2 The experience of Indonesia in providing coverage for the poor and informal sector

Indonesia represents an archipelago between Asia and Australia, with over 17 000 island, 497 districts and a total population of over 240 million. The GDP is US\$ 4200 (2012). 66% of the population is in the informal sector. There are 2100 hospitals (public and private) and the ratio of physicians to population is 1:3000. In 2013, the population health insurance coverage was reported to be 72%. A decade ago, the situation in Indonesia was different. The health insurance coverage was 11% and there was around 70% out-of-pocket expenditure.

There were major milestones in the path towards universal health coverage, including introduction of the Civil Servant Benefit Scheme (ASKES) in 1969, development of a health card in the early 1970s, introduction of a managed care system (JPKM) in the early 1990s, application of social security for formal sector employees (JAMSOSTEK) in 1992 and implementation of a social safety net programme for health following the economic crisis in 1998.

In 2004, Indonesia enacted the National Social Security System Law and in 2005, The Health Insurance for the Poor Programme was introduced, covering 76.4 million people. Local government health insurance initiatives started to expand in 2008, a prospective provider payment system was implemented. In 2010, Jampersal (health insurance for pregnancy and delivery) was introduced and in 2011, the Act on Health Insurance Carriers was declared and was implemented in 2014 with the main objective of merging several schemes into one.

The scenario of integration from existing management to the social security health carrier system described above required several action steps. In the first phase, the existing

Jamkesmas programme, civil servant, police and military health services were integrated and managed by the social security health carrier, Askes. Subsequently, the health programme in Jamsostek scheme was integrated to the social security health carrier. The Jamkesda programme was to be followed by informal sector integration into the scheme. The second phase involved the development of a workman security programme that was to be started on 1 July 2015.

Important issues in expanding universal health coverage included defining the informal sector, identifying the line characterizing the poor and near poor, financing and subsidies for the uncovered, obtaining information, providing education and public empowerment, ensuring convenience in the process of enrollment and flexible payment options and using pilot studies to guide implementation. In addition, collaboration with different levels of government was to be addressed. It was essential that emphasis was made on administrative costs and the impact on financial protection, productivity and on macro-growth. It is hoped that by 2019 all Indonesian citizens are eligible for Jaminan Kesehatan Nasional.

The recommendations derived from the Indonesian experience include the following.

- Strong leadership and political commitment are key to success.
- Comparative studies should be facilitated to assist policy makers in understanding the situation and making the best possible decisions.
- Education, advocacy and public debate are critical.
- Laws and regulations that guide the health insurance process in accordance with universal health coverage are to be developed.
- Covering civil servants, the poor and informal sector is essential.
- A basic benefit package should be wisely considered.
- It is critical to develop an appropriate infrastructure and provide adequate human resources that would support universal health coverage.

The aspects of quality, efficiency and accessibility should be adequately mounted in a health coverage programme.

2.7.3 Expanding informal workers' coverage as a prerequisite to ensure equity in universal health coverage

The Health Inequalities and Access to Social Security for Informal Workers in Latin America, Africa and Asia Project has the main objective to develop a global baseline of data and knowledge on the health of informal workers and their access to health and social security systems in order to illustrate entry points for action toward expanding universal health coverage. To achieve this objective, data analysis of country surveys from 15 Latin American, 6 Asian and 6 African countries and 22 case studies were examined. In addition, a mapping exercise was performed on key actors and interventions in 3 regions.

Informal sector workers are vulnerable for many reasons. Such reasons include the lack of control of the hazardous conditions of their employment, insecurity surrounding their

employment status which leads to a lack of control over their income, lack of protection against exploitation and discrimination and the likely risk to be poor or fall down on poverty.

The majority of workers in Asia (78.2%), Latin America (57%) and Africa (55.7%), are employed in the informal sector. For many countries of low and middle income, these trends have not changed in the last 20 years. Informal workers are heterogeneous, informality is present among all income quartiles and educational levels, across different economic activities and occupations, in both the formal and informal sector and across all status in employment categories. This heterogeneity implies that health needs and risks faced by informal workers are also diverse. Moving towards universal health coverage requires actions to expand health coverage to informal workers, taking into consideration their heterogeneity.

Most health systems do not take into account the conditions of work of informal workers. There are very few experiences where occupational health has been introduced as a right for informal workers. Also, the lack of programmes for payment of sick and maternity leave for informal workers acts as an important barrier since informal workers' incomes depends on their capacity to work. Information is fundamental to include key indicators in national surveys that provide information on informal workers' health status and equity in access.

2.7.4 Generating evidence on equity to inform expanding population coverage

The Right to Health approach puts the most disadvantaged and vulnerable communities at the centre of the health sector response. This approach is crucial to improve health sector performance through promotion of availability, accessibility, acceptability and good quality of the services with people centred focus. Furthermore, promoting the principles of a right-based approach in health system functions (accountability, transparency, effective participation, respect, equity and ethics) with priority being given to the disadvantaged, marginalized and vulnerable populations is a prerequisite towards achieving universal health coverage, securing social protection in line with international, regional and national commitments.

