

COVERING THE INFORMAL SECTOR

Report from a workshop on expanding access to health services and financial protection for people outside the formal employment sector



Background - the challenge of achieving Universal Health Coverage (UHC)

In recent years there has been a growing focus on providing universal health coverage (UHC) – access to health services for all people without the risk of financial catastrophe or impoverishment associated with obtaining care. One of the biggest challenges facing many low and middle-income countries (LMIC) is in providing coverage for people outside the formal employment sector. Coverage is particularly low among the near-poor who do not benefit from targeted interventions but constitute the bulk of the informal sector. For these groups, out-of-pocket (OOP) payments persist as a way of funding services despite being grossly inequitable and contributing towards household poverty.

Approaches to reduce the burden of OOP payments and increase funding for UHC have concentrated on expanding health insurance schemes, especially in sub-Saharan Africa. However, many of these schemes have achieved low population coverage, Rwanda being a notable exception, and generated little revenue for health. Some countries have also opted to implement tax-based financing mechanisms, such as general taxation in Thailand and a levy as part of Value Added Tax (VAT) in Ghana; others, including Tanzania and Rwanda, remain heavily dependent on funding from international donors.

The mix of financing approaches that countries use has equity and efficiency implications; however, the relative merits of these approaches vary across settings and there is currently a lack of strong evidence, and therefore consensus, on how best to cover the informal sector. The debates surrounding the choice of financing mechanism are further complicated by ideological factors, such as whether everyone should make direct contributions towards the costs of health care.

A workshop to debate the issues and challenge preconceptions

In August 2013, RESYST (Resilient and Responsive Health Systems) research consortium, in collaboration with the University of Rwanda School of Public Health and the Ministry of Health in Rwanda, organised a workshop on providing access to health services and financial protection for people outside the formal employment sector. Inspired by the lack of consensus on the issues, the workshop aimed to share country experiences of extending health coverage and to distil the key areas of debate. It brought together policymakers, practitioners and researchers from countries in Africa, Asia and Latin America to draw out experts' tacit knowledge of the issues and to critically assess the evidence.

The countries represented at the workshop were Ghana, Indonesia, Rwanda, Senegal, Tanzania and Thailand, which have implemented a range of approaches to cover the informal sector with varying levels of success. Rwanda has managed to achieve high levels of enrolment in its community-based health insurance (CBHI) schemes, due in part to widespread support from all levels of government and community participation in the running of health facilities. Thailand, on the other hand, achieved UHC by using general taxation to cover the population who didn't qualify for employee health insurance schemes.

These countries' experiences formed the basis of discussions about the relative merits of insurance versus tax-based financing mechanisms, during which the participants explored the key points relating to the mechanisms' efficiency and equity. An organised debate further enhanced these discussions and addressed the contentious issues of whether or not contributions are necessary for people to value health care, and how best to draw resources from the informal sector.

Key conclusions of the discussions

Providing coverage for the informal sector is an essential step in a country's path to UHC, especially in LMIC where this constitutes most of the population. Countries that have had success in extending coverage, such as Rwanda and Thailand, have strong political support for the concept of UHC, and have focused efforts on reaching the informal sector.

Whilst each country will decide on a mix of financing mechanisms to suit their own context, the workshop raised several issues worthy of serious consideration by decision-makers who are planning or reviewing their health financing strategy for universal coverage.

- › **Understanding the informal sector:** The informal sector is highly diverse and its composition varies across countries and within countries. Approaches to mobilising resources from the informal sector will therefore need to take into account local factors, including the capacity to pay of specific groups and the availability of organisational structures through which its resources can be tapped.
- › **Contributions from users:** The issue of whether to require contributions from users is complex and unresolved: contributions can bring accountability at local level, but they may carry high administrative costs as contributions can be costly to collect compared with the revenue they generate. Policymakers will need to consider evidence that is grounded in their own local reality about efficiency and equity of different ways of raising funds for health, and not rely on conventional understandings and received wisdom.
- › **Fragmented risk pools can put cross-subsidies at risk:** Where general revenue is being channelled into different pools with different levels of government subsidy, it can be difficult to secure effective cross subsidies.
- › **Purchasing is the linchpin of the financing system:** As well as providing a systematic way to define benefit packages, identify eligible providers, and set effective payment mechanisms, strategic purchasing can be used to create accountability from the payer side to complement the accountability mechanisms that operate through the providers. However, purchasers need to find novel ways to represent citizens' views and communicate service entitlements.
- › **Balancing centralised and decentralised functions:** Retaining locally generated funds can be an important means of improving transparency within the financing system, as well as avoiding delays and administrative costs. Providing these funds are supplemented with centrally collected resources to enhance equity, they can be an important means of reinforcing payer-led accountability.

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» Introduction

In August 2013 researchers, practitioners and policymakers gathered in Kigali, Rwanda to discuss and debate one of the biggest challenges to achieving Universal Health Coverage (UHC) – how to extend financial protection and equitable access to health services to those outside the formal employment sector.

The three-day workshop brought together representatives from six countries in Africa and Asia to share country experiences of extending health coverage to the informal sector. Held in Rwanda, the only country that has managed to achieve high levels of coverage through community-based health insurance (CBHI) schemes, the workshop focused on the merits and disadvantages of different financing approaches.

This report aims to capture a record of the workshop including profiles of participating countries and their efforts to extend coverage to the informal sector. It gives an overview of the central themes that were discussed during the workshop and summarises an organised debate on tax versus insurance-based financing approaches. Finally, it presents the key conclusions emerging from the discussions.



A health centre visited by the workshop participants



A bank receipt showing payment for the Rwandan social health insurance scheme. The stamps show where the card has been revalidated each year

» Who attended the workshop?

Organisers

The workshop was organised by RESYST (Resilient and Responsive health systems) research consortium, in collaboration with the University of Rwanda, College of Medicine and Health Sciences, School of Public Health (UR/CMHS/SPH) and the Health Financing Unit at the Ministry of Health in Rwanda.

› RESYST (Resilient and Responsive Health Systems) Consortium <http://resyst.lshtm.ac.uk>

RESYST is an international research consortium that aims to enhance the resilience and responsiveness of health systems to promote health and health equity and reduce poverty. It has partners in Kenya, India, Nigeria, South Africa, Tanzania, Thailand, Vietnam and the UK who conduct research across three themes: financing, health workforce and governance.

The RESYST financing theme focuses on how best to finance UHC in LMIC, of which covering the informal sector is one part. Researchers are also conducting multi-country studies on how to generate more revenue for health through improved systems of tax collection (expanding fiscal space), and on using strategic purchasing to ensure access to efficient and effective health services.

› University of Rwanda, College of Medicine and Health Sciences, School of Public Health <http://nur-sph.org>

The Center of Excellence for Health Systems Strengthening at the UR/CMHS/SPH has supported the Ministry of Health to develop the Rwandan national health research agenda and works jointly with the Ministry to implement it. The Centre also acts as a knowledge-broker between local and international researchers and policymakers, as well as a resource – providing access to important information and evidence to improve policy reforms.

