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policy and practice

Leaving no one behind? Reaching the informal sector, poor people and marginalised groups with Social Health Protection

Claude Meyer, meyerc@who.int
World Health Organization, Geneva, Switzerland

David Evans, devans4@worldbank.org
World Bank Group

Agnès Soucat, soucata@who.int
Fahdi Dkhimi, dkhimif@who.int
World Health Organization, Geneva, Switzerland

Patricia Akweongo, akweongo@gmail.com
University of Ghana, Accra, Ghana

Flora Kessy, fkessy@gmail.com
Nzumbe University, Tanzania

Jürgen Maurer, jurgen.maurer@unil.ch
University of Lausanne, Switzerland

Gorik Ooms, gorik.ooms@lshtm.ac.uk
London School of Hygiene and Tropical Medicine, UK

Manfred Stoermer, manfred.stoermer@unibas.ch
Swiss Tropical and Public Health Institute, Switzerland

Background

Among the various imperatives implicit in moving towards Universal Health Coverage (UHC), extending coverage to the most vulnerable groups in society is particularly challenging. Traditionally, health insurance schemes have covered people in the formal sector whose wages can easily be deducted to cover premium payments (civil servants, the military, employees of private enterprise, and so on), while those in the informal sector, including the very poor, are left to make do with community-based initiatives or obtain subsidised, free or low-cost (and often low-quality) health services from government or NGO providers (Wu and Sanders, 2007). Where health insurance initiatives designed for people working in the informal sector do exist, they are often small, fragmented and uncoordinated, rarely achieve broad coverage, struggle

to sustain coverage throughout the year and, when based on voluntary contributions, fail to reach poor people and marginalised groups (Mills et al, 2012; Ernst et al, 2012). Government funded 'insurance' schemes for the informal sector using general government revenues, such as those established in Thailand, Colombia and Mexico among others, are the exception rather than the rule.

The Geneva Health Forum workshop 'Leaving no one behind' focused on three thematic areas, namely, equity and reaching vulnerable groups, governance and accountability, and resource pooling and management. The workshop discussed topic specific presentations supported with relevant literature, country experiences and innovative approaches to ensuring that poor and or marginalised groups are not left behind on the path to UHC.

Equity and reaching vulnerable groups

Vulnerability and exclusion are driven by unequal power relationships interacting across four main dimensions – economic, political, social and cultural – and at different levels including individual, household, group, community, country and global levels. These unequal power relationships result in a continuum of inclusion/exclusion characterised by unequal access to resources, capabilities and rights which in turn leads to health inequalities (Popay et al, 2008). Other drivers of inequality include geographical remoteness, social marginalisation of certain groups, the stigma attached to certain diseases, and the long-term, repeated costs associated with chronic health conditions. A core aim of UHC is *universality*; by definition it is supposed to cover the whole population with the quality services they require while at the same time protecting them from the financial risk associated with paying for healthcare. However, the consensus is that for the most vulnerable members of society, it is hard to make the right to health a reality.

One way of addressing the issue is to target specific groups. But universality and targeting are not opposed concepts. They are complementary to attain progressive universalism. Various approaches to targeting have been used. Targeting allows for the focusing of scarce resources where they are most needed. One of the most effective ways to reduce poverty is to transfer cash to those people identified through such mechanisms. However, different forms of targeting based on sharp eligibility criteria can also lead to the creation of coverage gaps, sometimes described as the 'missing middle', a scenario in which people living just above an agreed poverty line find themselves excluded from coverage. In practice, targeting is never perfect due to the complexity of the mechanisms applied, lack of insight into household poverty levels and informal support networks, and the difficulty of data collection (Lavallee et al, 2010). Targeting may also increase existing health coverage fragmentation, which can hamper the cross-subsidy facilitated by resource pooling, among other negative effects. Because of these challenges, there is a strong argument for making universal entitlement a core principle.

With regard to financing health services to meet the needs of the most vulnerable, key considerations include accurately reflecting the country-specific social epidemiology of disease, and the dynamic relationship between socio-economic status and health (Marsden, 2011). The principal trade-off in service delivery is between providing full coverage of cost-effective services judged to be essential versus partial coverage of a more comprehensive range of such services. If resource constraints

make it necessary, WHO recommends starting out with full coverage of essential services and then adding services as fiscal space expansion permits (World Health Organization, 2010). Social epidemiology and equity should be key considerations in decisions regarding which services to cover, with priority being given to so-called 'diseases of the poor' as compared to 'diseases of the rich'. Whichever approach is taken, priority must be given to providing people-centred, quality health services across the continuum of care, notably at the primary health care level, and including effective referral to tertiary level services.