Generating evidence is important for monitoring health equity, in-depth research and creating a repository of relevant international and regional experiences. Monitoring health equity and its social determinants is an essential and strategic tool in influencing any policy including universal health coverage. Ongoing assessment of the combined impact of current policies, interventions and programmes on health and on its social determinants can provide policy-makers with early warning signals to review or amend these policies. Monitoring can provide policy makers with an overview of the general situation, identify issues and raise questions for further investigations. Monitoring should adhere to the standard scientific criteria, but it further needs to have clear policy relevance and be simple, affordable, sustainable and timely. Monitoring is explicitly intended to have practical relevance for policy-making in the shorter term.

Steps in building a basic monitoring system involve identification of social groups of a priori concern, identification of major avoidable health disparities among social groups and identification of sources of data and relevant indicators to describe health status and its trend

overtime. It uses simple descriptive summary measures, namely absolute and relative inequity and it relies on the currently available data as a starting point rather than engaging in new data production. A comprehensive health equity surveillance system adopts a wider range of health measures and goes beyond the four broad categories of the traditional social stratifiers. It examines the effects of multiple complex stratifiers. Besides the basic health information, it incorporates data on important social determinants of health along the causal pathway, ranging from daily living conditions to more structural drivers of health inequities. Such surveillance system needs to allow for building time trends for health, consequences of ill health and their social determinants for the different social strata and by gender. In addition to simple measures of health inequity, it should include more complex measures of health inequity that capture the distribution of health across the social and regional groups of population.

Monitoring raises questions for further investigation, but it will not explain the causes of widening, stagnant or narrowing gaps. More complex methodological and explanatory research is needed to guide and complement the simpler approaches suitable for ongoing monitoring. It is important to structure a repository of systematic reviews and policy analysis of current policies in the international and regional arena. These repositories allows the extraction of valuable lessons from current experiences through identifying the factors that hinder, or conversely, contribute to achieving the full potential of the policies and evaluating the role of various policy actors. This repository of research is intended to generate the necessary political awareness for evidence-based experience and should aid in the development of future policies.

Health can be construed broadly to encompass indicators of all measurable aspects of health and the health sector. WHO's monitoring, evaluation and review framework organizes health indicators into four components. Within each component various categories of indicators are defined that allow the measurement of health at many levels. Indicators of inputs and processes are broad, affecting many other parts of the health sector. Indicators that fall under outputs and outcomes tend to be quite specific to a particular health topic and may respond quickly to changes and progress in the health sector. Impact indicators, which are slower to respond to policy, programme and practice changes, are important to provide a snapshot of the health of a population.

The components of the monitoring, evaluation and review framework can also be loosely linked to the type of data that is used. Outcomes and impact indicators tend to be calculated using individual-or household-level data. Inputs and processes or outputs are often calculated using subnational-level data. Certain input and process indicators, such as total health expenditure, are calculated at the national level. The monitoring of expansive health topics requires a broad range of health indicators from each component of the monitoring, evaluation and review framework to represent the entire continuum of health services within that topic. For example, the global movement towards equitable universal health coverage – a broad and ambitious agenda – relies on health monitoring of many diverse aspects of health. The package of indicators to measure progress towards universal health coverage will be strengthened by the inclusion of all relevant health indicators for which reliable data are available. For narrowly-focused or disease-specific health monitoring, certain input and

process indicators may be less relevant. Monitoring for a single disease such as malaria may not cover indicators such as governance and financing of the health care system, which are related to all health topics but only peripherally related to malaria. It may be appropriate to look more closely at certain outputs and outcome components that contain a number of health indicators that are highly relevant to malaria (for example, health service indicators can be subdivided into categories of malaria treatment indicators, malaria prevention indicators, and so on). It would also be appropriate to include relevant impact indicators, such as malaria incidence rate.

Many dimensions of health inequality should be covered by the selected equity stratifiers. Ideally, health inequality should be analysed and reported using every relevant dimension with available stratifying data. Historically, the greatest emphasis has been placed on health inequality by economic status, and many analyses of health inequality include only wealth-based inequality. However, there are many other policy-relevant equity stratifiers to describe health inequality, including education, social class, sex, province or district, place of residence (rural or urban), race or ethnic background, and any other characteristic that can distinguish population minority subgroups (for example, language, immigrant status). Equity stratifiers should have relevance within the population. Criteria to define subgroups depend on data collection, data availability and population characteristics.

Benchmarking is a crucial part of monitoring. External benchmarking assesses performance based on normative international or national standards, e.g. MDGs or national health objectives. Internal benchmarking assesses performance locally based on its previous performance by plotting progress within a time period.

2.7.5 Health care integration and alternative health financing: perspective for refugees operations in UNHCR

The basis on which the system is built is that of health as a human right. Refugees should enjoy access to health services equivalent to that of the host population and under all circumstances, these services must meet minimum humanitarian standards. Wherever national health service delivery programmes are available and accessible, these are chosen in preference to setting up parallel systems for refugees in order to ensure sustainability, value-for-money and equal access to comprehensive essential health services.