› Ministry of Health, Rwanda www.moh.gov.rw

The Health Financing Unit at the Ministry of Health in Rwanda is responsible for planning and implementing the country's health financing strategy, including its health insurance and pay-for-performance policies.

“I was excited to bring [workshop participants] to the community to show them how our Community Health Workers are working and how they are mobilising people to come into the scheme” - Mr Joseph Shema, Ministry of Health, Rwanda

Workshop participants

Ms Carolyn Bancroft	Rockefeller Foundation	USA
Honourable Minister Dr Agnes Binagwaho	Ministry of Health	Rwanda
Mr Pascal Birindabagabo	Ministry of Health	Rwanda
Dr Jane Chuma	KEMRI-Wellcome Trust	Kenya
Professor Bart Criel	Institute of Tropical Medicine	Belgium
Dr Ousseynou Diop	DGPSN (General Delegation for Social Protection and National Solidarity)	Senegal
Mr Fahdi Dkhimi	Institute of Tropical Medicine	Belgium
Ms Helen Dzikunu	Independent consultant	Ghana
Professor Kara Hanson	London School of Hygiene & Tropical Medicine	UK
Dr Ayako Honda	University of Cape Town	South Africa
Dr James Humuza	UR/CMHS/SPH	Rwanda
Mr Collins Kamanzi	UR/CMHS/SPH	Rwanda
Dr Mwihaki Kimura	Rockefeller Foundation	Kenya
Professor Di McIntyre	University of Cape Town	South Africa
Dr Gemini Mtei	Ifakara Health Institute	Tanzania
Mr Jean Louis Mukunzi	Ministry of Health	Rwanda
Mr Medard Munandekwe	UR/CMHS/SPH	Rwanda
Mr Alfred Ndiaye	Centre de Recherche en Politiques Sociales (CREPOS)	Senegal
Dr Manasse Nzayirambaho	UR/CMHS/SPH	Rwanda
Dr Pujiyanto	University of Indonesia	Indonesia
Mr Joseph Shema	Ministry of Health	Rwanda
Dr Orielle Solar	FLASCO	Chile
Dr Samrit Srithamrongsawat	National Health Security Office	Thailand
Mr Syafranelar	Ministry of Health	Indonesia
Dr Viroj Tangcharoensathien	International Health Policy Programme	Thailand
Dr Jeanette Vega	Rockefeller Foundation	Chile

The workshop brought together policymakers, practitioners and researchers from each country to draw together their tacit knowledge and critically examine the evidence

» Key concepts and definitions

The workshop started with a discussion about the key concepts and what they meant to participants.

Universal Health Coverage - an evolving concept

The World Health Organization defines UHC as ensuring that all people obtain the health services they need without suffering financial hardship when paying for them. At its core, UHC is concerned with equity and social solidarity: it is about ensuring that all people can access services, and that they contribute according to their ability to pay.

Workshop participants agreed that whilst UHC primarily focuses on saving lives, i.e. ensuring access to essential services, the concept of universal coverage has evolved to encompass health care and services that are needed to sustain a comfortable life. This has altered people's expectations and health systems need to be responsive to the changing health needs of populations' and their expectations.

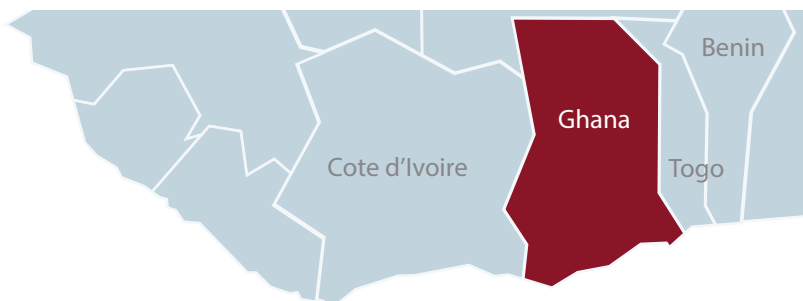
“You cannot separate health services coverage from the quality of our health systems: never believe you can have universal health coverage without a strong decentralised health system, never believe you can have sustained universal health coverage without a flexible health system that will adapt to the needs of the people” - Honourable Minister Dr Agnes Binagwaho, Minister of Health, Rwanda

What do we mean by the informal sector?

In many LMIC, only a small proportion of the population works inside the formal employment sector with related employees' protections, workplace regulations and social benefits including health insurance. The rest of the population comprise the informal sector, although its composition varies significantly across countries. In the context of this workshop, we understood the informal sector to encompass people who do not receive health coverage through formal employment arrangements including those who work for unregistered or small enterprises, in subsistence agriculture, are unemployed or are not economically active. The definition also includes people who are poor and unable to afford financial contributions to the cost of health care.

“Often the line between the formal and informal sector is not clear: people move between sectors over time, and even within ‘formal’ firms, there can be workers who do not receive the social benefits offered to others” - Dr Orielle Solar, FLASCO, Chile

» Country profiles



Ghana

National Health Insurance Scheme (NHIS) aimed at providing equal and affordable access to health services for all citizens. A centrally managed programme that draws on a network of district offices to reach the informal sector.

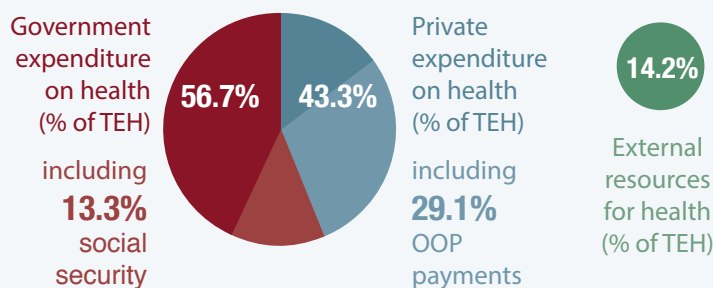
Key information

24.3m Population ¹	\$1,594 GDP per person ¹	4.8% Total expenditure on health (TEH) as % of GDP ²
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Health Indicators