Currently, many countries offer public health services to their populations, including the poor and marginalised, at low cost. These services are typically funded from general government revenues. However, most countries struggle to find the funds to ensure that good quality services are available and accessible everywhere, resulting in those people who can afford it resorting to often poorly regulated private sector service providers which they pay for out of pocket, with others foregoing care altogether (Xu et al, 2007).

Prospects for global economic recovery currently look uncertain (IMF, 2016). Resource poor countries will experience difficulties in mobilising necessary funds to ensure UHC. For them, international financial support is necessary to make coverage universal. But how wealthier countries should support and engage with governments of poorer countries is the subject of ongoing debate. Some argue that they might usefully focus on funding global public goods that disproportionately affect people in low-income countries. Others argue that development banks, bi-laterals and the likes of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), President's Emergency Plan For AIDS Relief (PEPFAR), President's Malaria Initiative (PMI), the Global Financing Facility (GFF) and the Global Alliance for Vaccines and Immunization (GAVI) may play a significant role. It will also be vital to improve the effectiveness of aid and to ensure that funds are put to optimal use.

It was suggested that at the global level the transition from the Millenium Development Goals (MDGs) to the Sustainable Development Goals (SDGs) implies a greater emphasis on equal relationships and mutual accountability between developed and developing countries, and a move away from the aid paradigm. Some proposed that the transformation of global development cooperation principles from a donor/recipient scheme towards the idea of shared responsibility made it worth exploring the creation of a global fund for health (Ooms et al, 2014).

Governance and accountability

Mobilising greater resources for health requires stronger governance and greater accountability. UHC is a social contract and citizens are the holders of public resources as tax payers and as voters. Citizens' voice and control is the guarantee that resources, including health professionals, and medicines, are optimally employed by all stakeholders, to provide health services to the entirety of the population. Governance and accountability issues are not solely the concern of high-level government and health system officials, but arise at all levels of the system and in all systems.

The policy objective of the Ghana National Health Insurance Scheme (NHIS) established in 2003 is 'to assure equitable and universal access for all residents of Ghana to an acceptable quality package of essential healthcare'. About 60 per cent of Ghana's population is currently covered and those who are indigent, children,

aged persons and pregnant women are exempt from contributions. But one of their challenges is governance and accountability. For example, while the government treasury charges 2.5 per cent VAT to finance the NHIS, there is no reporting of how much this 2.5 per cent amounts to each year, while the release of money to the NHIS is unpredictable. The NHIS itself also lacks transparency and healthcare providers tend to overcharge the NHIS for services. Abuses are also observed at the consumer level, with a significant proportion of healthcare users going to higher level facilities with ailments that could easily be attended to at the primary healthcare level, thus bypassing the gate-keeping system.

Separating the purchasing and provision functions can help increase accountability and responsibilities for delivering quality health services through contractual arrangements (World Health Organization, 2010). Accountability in such arrangements translates into the provider ensuring quality services that are available to be purchased and the purchaser ensuring timely payment for services delivered. As a result, both provider and purchaser must guarantee the end user access to quality services whenever needed. The end user is also incentivised to be accountable for avoiding behaviours that threaten the functioning and sustainability of the system, for example by going to the emergency department of hospitals with health issues that can be handled at the primary healthcare level. Where the SHP contract is broken, it is the poor that generally pay the highest price.

The workshop supported that the establishment of robust PHC networks is key to promoting greater accountability, promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of health services. Accountability can also be enhanced through rights-based social accountability approaches applied at the community level, as in Guatemala (Flores and Gomez, 2015). However, rights-based social accountability should not be seen as a quick fix for improvement in coverage and health status. Explicit political commitments to UHC, emphasising the human right to health, is also key to supporting health system democratisation. The development of SHP generally relies on the advocacy efforts of SHP champions, which are greatly supported by the active participation of Civil Society Organisations, unfettered media and robust opposition to incumbent governments. Needless to say, the work of these different entities is greatly facilitated where there is information transparency.