The strategic objectives for the period from 2014–2018 are to:

- improve access to quality primary health care programmes;
- decrease morbidity from communicable diseases and epidemics;
- improve childhood survival;
- facilitate access to integrated prevention and control of noncommunicable diseases, including mental health services;
- ensure rational access to specialist referral care; and
- ensure integration into national services and explore health financing mechanisms from the context of refugees.

There are several prerequisites for health insurance. Health insurance schemes must be open and non-discriminatory to all members of the community, including those with medical pre-conditions. In addition, health insurance schemes must be combined with mechanisms to financially protect vulnerable persons to access health services. Clear and objective eligibility criteria are required and health services should be available free-of-charge (primary health care, maternal and child health, HIV, tuberculosis etc.).

Many lessons have been learnt over time, including the following.

- Health insurance schemes for refugees should be strategically implemented where and when national health systems facilitate the integration.
- Communities' informed consent ensures buy-in and continuous contribution.
- Enrollment should be binding and if necessary contingent with other modes of assistance (health, financial).
- Insurance schemes cannot be co-implemented with parallel health services or reimbursement models for health care.
- Insurance schemes cannot be targeted at vulnerable individuals only.

There are also many challenges. The concept of refugees paying for their health insurance premium is somewhat counter-intuitive to the objectives of UNHCR. Also, health insurance schemes are bound to fail if not communicated well to and supported by refugees. Refugees need livelihood opportunities and self-reliance to sustain premium payment. Refugee-only health insurance schemes require long-term financial substitution (by UNHCR). Integrating refugees into existing insurance schemes is more effective.

Health insurance requires a fundamental change of mind set of the community. We need to advocate for access to social protection and there is a crucial requirement to understand and use the concept of shared risk. It is important, though, that vulnerable groups are not targeted alone. It is essential to focus on prevention of vulnerability and to make enrollment binding and contingent wherever possible. Some countries are advancing their legislation and systems to provide comprehensive social security and health coverage under some form of contribution mechanism. Countries such as the Islamic Republic of Iran, Ghana and Nigeria are well advanced. Countries such as Cambodia, Malaysia, Morocco, and Tunisia are progressing and others such as Thailand offer health insurance to migrants. Countries in west, central and southern Africa, with a small stable refugee population, offer opportunities for integrating refugees into the national health system and health insurance framework.

2.7.6 Demand-side financing and its role in achieving universal health coverage

Demand-side financing schemes implicate subsidies that are either consumer-led, such as conditional cash transfer, vouchers and health equity funds, or provider-led in the form of capitation or reimbursement before or after service delivery typically on a contractual basis. It is undeniable that most countries still have a long way to go to achieve universal health coverage, partially due to the presence of a large informal sector that is difficult to include under social health insurance or tax revenue financing schemes. Demand-side financing can hence be a useful tool for coverage of selected services for target population groups such as

the poor or informal sector. The example of Cambodia was presented to illustrate how cooperation between the Cambodian government, nongovernmental organizations and development partners resulted in the creation of a health equity fund for the poor and the informal sector which, together, comprise 80% of the population.

The implementation of demand-side financing schemes has been shown to drive health-seeking behaviour in beneficiaries and increased utilization of health services including immunization, sexually transmitted diseases, maternal and child health care services. Meanwhile, no evidence exists to show that competitive arrangements provide better quality of services than demand-side financing schemes, especially those that involve producer-led subsidies. Slight but effective steps can be taken to further enhance quality of services; for example, Bangladesh, Egypt and Rwanda are examples of countries where the implementation of a monitoring system and provision of awards to health care providers helped improve the quality of health care services provided under similar schemes. Similarly, by linking subsidies with output, major efficiency gains are likely to be recognized. In Nicaragua, for example, vouchers for the treatment of sexually transmitted diseases have been found to be highly cost-effective. Demand-side financing schemes have also been shown to reduce socioeconomic disparities in access to certain health services in countries such as Bangladesh and Pakistan. However, this is dependent to a large extent on prior existence of effective population targeting mechanisms. Tanzania and Bangladesh have had successful experiences in significantly reducing out-of-pocket expenditure with the implementation of demand-side financing schemes.

Demand-side financing shows several advantages, including the potential to target subsidies, provide greater choice for users and empower users. Provider payment is linked with performance, which promotes competition among providers. It tends to improve health seeking behaviour, equity, efficiency and quality of care. However, there are some disadvantages that come with demand-side financing. The set-up is complex, administrative cost of the management agency is expensive and it imposes an increased workload on strained workforce. There are side effects for providing an incentive for providers, such as falsification of number of services provided and neglect of services that are not linked to remuneration. There is also the potential for corruption and the possibility of over-prescribing services (such as Caesarean section).