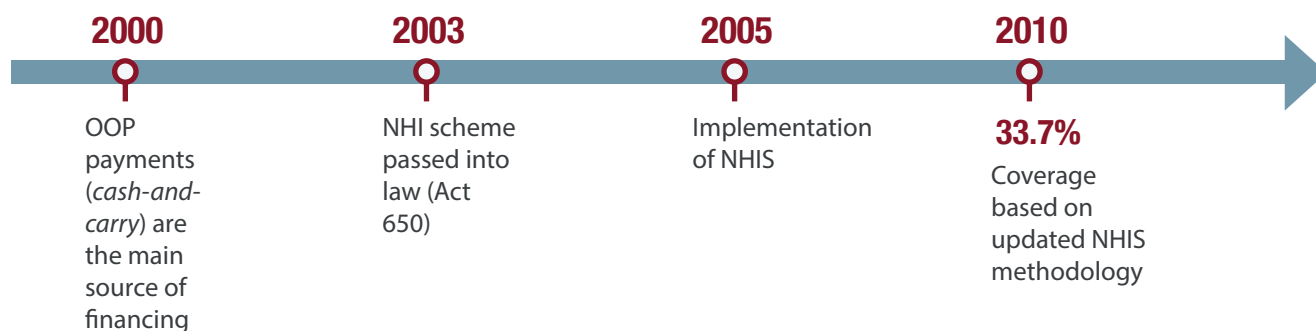
64 years Life expectancy ²	72 <5 mortality rate per 1,000 live births ³	350 Maternal mortality ratio per 100,000 live births ²
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Sources of health financing²



Source: ¹UNdata, 2010; ²WHO, 2011; ³WHO, 2012

Evolution of NHIS



Measures to cover the informal sector: National health insurance scheme (NHIS)

Population coverage

- Compulsory membership for every citizen although this is not enforced.
- 8 million people hold an active NHI card.
- Coverage for the informal sector is higher for people that live close to a health facility.
- People that are not covered pay OOP to use health services.

Service coverage

- Members are entitled to access all levels of care, essential medicines and some selected drugs.
- Primary care facilities are responsible for referrals to secondary and tertiary care.
- The scheme covers patients with Aids related illness.

Cost coverage

- Financed through indirect tax (2.5% levy on VAT) covering approx 70% of funding; employees social insurance contributions (20-25%) and annual contribution from subscribers (<5%).
- Approx US\$3.50 - US\$24 per person per year. Intended to vary with income but districts often charge flat rate.

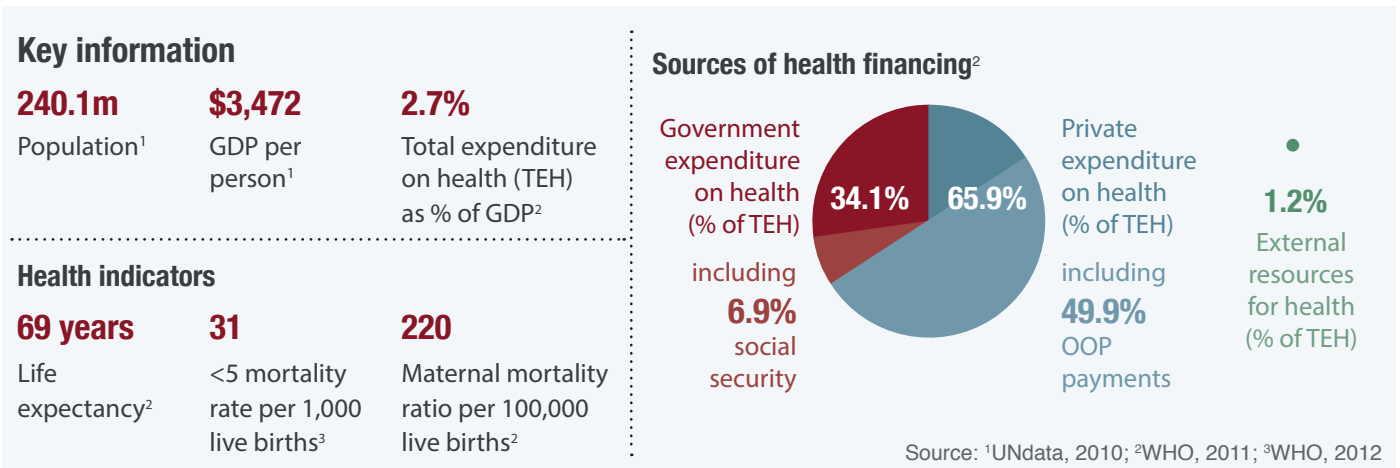
Targeting the poor

- Exemptions for payments for unemployed.
- Uses existing CBHI schemes to reach the informal sector.

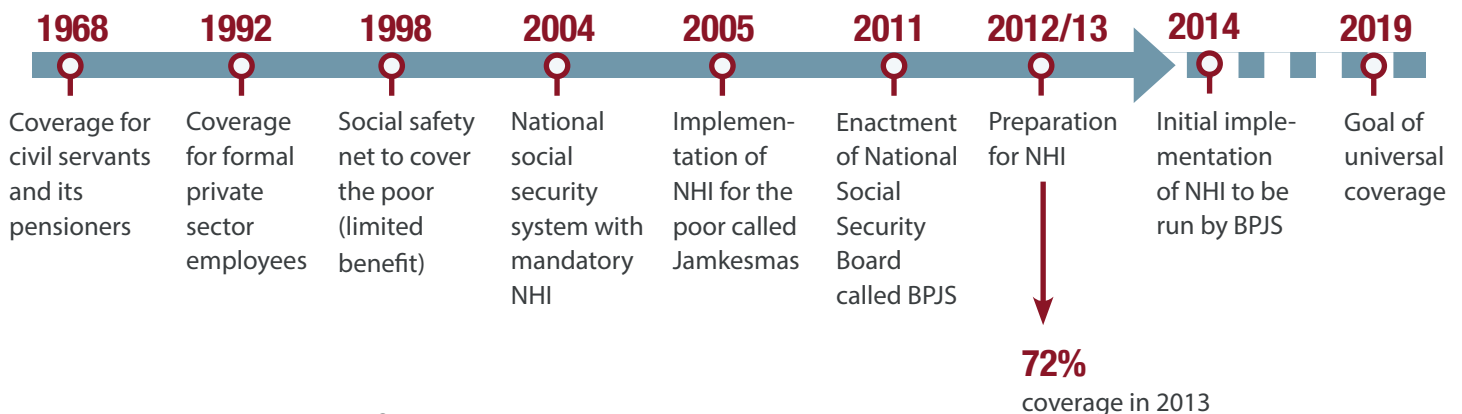


Indonesia

In 2014 a National Health Insurance (NHI) Scheme will integrate all social insurance programmes in Indonesia, including Jamkesmas - the existing government-funded insurance scheme for the poor.