Improving accountability at the global level is also crucial, and there is a clear need to hold actors accountable on financing. Substantial efforts need to be made to protect the funds available for development financing from being misallocated and diverted due to corrupt practices.

Resource pooling and management

Evidence shows that mobilisation, pooling and allocation of public resources is critical to covering vulnerable groups, and domestic revenue mobilisation and pooling are important pillars of UHC. The challenge is mobilising and pooling sufficient resources to fund rapid progress towards UHC. That domestic public financing is key to developing UHC was explicitly recognised at the 2015 Addis Ababa conference. Most low- and middle-income countries, with a majority of them currently experiencing positive economic growth, can increase fiscal space for health through a combination of improved revenue collection strategies and/or greater priority for health in

government budget decisions. Raising public health spending to 3 per cent or to 5 per cent of GDP would result in substantial additional resources for health (McIntyre and Meheus, 2014). Getting more health for the money, improving efficiency in the use of pooled resources, is also critical.

There is broad agreement regarding the merit of establishing a single pool or a limited number of large pools with diverse populations. Countries that have managed to merge different financing schemes have a greater capacity to allocate resources in an equitable manner via cross-subsidisation between territories and socio-economic groups. In order to create a single pool, some countries may need to increase contributions to cross-subsidise the informal sector members, or provide substantial government subsidies. By acknowledging this, a strong argument is being made for integrating financing schemes designed to cover the poor and informal workers with other financing schemes from the outset. The reality is that pools tend to be established sequentially, with easily identified or levied groups. Once these first pools are established, their members often resist integration of populations in later stages whom they consider high-risk groups, that is, the poor, informal workers and vulnerable groups.

Improving information gathering and transparency is key to advancing the pro-poor UHC agenda. Financial and health services utilisation data for effective management of resources is often scarce with many countries. Some countries are still lacking even basic vital registration systems. Other challenges include fraudulent reporting, over and underreporting; lack of complete and consistent data; and lack of agreement on standard terminology and coding for data generated by health facilities and community-based programmes, and surveillance data from surveys and facilities, making it impossible to aggregate and analyse data in a consistent and coherent way. It is therefore essential that the quality of data be recognised as a core health system objective.

Conclusions and recommendations

The workshop held during the 2016 Geneva Health Forum conference reviewed country experiences and innovative approaches to ensuring that poor and/or marginalised groups are not left behind on the path to UHC. Presentations and discussions held during the workshop made it possible for lessons to be drawn from the most promising experiences which are relevant to the development of inclusive UHC-related policies, strategies and guidelines. The workshop formulated a series of concrete recommendations which are relevant to health financing and social health protection reforms aimed at UHC in low- and middle-income countries, as presented below:

- Universal entitlement should be a core principle; particular efforts should be focused on the poorest most excluded segments of society. This is the progressive universalism pathway.
- Where resource constraints make it necessary, it is recommended that countries start out with full coverage of essential services making sure the poor are covered and then add services as fiscal space expansion permits.

- When expanding services, the social epidemiology of disease must be considered (in addition to value for money) to ensure a 'pro-poor' (and not just 'cost-effective') use of public funds.
- Priority must be given to providing quality services across the continuum of care (notably at the primary healthcare level, including effective referral), to ensure trust in UHC systems.
- Evidence shows that mobilisation and allocation of public resources is critical to cover vulnerable groups; some countries will require continued donor support to supplement domestic resource mobilisation efforts by governments.
- Establishing large and inclusive resource pools allows countries to allocate resources in an equitable manner via cross-subsidisation between territories and socio-economic groups. There is thus a strong argument for integrating financing schemes designed to cover the poor and informal workers with other financing schemes from the outset; where this is impossible, virtual pooling should be applied.
- It is critical to ensure inclusive governance that reflects the concerns and needs of vulnerable groups. Ensuring that citizens have a voice is crucial to inclusive governance, increasing transparency and accountability, two prerequisites for the provision of health services to the entirety of the population, leaving no-one behind.
- Accountability and transparency are crucial to advancing the UC agenda, and are supported by information transparency, unfettered media and robust opposition voices to incumbent governments. At the global level, firmly opposing corrupt practices and supporting accountability mechanisms are needed grounded in human rights obligations, with transparent and accountable financing mechanisms

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Conflict of interest

None declared.

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