There is a requirement for several technical, as well as political improvements that would ensure the efficiency of use of demand-side financing. Thus, a strong political will is critical for financial sustainability. Timely disbursement of funds to providers and beneficiaries is essential. The health system must demonstrate readiness to meet increased demand (in terms of quality of care, human resources, and drugs). The administration is required to demonstrate transparency to expose fraud and corruption, efficiency in the distribution of incentives, financial management of the scheme, effective communication of policies to implementers and the public. The duration and sustainability of the scheme, as well as socio-cultural beliefs, motivations, and level of health awareness should be seriously considered.

Demand-side financing schemes increase demand for health services and availability of services affect demand under demand-side schemes positively or negatively. Countries wishing to implement demand-side financing schemes must strengthen health systems, including improvement of health infrastructure and human resources management. Inadequate service delivery will demotivate beneficiaries from health seeking and limit access to care. Implementation of demand-side financing schemes can play a significant role in health systems strengthening.

Prior to implementation of demand-side financing, the following steps are suggested for group 2 and 3 countries.

- Identify financial barriers to access to particular health services. This can be done through analysis of existing data or primary data.
- Develop strong policies if a financing intervention is needed to overcome financial barriers.
- Discuss with key stakeholders to determine whether a demand-side financing scheme is appropriate. All stakeholders should be involved in the design phase.
- Conduct a feasibility study and a well-designed pilot programme to inform potential scale-up.
- Create institutional arrangements for effective implementation of policies and development of systems (identifying beneficiaries, design benefit coverage, communicating schemes, managing funds and monitoring).
- Ensure selection criteria for intended beneficiaries are contextually appropriate.
- Include services in the benefit package that are underutilized by the target group for financial reasons.
- Ensure adequate administration and financial resources are in place for timely processing and implementation.
- Create incentives to motivate health care providers.
- Expand the service delivery capacity of health facilities.
- Institute effective regulations and accreditation procedures in order to involve the private sector in competitive demand-side financing implementation arrangements.
- Secure longer-term funding to ensure scale-up and sustainability if the pilot initiative is successful.

2.8 Monitoring universal health coverage in the global development agenda

Dr Arash Rashidian, Director, Information Evidence and Research, WHO EMRO

Dr Mohga Kamal-Yanni, Senior Health Policy Advisor, Oxfam GB, United Kingdom

Mr Altijani Hussin, Health Economist, Dubai Health Authority, United Arab Emirates

H.E. Takehiro Kagawa, Ambassador of Japan in Egypt

Universal health coverage is not equivalent to the establishment of social health insurance. Dr Arash Rashidian maintained that there are other effective approaches, namely through national health systems. A main argument for a third party insurer arises because of a provider-purchaser split argument. It is important that a third party keeps the interests of the public in mind as providers may overprovide and overspend.

A comparison between the Islamic Republic of Iran and Turkey in their efforts towards universal health coverage is tempting because they have similar populations, they have both established social health insurance systems since the 1960s (Turkey) and 1970s (Islamic Republic of Iran) and they have a similar composition of the main insurers.

In the case of Turkey, the path towards expanding coverage and health reform involved funds financed via employees, employers and general revenue. Both countries had insurance funds “merge” or integration objectives since the 1990s. The reform in social health insurance organizations had proved difficult. Since 2003, the story was different. Turkey, in the pre-reform period, suffered from important “benefit” disparities between the different funds. So far, this has been less of a problem in the Islamic Republic of Iran. In particular the social insurance organizations’ benefit package was more limited. Turkey’s insurance scheme in 2003 involved Active Civil Servants Insurance Fund, Bag-Kur’ or the ‘Social Insurance Agency of Merchants, Artisans and the Self-Employed’ and ‘Government Employees Retirement Fund’. Public and private providers were contracted with various copayments and various levels of access. The Social Insurance Organization owned the facility only. The Green Card allowed inpatient care only. There were various benefit packages and blue-collar workers had limited access to care.

In the Islamic Republic of Iran, there were more similarities in benefit packages. Blue-collar workers enjoyed a relatively better coverage. There was access to all insurance contracted facilities and zero premiums at owned facilities. The main policies for expanding coverage in the Islamic Republic of Iran involved a geographical coverage approach, development of a rural insurance fund since 2005, covering any citizen without compulsory insurance and applying a zero premium programme. Social health insurance coverage was 95% in 2015. There is ongoing reform in some areas. The out-of-pocket expenditure was found to be over 40% of the total health expenditure. Addressing this issue started in 2014.

Similarly, the key policies in Turkey included expanding of the coverage of the Green Card programme and expanding the non-poor informal sector coverage in the main scheme. Unlike Iran, reform has already been established such that the out-of pocket expenditure in Turkey was found to be below 20% of the total health expenditure and the coverage was 98%.

The figures in the pre-reform period show that both countries shared a similar experience with exaggeration of population coverage figures pre-reform by some of the insurance organizations. Indeed, in pre-reform Turkey, insurance coverage figures ranged from 67% (as determined by independent surveys) to 85% (as reported by insurers). Since the mid-1990s Iranian social health insurers claimed actual population coverage of over 90%, while independent studies put it at 74% in 2002 and 83% in 2010. The numbers were boosted for several possible reasons such as adding when someone is insured and forgetting to delete when they are no longer covered. The presence of seasonal workers, renewal gaps and changes in dependency status were other confounding factors. Low technology with its impact on data collection was an important issue. Finally, there might have been inherent interests to pump up the figures due to linking of insurance figures with political positions and because insurance figures impact the way mid-level managers are perceived and their performance is assessed.