Evolution of health insurance coverage



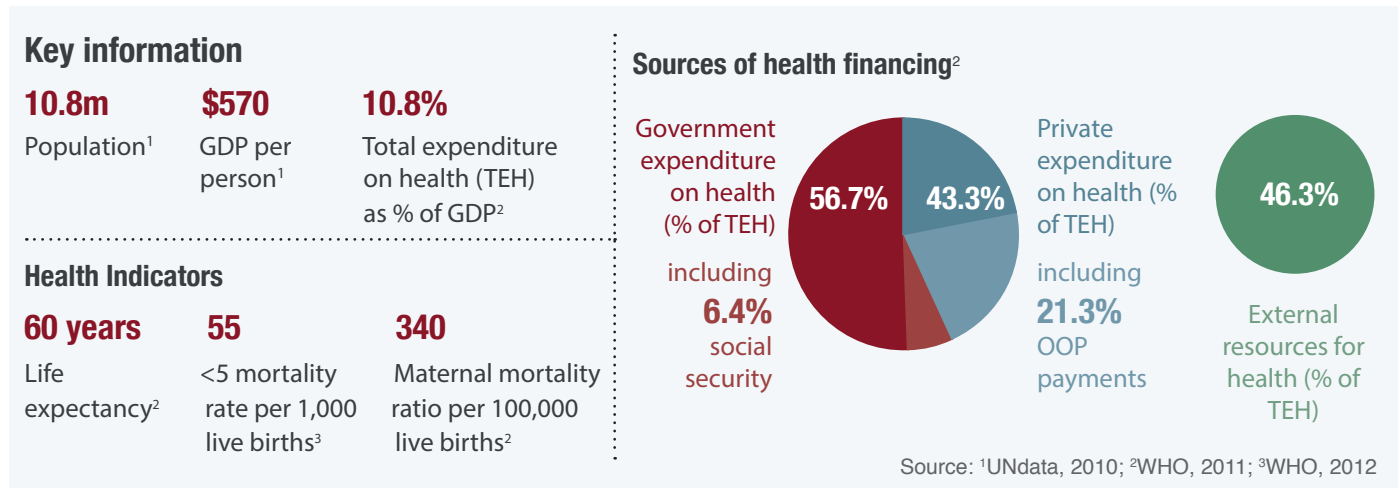
Measures to cover the informal sector: Jamkesmas

Population coverage	Service coverage	Cost coverage	Targeting the poor
<ul style="list-style-type: none"> Jamkesmas covers approximately 76.4 million people. Coverage rates for the poor and near poor was approx 35% in 2010. 28% of the population are not covered by any form of insurance. NHI will be compulsory for formal sector employees and voluntary for the informal sector. 	<ul style="list-style-type: none"> Members can access services at all community clinics (<i>puskesmas</i>), inpatient (3rd class) services at public hospitals and some private hospitals. There are, however, large geographical disparities in the availability and quality of services. 	<ul style="list-style-type: none"> Jamkesmas is funded through government revenue (from social security funds) and administered by the MoH. The NHI will pool all existing insurance schemes, with central government paying for the poor. Informal sector workers (who are not poor) are expected to contribute to the scheme. 	<ul style="list-style-type: none"> Jamkesmas is specifically for the poor and near-poor although members also include the non-poor. Eligible households are identified through a census that covers housing, sanitation, electricity and asset ownership, and then individuals are enrolled by district-level health staff.

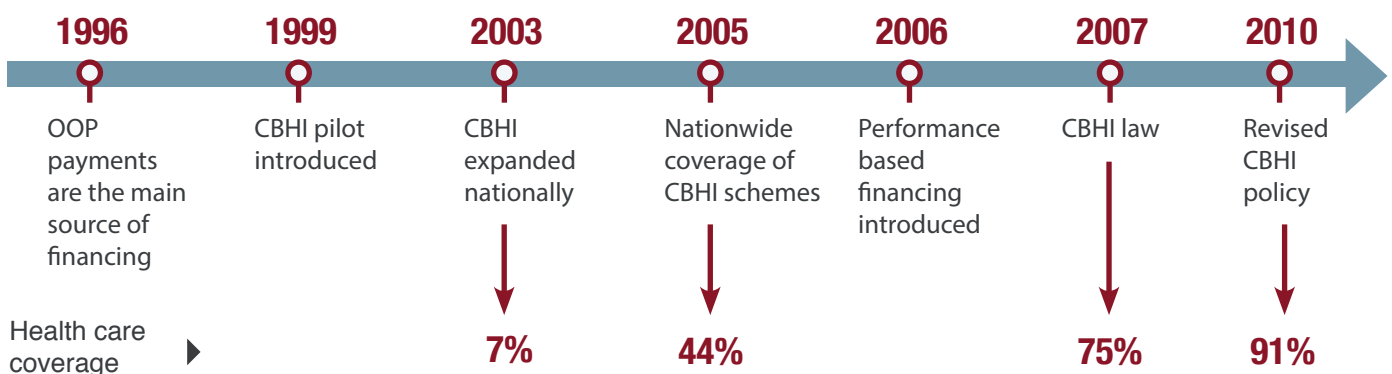


Rwanda

Efforts to achieve UHC through CBHI programmes comprising: Military Medical Insurance, the Rwanda Health Insurance Scheme and the Mutuelles de Sante which targets the informal sector.

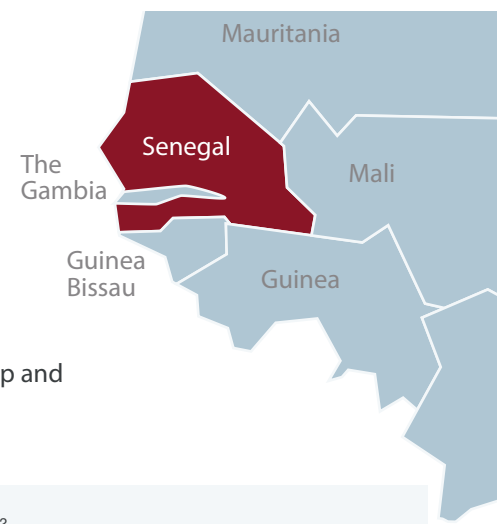


Evolution of CBHI



Measures to cover the informal sector: Mutuelles de Sante

Population coverage	Service coverage	Cost coverage	Targeting the poor
<ul style="list-style-type: none"> By 2010, 91% of the Rwanda population was insured through Mutuelles de Sante. Membership is voluntary and coordinated at the district level. Enrolment and outreach takes place at the community level targeting the rural and informal sector. 	<ul style="list-style-type: none"> Members are entitled to a minimum package of activities - all services and drugs provided by the local health centre. Local health centres are responsible for referrals to district/national hospitals. Members can also access curative services at all public and private non-profit health centres. 	<ul style="list-style-type: none"> Financed through government, donor and individual contributions. Members are grouped according to household wealth to determine their annual premiums (approx \$6 per person). Co-payments of \$0.30 for use of primary health services, and 10% at hospital. 	<ul style="list-style-type: none"> Contributions for the poorest are paid by the government, donors and from local 'mutuelle' level funds (approx 1.5 million people). The Ministry of Local Government is responsible for identifying the poor, not the Ministry of Health.



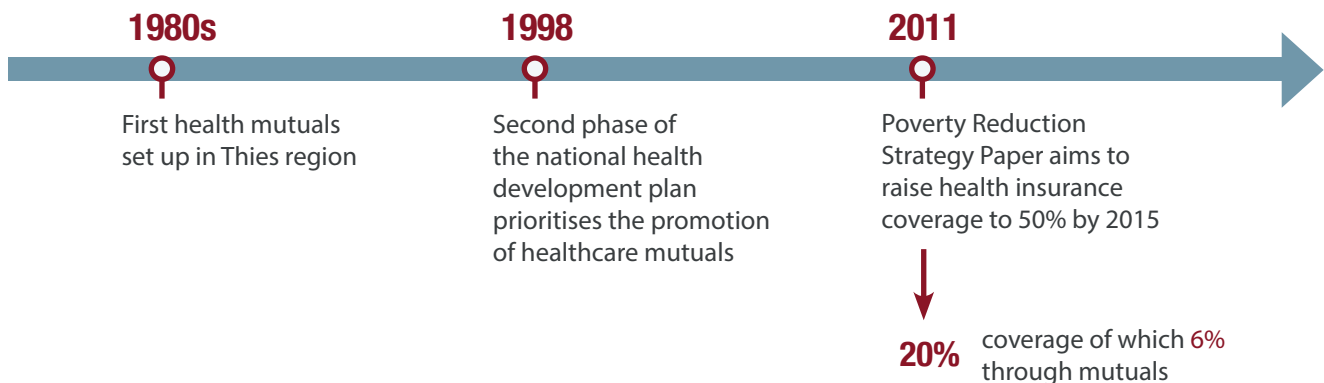
Senegal

Over 200 Mutuelles de Sante (mutual health organisations or mutuals) have been set up and run by rural and informal sector workers to provide insurance to its members.

Key information			Sources of health financing ²		
12.9m Population ¹	\$1,084 GDP per person ¹	6% Total expenditure on health (TEH) as % of GDP ²	Government expenditure on health (% of TEH) including 2.3% social security		Private expenditure on health (% of TEH) including 32.7% OOP payments
Health Indicators 61 years Life expectancy ² 60 <5 mortality rate per 1,000 live births ³ 370 Maternal mortality ratio per 100,000 live births ²					

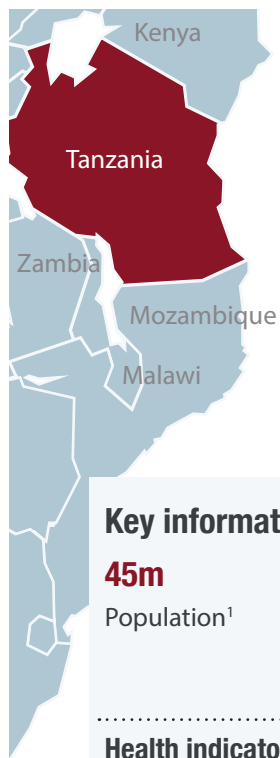
Source: ¹UNdata, 2010; ²WHO, 2011; ³WHO, 2012

Evolution of health mutuals



Measures to cover the informal sector: Mutual health organisations (e.g. Fandene mutual)

Population coverage	Service coverage	Cost coverage	Targeting the poor
<ul style="list-style-type: none"> Over 200 mutuals set up by community members to cover the informal sector. There are a number of different schemes/pools e.g. one for renal dialysis, one for labour and delivery. Despite operating for many years, mutuals have limited coverage (about 6% of the population). 	<ul style="list-style-type: none"> Packages of services provided vary across mutuals but often include: primary health care, tests, x-rays and inpatient services. 	<ul style="list-style-type: none"> Individuals make contributions on a voluntary basis. Most of the mutuals charge individuals about 200 CFA Francs per month (US\$0.4). There are no government subsidies but some mutuals receive technical assistance from NGOs and donors. 	<ul style="list-style-type: none"> Mutuals are intended to provide insurance for the poor, however, the poorest members of society often remain excluded. Some mutuals provide care for vulnerable groups with funding from NGOs.



Tanzania

Community Health Fund (CHF) is a voluntary pre-payment scheme that is funded by household contributions which are matched by the government.

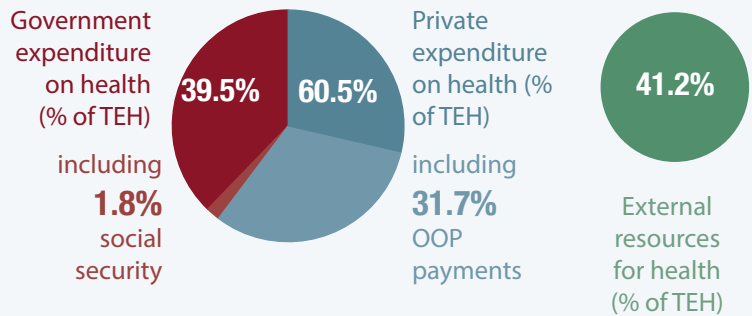
Key information

45m Population ¹	\$530 GDP per person ¹	7.3% Total expenditure on health (TEH) as % of GDP ²
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Health indicators

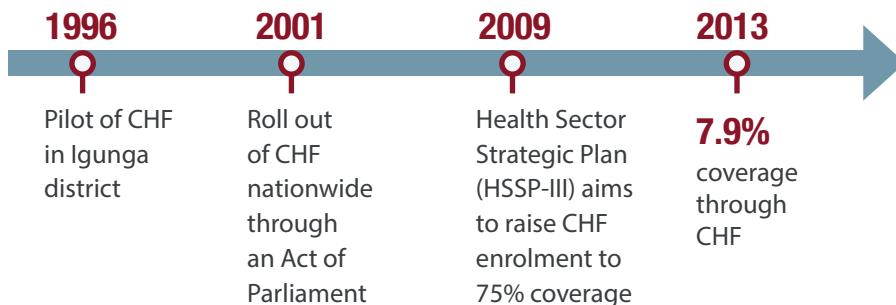
59 years Life expectancy ²	54 <5 mortality rate per 1,000 live births ³	460 Maternal mortality ratio per 100,000 live births ²
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Sources of health financing²



Source: ¹UNdata, 2010; ²WHO, 2011; ³WHO, 2012

Evolution of CHF



Plans to improve coverage

- Harmonise management and administration of CHF with the National Health Insurance Fund (Formal Sector Scheme).
- Engage non-government providers to improve service availability.
- Increase investment in primary health care.
- Introduce facility bank accounts.
- Develop a national health financing strategy.

Measures to cover the informal sector: Community Health Fund

Population coverage

- The CHF covers approximately 7.9% of the population, although coverage varies across districts.
- Membership is voluntary and managed at the district level.

Service coverage

- Households register at one primary health care facility of their choice and access is limited to this facility.
- Variations across districts, e.g. some include district hospitals.
- CHF funds are mainly used by facilities to purchase drugs and supplies and for renovations.

Cost coverage

- Financed through household contributions (between US\$4.2 and US\$12.7 per year), as agreed by members of the community.
- The government matches members' contributions by 100%.
- CHF have high administration costs (approx 30% of revenue).

Targeting the poor

- The CHF targets the poor and those living in rural areas.
- The idea is that households can pre-pay for health care during harvest time and use services throughout the year.
- Waivers for the poor, although in practice this rarely happens partly because of difficulties in identifying the poor.