Several lessons have been learnt from the experiences which include the following.

- Public revenue funded approaches have been the main strategies to expand insurance coverage to “universal” levels.
- “Individual” social insurance funds have political and reputational reasons to boost population coverage figures.
- There is likely to be misguided information for policy makers precluding their ability to reach universal health coverage.
- If it is decided that a “third party” would be utilized to manage the financial and service provision of the health care providers, it is important to consider carefully who will monitor the performance (and figures) of the social insurance organizations.

Dr Mohga Kamal-Yanni approached her presentation by first asserting that universal health coverage is not the same as ‘health insurance’, or at least it is not synonymous with contributory health insurance schemes.

There are general principles in assessing health system financing, as follows.

- Health is a human right not a commodity.
- Health is essential for poverty reduction, shared prosperity, reversing inequality and economic growth.
- Universal coverage should include quality services.
- Equity should correlate with access irrespective of the ability to pay.
- A good system reflects the seriousness of political will.
- A good system requires adequate financial resources.
- Citizen participation is essential in monitoring services.

Key aspects of universal health coverage are equitable access, which involves removing financial barriers, especially direct payments or user fees. Compulsory prepayment is another important aspect. Ideally a single national pool should exist and small groups are inefficient. Single schemes (as in South Korea, Kyrgyzstan and Moldova) have low administrative costs compared to multiple schemes (as in France). Evidence from countries that have progressed towards universal health coverage demonstrates that the government must cover costs for those who cannot afford payment.

The feasibility of tax revenue financing of health systems was discussed as an attractive modality of financing that is often overlooked. In light of this discussion, the significance of the informal sector and its overwhelming presence in most low-and-middle-income countries was noted yet again. It was made clear that coverage of the informal sector should be addressed as a priority if progress towards universal health coverage is to be made. At the point of their inception, universal health coverage programmes should be devised to allow for the coverage of the whole population, with the informal sector in mind as an important subset of the population to be covered from the very beginning. The formerly mentioned programmes were discussed in contrast to universal health coverage programmes that target the formal sector primarily, and only take into consideration ways to include the informal sector in later stages of implementation. It was emphasized that health insurance is only one

of many modalities of health systems financing that could be utilized to achieve progress towards universal health coverage, which also include user fees, public funding, and tax revenue financing.

Each modality of financing was deliberated in detail. Out-of-pocket payment was addressed briefly and the conclusion was reached that such a method of financing would only increase inequality because its widespread continuation meant that a large percentage of the population would either be unable to afford treatment or would fall into poverty as a result of catastrophic payments for health services. As a result, out-of-pocket payment was excluded as a means towards universal health coverage. Next, the option of user fees for public facilities was tackled, and again subsequently dismissed as a modality of financing that would help a nation progress towards universal health coverage because of the inequity of implementation. The third modality of financing that was discussed was health insurance, which was further divided into private, community-based and social health insurance schemes.

Private health insurance schemes usually entail high premiums, which are unaffordable by the majority of the population. Moreover, private health insurance firms may opt out of providing certain services, especially to those who have or are at high risk of chronic diseases. Additionally, private health insurance does not foster the concept of risk pooling, which is crucial for progress towards universal health coverage. The example of Georgia, where 43% of the national health budget is spent on private health insurance, was given to illustrate the pitfalls of private health insurance as a major modality of health systems financing. Despite the significance of private health insurance in terms of expenditure, half of the poorest quintile of the country was ineligible and unable to afford enrolment, and out of pocket payments remained excessively high. Community-based insurance, which is usually a common method of financing health systems for small groups of people such as villages, was debated; and it is because of its small scale of coverage that the system generates low revenues and entails a low level of risk pooling, making it difficult to scale up the scope of coverage in later stages.

It was made evident that while social health insurance schemes have yielded much success in high-income countries, its feasibility and achievability in low and middle income countries can be debated. High-income countries are typically characterized by certain circumstances and factors, such as a large formal sector and low poverty rates that make social health insurance schemes more viable and sustainable. Conversely, in low and middle income countries, even when social health insurance is mandatory for the informal sector, it becomes challenging to force people to join, leading to a system that becomes de facto voluntary and characterized by low coverage and fragmented risk pooling.

Tax revenue financing is considered the most equitable and feasible financing system for low and middle-income countries where a significant informal sector exists. It was brought to light that with current taxation systems, these countries reach only 63% of their tax potential on average. Billions of dollars are not included in tax revenues annually due to corporate tax exemption and tax dodging by firms. Despite its great potential in creating a single risk pool on the national level, tax revenue financing requires significant global and national commitment to solidifying rules and regulations on taxation. In conclusion,

governments must fight the temptation to start coverage schemes with the formal sector and to include the informal sector as a supplementary group in later stages. She also pointed to the positive correlation between the size of the informal sector in an economy and the need for government revenue funding in the form of tax revenues.