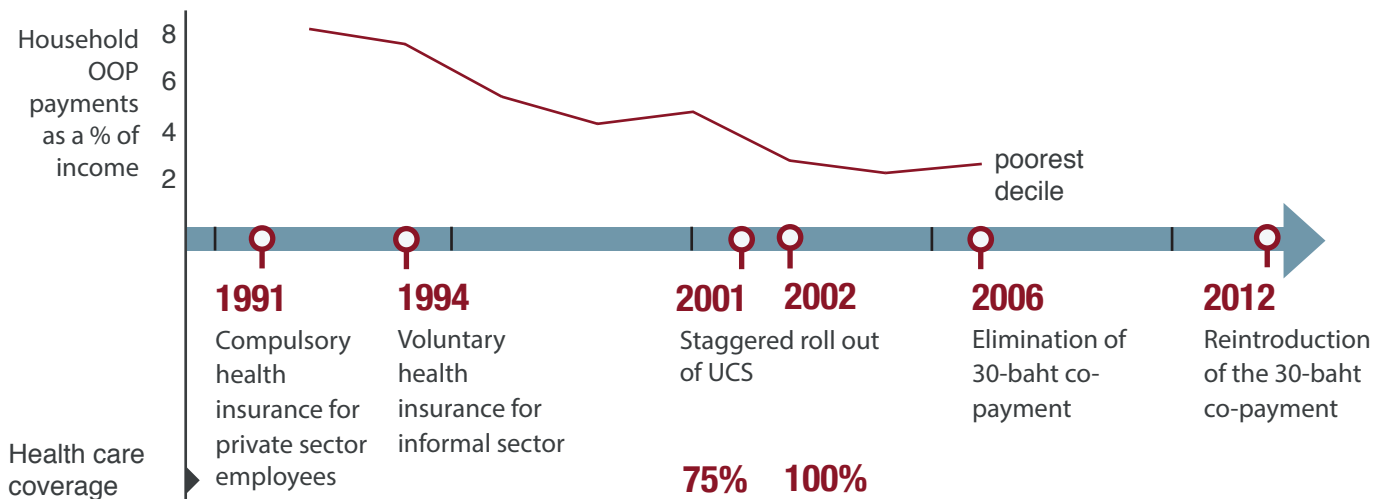


Thailand

Tax funded Universal Coverage Scheme (UCS) that aims to provide access to essential health care and reduce catastrophic health expenditure for the whole population.

Key information			Sources of health financing ²		
66.4m Population ¹	\$5,192 GDP per person ¹	4.1% Total expenditure on health (TEH) as % of GDP ²	Government expenditure on health (% of TEH) 75.5% including 7.5% social security	Private expenditure on health (% of TEH) 24.5% including 13.7% OOP payments	0.4% External resources for health (% of TEH)
Health indicators 74 years Life expectancy ² 13 <5 mortality rate per 1,000 live births ³ 48 Maternal mortality ratio per 100,000 live births ²					

Source: ¹UNdata, 2010; ²WHO, 2011; ³WHO, 2012



Measures to cover the informal sector: Universal Coverage Scheme (UCS)

Population coverage	Service coverage	Cost coverage	Targeting the poor
<ul style="list-style-type: none"> UCS covers approximately 74% of the population (48 million). This is an additional 14 million people who were previously uninsured for health care costs. Coverage is for those not eligible for Social Health Insurance and Civil Servant Medical Benefit Scheme (CSMBS) for government employees. 	<ul style="list-style-type: none"> Access to comprehensive outpatient and inpatient services including maternity, prevention, promotion and rehabilitation services and essential drugs. Members are required to register with a contracted primary health care network. Health care providers are from both the private and public sectors. 	<ul style="list-style-type: none"> UCS is funded through general tax. A 30-baht co-payment was abolished in 2006 and then reintroduced in 2012 for those willing to pay. Provider payment is based on the number of beneficiaries registered with a network for outpatient services, and on diagnosis-related groups for inpatient services. 	<ul style="list-style-type: none"> UCS ensures that the whole population is entitled to health care, regardless of their income. In particular, it covers people who are not eligible for employee health insurance including the informal and agricultural sector.

Source of graph: Chapter 7, Why and how did Thailand achieve Good health at low cost? In Balabanova D, McKee M and Mills A (eds). 'Good health at low cost' 25 years on. What makes an effective health system? London: London School of Hygiene & Tropical Medicine, 2011.

» Rwanda - a unique success story for CBHI

On the second day of the workshop, participants learned more about Rwanda's CBHI scheme called Mutuelle de Santé by visiting a CBHI administrative office, a district health centre and a community health worker cooperative. The visit inspired discussions about how Rwanda, uniquely, has managed to achieve high population coverage through CBHI.

How has Rwanda achieved high levels of coverage?

1. Strong administrative and political support

The government is committed to the goal of UHC and recognises the integral role that CBHI can play in achieving this. Central government commitment is demonstrated through the technical support it provides to district levels, for example health-financing experts from the Ministry of Health who help to supervise the implementation and management of the schemes.

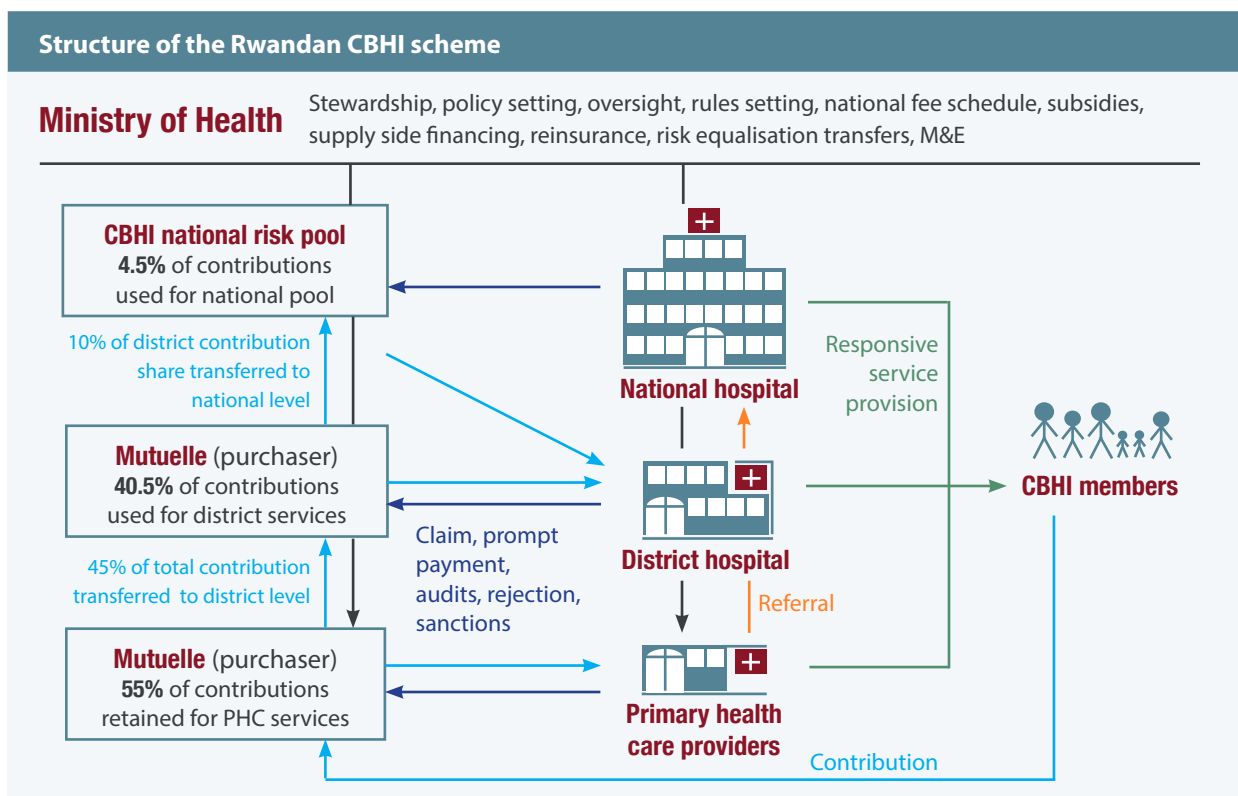
2. Autonomous facilities and local ownership