Mr Altijani Hussin discussed how data monitoring by the Dubai Health Post Office has been useful in providing key pieces of information. For example, the source of health funding (88% from insurance companies and 12% from patients) was identified. The providers who received these funds were also highlighted. Indeed, hospitals accounted for 59% of the service provision as compared to 28% provided by clinics and 12% by pharmacies. The data additionally demonstrated the nature of the services provided. 29% of services were in the form of inpatient visits, 28% were consultations, 22% were ancillary services and 21% were in the form of pharmaceuticals. Other key pieces of information provided demonstrated that the major beneficiaries were in the 20–39 year-old age group.

A large percentage of the population covered in Dubai in 2014 belonged to the 30–34 year age group whether males (accounting for 13%) or females (accounting for 5%). Data sources show the predominance of male expatriates in the 30–34 year age group and allow for population adjustment based on the composition of expatriates. Data also enable a view of the composition of the body of expatriates, showing that Asian expatriates represent the largest sector of expatriates insured (66%) and utilizing services (46%). Data additionally provide information on the major disease categories (as identified by WHO) and demonstrate that the top ten disease categories in the United Arab Emirates account for 83% of the total health expenditure.

Key messages derived include:

- the importance of innovation based on local needs;
- that technology is critical as a driving force;
- that health authorities should partner with the private sector in collection, pooling and purchasing of health services; and
- that political commitment, regulations and stepwise implementation are critical to achieve success.

3. SUMMARY OF KEY MESSAGES

- While general government expenditure on health as a percentage of total government expenditure in the Region is higher than the WHO recommendation of 4.5% in most countries, it is considerably lower than the global average of 11%. In order for government spending on health to increase, it is inevitable that either health must be given a higher priority on the government's spending agenda, or total government spending increases.
- In terms of policy options aimed at extending health coverage to ensure that the informal sector is included, it is important to think from a holistic perspective and to focus on the progress of the population as a whole rather than one particular sector.

- Public spending is key for universal health coverage. While clearly a necessity for universal health coverage, public funding is not sufficient. Indeed, extensive pooling of funds is required. It is also important to maximize redistribution of financial resources from those with low health needs to those with high health needs. Importantly, the resource pool needs to be large, diverse, compulsory, and non-fragmented.
- Including the poorest populations in strategies towards universal health coverage requires consideration of each access step: financial accessibility, safety and quality, capacity and service availability, and physical accessibility and timeliness.
- Long-term fiscal projections are an essential component of planning for sustainable expansions of health coverage. As countries seek to expand the coverage and benefits provided by their health systems under a global drive for universal health coverage, decisions taken today – whether by government or individuals – will have an impact tomorrow on public spending requirements. To understand the implications of these decisions and define needed policy reforms, long-term projections for public spending on health should be calculated and different scenarios related to population coverage be analysed.
- If a country develops a reasonably good universal health coverage plan, it is better to start than to keep waiting for a “perfect” design. The private sector must be leveraged to complement government efforts. It is critical for the government to target poor and informal workers for whom cost will need to be borne by the government. Focus should be on ease of access for beneficiary rather than ease of implementation.
- The involvement of the private sector in public/private partnerships in developing countries can be exhibited in different roles ranging from analysis, concept development, formation of a detailed operating model, implementation and steady state operations.
- Strong leadership and political commitment are key to success and a multifaceted approach is critical in achieving universal health coverage. Comparative studies should be facilitated to assist policy makers in understanding the situation and making the best possible decisions. Simultaneously, education, advocacy and public debate are critical. Laws and regulations that guide the health insurance process in accordance with universal health coverage are to be developed. A basic benefit package should be wisely considered. A key aspect in the approach towards achieving universal health coverage is the development of an appropriate infrastructure and providing adequate human resources that would support universal health coverage;
- The aspects of quality, efficiency and accessibility should be adequately monitored in a health coverage programme.
- Most health systems do not take into account the conditions of work of informal workers. There are very few experiences where occupational health has been introduced as a right for informal workers. Also, the lack of programmes for payment of sick and maternity leave for informal workers acts as an important barrier since the incomes of informal workers depend on their capacity to work. It is important to include key indicators related to occupational health and maternity leave for informal sector workers to monitor their access to health care services.
- Generating evidence is important for monitoring health equity, in-depth research and creating a repository of relevant international and regional experiences. Monitoring health equity and its social determinants is an essential and strategic tool in influencing

any policy including universal health coverage. Ongoing assessment of the combined impact of current policies, interventions and programmes on health and on its social determinants can provide policy-makers with early warning signals to review or amend these policies.