Despite being centrally led with regards to policy, regulation and evaluation, the management and administration of health facilities has remained autonomous, allowing facilities to respond to the needs of the local community. The community is also involved in the operation of the mutuelles, for instance by participating on committees or serving as voluntary health workers.

3. Collaboration and coordination between levels of the health sector

Successful merging of a centralised financing policy with community-based schemes has required trusting relations and coordination between different actors – for instance, district government trusting local authorities to identify beneficiaries for exemption from contributions. Revenue that is generated from members' contributions is also shared across levels of the health sector as shown in the diagram below.

In Rwanda health coverage reached 91% of the population by 2010



4. Extensive efforts to enrol members and maintain subscriptions

Within communities there are considerable efforts to increase enrolment by voluntary health workers and local leaders. District mayors' performance contracts include CBHI and they are regularly assessed on the performance of CBHI in terms of coverage, amongst other criteria, which further encourages them to promote CBHI policy.

“In Rwanda, we have made much progress towards universal health coverage. Now the challenge is to work with health care providers to ensure that people can access a comprehensive package of high quality services at low cost, and that they can avoid the financial burden of using services” - Mr Jean Louis Mukunzi, Health Insurance Policy Expert, Ministry of Health, Rwanda.

Maintaining a balance between decentralisation and centralisation

Some of Rwanda's success appears to be in its ability to strike a balance between a centrally driven health financing policy with strong leadership and technical capacity passed on to the district levels, and a decentralised system for collecting payments and transferring revenue to facilities. Retaining revenue at the local level has enabled facilities to respond to local health needs and strengthened accountability.

Ghana has also used schemes located at district level to scale-up its national health insurance scheme (NHIS); however, it has adopted a much more centralised approach and removed financial autonomy from the local level, and this has led to concerns about the accountability and transparency of the NHIS.

Ms Helen Dzikunu from Ghana explained the consequences of this approach:

“Unlike Rwanda, health insurance schemes in Ghana have not maintained autonomy over spending decisions. Money that is collected from the communities is transferred to the national level before being re-distributed back to health insurance schemes and payment of health facilities. This creates a time lag and means that health facilities are often short of funds.

Also in Rwanda there is community participation in the scheme – section leaders [from the community] attend local government meetings to voice their satisfaction or dissatisfaction and give ideas. In Ghana, on the other hand, there is no opportunity for the community to participate and there are no groups to represent or protect the communities.

We started off with the idea of decentralisation as a key policy. Now community participation is nil - they have taken the power away from the local level.”

» Comparing different financing approaches

On the final day of the workshop participants reflected upon what they had learned from the country experiences and discussed the merits and disadvantages of different financing approaches to cover the informal sector including contributory insurance schemes and non-contributory mechanisms such as tax-financing and donor funding. These were considered in relation to efficiency and equity.

Efficiency

The efficiency of a health financing mechanism has two components: how much money it generates after costs of collection are taken into account, and the extent to which it promotes resources being used on quality services that meet the health needs of the population.

Efficiency in revenue generation:

- Workshop participants queried how much revenue CBHI schemes are able to generate. Contributions have to be low to be affordable; however, even small amounts that are retained at local level can be extremely important in facilities being able to deliver services and ensure that medicines are available. More specifically, these small amounts may be vital for the facility, because it is often the only direct resources that can be managed with some degree of autonomy.
- There were also discussions about the cost of administering funds through community-based schemes. Currently, there is a lack of evidence on how big these costs are, although they are thought to be greater than other financing mechanisms such as tax collection. The CHF in Tanzania is estimated to have high administration costs constituting approximately 30% of its revenue. However, some participants pointed out that some level of transaction costs is unavoidable to ensure accountability and community participation.

Efficiency in use of resources:

- Discussions about efficiency in the use of resources focused on how to pay providers (provider payment mechanisms) and on how to ensure quality in services that are purchased.

Provider payment mechanisms:

- Rwanda has adopted a pay-for-performance (P4P) approach, whereby health care providers receive bonuses based on process measures of quality.
- Thailand pays providers based on the number of people registered at a facility (capitation) and diagnosis related groups (DRG). The introduction of DRG requires a high level of information infrastructure and audit capacity in order to monitor how the mechanism works and avoid side effects, such as gaming.
- Participants highlighted the challenges in moving from one mechanism to another, e.g. from fee-for-service to capitation, and the need for good governance structures and evaluation capacity to ensure that the mechanism is effective and the expected outcomes are achieved.

Ensuring quality in the services purchased:

- Purchasers can play an important role in ensuring quality health care services, for instance by including instruments to monitor quality, or by providing incentives.
- It is possible to involve professional organisations in quality assurance mechanisms. If this occurs, it is important to align the interests of professional organisations with those of the purchasers, members and the public.

Equity

There are two sets of issues concerning equity: who bears the burden of paying for health care, and who benefits from health services.

Equity - who contributes?

- Equitable financing approaches mean that people contribute towards health care according to their ability to pay. Out-of-pocket payments for health services are the least equitable financing instrument as poorer households pay a larger proportion of their income than relatively wealthy households.
- The challenge of the informal sector is in identifying people's ability to pay and to equitably draw resources from them. Rwanda has developed a seemingly successful system for categorising people and identifying poorer groups who are exempt from contributions (*ubedehe*). Ghana also offers exemptions for the poor, however, in reality districts often charge a flat rate for all people due to difficulties in identifying their income.

“Making a small contribution through community based insurance schemes is still better than OOP and may have an important role to play in a transition towards a tax-funded system.”