- Health insurance requires a fundamental change of mind set of the community. There is a need to advocate for access to social protection and there is a crucial requirement to understand and use the concept of shared risk. It is important, though, that vulnerable groups are not targeted alone. It is essential to focus on prevention of vulnerability and to make enrolment binding and contingent wherever possible.
- Public revenue funded approaches have been the main strategies to expand insurance coverage to “universal” levels. “Individual” social insurance funds have political and reputational reasons to boost population coverage figures. There is likely to be misguided information for policy-makers precluding their ability to reach universal health coverage. If it is decided that a “third party” would be utilized to manage the financial and service provision of the health care providers, it is important to consider carefully who will monitor the performance (and figures) of the social insurance organizations.
- Health insurance schemes for refugees should be strategically implemented where and when national health systems facilitate the integration. Communities’ informed consent ensures buy-in and continuous contribution. Enrolment should be binding and if necessary contingent with other modes of assistance (health, financial). Insurance schemes cannot be co-implemented with parallel health services or reimbursement models for health care. Insurance schemes cannot be targeted at vulnerable individuals only.

4. RECOMMENDATIONS

To Member States

1. Develop country-specific roadmaps for achieving universal health coverage based on the regional framework for action on advancing universal health coverage and drawing upon the experience of other countries of the Region or beyond.
2. Advocate for universal health coverage through a bottom-up approach, which involves covering the poor, vulnerable, informal sector, then the formal sector, rather than a trickle-down approach, which entails covering the formal sector first and the informal and vulnerable groups later.
3. Prioritize health financing in the government’s budget or increasing government spending to enable health coverage of the poor informal sector through social health insurance arrangements, a national health service or other approaches.
4. Ensure extensive pooling of health funds and decreasing fragmentation to maximize redistribution of financial resources from those with low health needs to those with high health needs and decrease financial risk.
5. Apply data collection and analysis methods to monitor the advancement in population coverage as well as enable policy-makers to make evidence-based decisions regarding country-specific health coverage conditions.

6. Acknowledge the diversity of the informal sector which includes the poor, non-poor and other vulnerable groups such as the unemployed, refugees, elderly, internally displaced, expatriate workers or migrants.

To WHO

7. Support the countries of the Region in forming country-specific roadmaps to move towards increasing the coverage of the informal sector and vulnerable populations.
8. Facilitate sharing of experience between countries regarding their effort to achieve health coverage of the informal and vulnerable groups.
9. Encourage collaboration between countries and other UN organizations to facilitate the availability of the required technical and financial resources to achieve universal health coverage.
10. Collaborate with Member States in the formation of a sustainable, simple and affordable framework for monitoring and evaluating population coverage and universal health coverage.
11. Advise Member State governments in their efforts to issue legislation enabling the achievement of universal health coverage.

Annex 1**PROGRAMME**

8:00–08:30	Registration	
08:30–08:45	Opening address	<i>Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean</i>
08:45–09:00	Objectives of the meeting, agenda and introduction of participants	<i>Dr Awad Mataria, WHO EMRO</i>
09:00–09:15	Moving towards universal health coverage in the Region: commitments and framework for action	<i>Dr Sameen Siddiqi, WHO EMRO</i>
09:15–09:25	Opening remarks on behalf of the World Bank	<i>Dr Daniel Cotlear, World Bank</i>
09:25–10:00	Open discussion	<i>Moderated by: Dr Ala Alwan, WHO Regional Director</i>

Session 1: Informality and vulnerability and universal health coverage in the Region

Chair: Dr Ahmed Galal, Managing Director, Economic Research Forum, Egypt

10:30–10:45	Understanding informality and vulnerability in the context of the Region [<i>Skype</i>]	<i>Prof Akbar Zaidi, Columbia University, New York</i>
10:45–11:00	Situation analysis of universal health coverage of informal sector and vulnerable groups in the Region	<i>Dr Awad Mataria, WHO EMRO</i>
11:00–11:30	General discussion	
11:30–12:00	<i>Spotlight:</i> Reforming the health system for universal health coverage – the case of the health transformation plan in the Islamic Republic of Iran <i>Discussant:</i> Dr Matthew Jowett	<i>Dr Davoud Danesh Jafari, Ministry of Health and Medical Education, Islamic Republic of Iran</i>
12:00–12:30	General discussion	

Session 2: Global experience in expanding coverage to the non-poor informal sector

14:00–14:15	Reaching out to the non-poor informal sector: Findings from the World Bank UNICO study	<i>Dr Daniel Cotlear, World Bank</i>
14:15–14:30	Extending coverage to the non-poor informal sector: rethinking the policy options	<i>Dr Matthew Jowett, WHO HQ</i>

- 14:30–14:45 The Experience of the Fondo Nacional de Salud in Chile in covering the non-poor informal sector: Lessons for the Region
[Skype] *Dr Jeanette Vega, Fondo Nacional de Salud (FONASA), Chile*

14:45–15:30 General discussion

Session 3: Expanding coverage to the non-poor informal sector in the Region

- 16:00–17:30 Moderated panel discussion – short interventions followed by general discussion
Jordan (Royal Court) – *Dr Hani Brosk Kurdi, High Health Council, Jordan*
Egypt (PTES) – *Dr Hassan Nagi, Specialized Medical Councils and Programme of Treatment at the Expense of State, Egypt*
Lebanon (MOPH) – *Ms Hilda Harb, Statistics Department, Lebanon*

Session 4: Global experience in expanding coverage to the poor informal sector

- 08:30–08:50 Expanding coverage to the poor informal sector – global experience and lessons learned *Prof Barbara McPake, University of Melbourne, Australia*
- 08:50–09:05 Turkey’s green card programme and its role in expanding coverage to the informal sector *Dr Volkan Cetinkaya, WHO EMRO*
- 09:05–09:20 Covering the poor in India – the Example of RSPY *Dr Nishant Jain, GIZ, New Delhi, India*
- 09:20–09:35 Health service coverage for the vulnerable in South Africa: Moving towards universal health coverage *Dr John Ele-Ojo Ataguba, University of Cape Town, South Africa*
- 09:35–10:30 Plenary discussion

Session 5: Using social health insurance to expand coverage to the poor informal sector

- 11:00–11:15 Reaching out to the poor: The experience of RAMED in Morocco *Mr Mostafa Chouitar, Ministry of Health, Morocco*
- 11:15–11:30 Reaching out to the Poor: The experience of AMG I and II in Tunisia *Dr Sofiene Manaii, Ministry of Health, Tunisia*
- 11:30–11:45 The experience of Sudan in using the Zakat fund to expand health coverage to the informal poor under the National Health Insurance Fund (NHIF) *Dr Mahgoub Abd Elrahim, National Health Insurance Fund, Sudan*
- 11:45–12:30 Plenary discussion

Session 6: Closing the gap in population coverage: addressing special groups

14:00–14:10	Expanding coverage to the expatriate populations in Bahrain	<i>Dr Mariam Aljlahma, Ministry of Health, Bahrain</i>
14:10–14:20	Expanding coverage to the expatriate populations in Abu Dhabi – Daman’s experience	<i>Mr Jan Schmitz-Huebsch, Munich Health Daman Holding, Abu Dhabi, United Arab Emirates</i>
14:20–14:30	Dubai universal health coverage: the expatriates population	<i>Dr Haidar Saeed Al Yousuf, Dubai Health Authority, United Arab Emirates</i>
14:30–14:40	Health care coverage for uninsured expatriates in Saudi Arabia	<i>Dr Abdulwahab Alkhamis, Saudi Arabia</i>
14:40–15:30	Plenary discussion	

Session 7: Developing an agenda for expanding population coverage in the Region

16:00–17:30	Group work: what is needed to expand coverage to the poor and non-poor informal sector in the three groups of countries	
17:30–18:30	Side meetings	

Session 8: Ensuring equity in expanding population coverage – going beyond health financing

08:30–08:50	Lancet Commission on Global Health Equity: What lessons for expanding health coverage	<i>Prof Rita Giacaman, Birzeit University, Palestine</i>
08:50–09:05	Expanding informal worker coverage as a prerequisite to ensure equity in universal health coverage	<i>Prof Orielle Solar, Flasco Chile, Chile</i>
09:05–09:20	Covering the poor in Indonesia: how does it work?	<i>Prof Ali Ghufron Mukti, Indonesia</i>
09:20–09:35	Thinking universal health coverage for the largest refugee populations on earth: Palestine refugees	<i>Dr Akihiro Seita, UNRWA</i>
09:35–09:50	Expanding coverage to refugee populations through health care integration and alternative health financing	<i>Dr Hany Fares, UNHCR</i>
09:50–10:05	Generating evidence on equity to inform expanding population coverage in the Region	<i>Dr Zeinab Khadr, Cairo Demographic Center, Egypt</i>
10:05–10:20	Using demand-side financing to expand population coverage [Skype]	<i>Dr Shakil Ahmed, University of Melbourne, Australia</i>
10:20–10:45	General discussion	

Session 9: Monitoring universal health coverage in the global development agenda

Chair: H.E. Amb. Takehiro KAGAWA, Ambassador of Japan in Egypt

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| 11:00–11:15 | Monitoring the Numbers – Lessons from the Islamic Republic of Iran and Turkey’s experience in expanding coverage to the informal sector | <i>Dr Arash Rashidian, WHO EMRO</i> |
| 11:15–11:30 | Universal health coverage: How to ensure that nobody is left behind | <i>Dr Mohga Kamal-Yanni, Oxfam GB, United Kingdom</i> |
| 11:30–11:45 | Dubai health post office: Using data in monitoring health coverage and access | <i>Mr Altijani Hussin, Dubai Health Authority, United Arab Emirates</i> |
| 11:45–12:00 | Universal health coverage in SDGs and the importance of expanding population coverage in the post 2015 global development agenda | <i>H.E. Takehiro Kagawa, Ambassador of Japan in Egypt</i> |
| 12:00–12:30 | General discussion | |

Session 10: Closing and next steps

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| 14:00–14:30 | Group presentations | |
| 14:30–14:45 | Main messages for the Region on extending universal health coverage to the informal sector and vulnerable groups | <i>Dr Awad Mataria, WHO EMRO</i> |
| 14:45–15:00 | Closing remarks | <i>Dr Ala Alwan, Regional Director</i> |

Annex 2

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