- Dr Viroj Tangcharoensathien, International Health Policy Program, Thailand

Equity - who benefits?

- Equity in health is an outcome that is not simple to reach - equity in financing is a necessary but not sufficient condition. In many countries, structural exclusionary processes play a role in explaining why even a well-defined financing system may not be sufficient to ensure that everyone has access to healthcare services.
- Many of the countries represented at the workshop have separate pools and benefit packages for people in the formal and informal sectors. In Rwanda and Tanzania for example, formal sector employees have access to a greater range of services than those outside the formal sector. The CHF in Tanzania only covers a limited number of outpatient services for the informal sector, while the formal sector schemes provide a comprehensive package of benefits.
- Thailand's tax-funded system also has separate pools; however, it has managed to provide an extensive range of services for those outside the formal sector.
- In contrast, Ghana has a single pool – whether formal or outside the formal sector, everyone has access to the same health services through the NHIS.

Equity in health is an outcome that is not simple to reach
- equity in financing is a necessary but not sufficient
condition to ensure everyone can access services

» Debate - tax versus insurance-based financing

During the workshop an organised debate aimed to address the contentious issues of how best to draw resources from the informal sector and whether or not contributions are necessary for people to value health care. The debate began with a head-to-head discussion between Professor Di McIntyre and Professor Bart Criel who took differing stances on how to secure resources for health, starting with Di advocating for an increase in tax-based financing:

“In situations where there is a strong view that everyone must contribute to funding health care, indirect taxes can be an efficient, equitable and evidence-based solution for increasing resources for health”

In most low and middle-income countries, the biggest share of government revenue comes from indirect taxes because there is such a small formal sector and small income tax base. Focusing on indirect taxes such as VAT, fuel levies or import duties is the best way to get revenue from the informal sector.

Indirect taxes can be efficient and equitable because the system for drawing indirect tax already exists, so it is an issue of increasing those taxes, as well as considering other innovative ways of raising funds. In all the studies that have been done in low-income countries, most indirect taxes (particularly VAT) are progressive because necessities such as basic foodstuffs are exempt. This means that people with more income pay a higher percentage of that income in tax.

Issues related to the scale-up of indirect taxes

- How do we ensure that revenue from VAT actually goes to funding health care?
- In some middle-income countries including South Africa, VAT is regressive and places a greater burden on poor people. The evidence suggests that as countries get richer, indirect taxes become more regressive.
- Indirect taxation is politically unpalatable for many politicians as it is considered by some to be a cause of inflation, also it is difficult to argue the case for earmarked taxes for health rather than for education or other sectors.
- If countries rely too heavily on indirect taxes, there might come a point where relatively wealthy people become less willing to pay taxes and look for ways to avoid these, and it could also affect social cohesion.

“Countries are very different and for each country it is important to understand the tax system - which elements are progressive and which are not” - Dr Viroj Tangcharoensathien, International Health Policy Program, Thailand

A key concern in the debate about contributory versus non-contributory systems is whether or not service entitlements are linked to contributions. Requiring people to contribute towards their health care has major equity considerations as there are some people who cannot afford to contribute even a small amount. However, Professor Bart Criel highlighted one benefit of people contributing directly towards their own health care:

“Small, local contributions may help to strengthen social solidarity which is a pillar in building sustainable and equitable health care financing”

Considering only equity and equality is not addressing the whole issue – especially with regards to sustainable systems for collecting domestic revenue, as this also requires consideration of individuals’ perceptions and sense of social solidarity. People need to be aware of what they are paying for, why they are paying, and for whom they are paying. Small contributions e.g. local payments, taking into account ability to pay, can foster a sense of ownership and complement larger non-contributory systems.

These payments can have a strong symbolic value. They give social solidarity a face within the local community, and provoke discussions and debates within communities about issues such as risk sharing and redistribution, which are crucial in safeguarding the sustainability of the health system in the long term.

Points of discussion regarding the need for contributions

- Why do we demand demonstration of solidarity from small communities but not from society as a whole? Why would local insurance schemes be more effective and equitable than a system that asks a society to pool all the funds in a common pool and then subsidises those who cannot pay?
- In divided societies such as South Africa, health systems as a social institution can contribute to building social solidarity if everyone is using the same services. So, the face of solidarity can be through using - rather than paying - for health services.
- However, contributing to a scheme can give people a voice to hold health care providers to account. When contributions are made through indirect taxes, people are less aware of what they have contributed towards, diminishing lines of accountability.

“In Ghana people are not educated to know that [they have contributed through tax and therefore] revenue ought to be shared to reach all of us, we need to let the people understand that - I pay tax, and because I pay tax, I have a right to access the services.”

- Ms Helen Dzikunu, Ghana.

Important questions remain as to how contributions can be both progressive and compulsory, and how to separate the level of contribution from health service utilisation so that costs do not prevent people from seeking and using health care.

» Key conclusions of the discussions

Providing coverage for the informal sector is an essential step in a country's path to UHC, especially in LMIC where this constitutes most of the population. Countries that have had success in extending coverage, such as Rwanda and Thailand, have strong political support for the concept of UHC, and have focused efforts on reaching the informal sector.

Whilst each country will decide on a mix of financing mechanisms to suit their own context, the workshop raised several issues worthy of serious consideration by decision-makers who are planning or reviewing their health financing strategy for universal coverage.

- › **Understanding the informal sector:** The informal sector is highly diverse and its composition varies across countries and within countries. Approaches to mobilising resources from the informal sector will therefore need to take into account local factors, including the capacity to pay of specific groups and the availability of organisational structures through which its resources can be tapped.
- › **Contributions from users:** The issue of whether to require contributions from users is complex and unresolved: contributions can bring accountability at local level, but they may carry high administrative costs as contributions can be costly to collect compared with the revenue they generate. Policymakers will need to consider evidence that is grounded in their own local reality about efficiency and equity of different ways of raising funds for health, and not rely on conventional understandings and received wisdom.
- › **Fragmented risk pools can put cross-subsidies at risk:** Where general revenue is being channelled into different pools with different levels of government subsidy, it can be difficult to secure effective cross subsidies.
- › **Purchasing is the linchpin of the financing system:** As well as providing a systematic way to define benefit packages, identify eligible providers, and set effective payment mechanisms, strategic purchasing can be used to create accountability from the payer side to complement the accountability mechanisms that operate through the providers. However, purchasers need to find novel ways to represent citizens' views and communicate service entitlements.
- › **Balancing centralised and decentralised functions:** Retaining locally generated funds can be an important means of improving transparency within the financing system, as well as avoiding delays and administrative costs. Providing these funds are supplemented with centrally collected resources to enhance equity, they can be an important means of reinforcing payer-led accountability.

» Gaps in the evidence base

During the workshop participants identified several areas where there is a need for more research.

» Contextualising evidence about alternative financing approaches

- More evidence is needed on the distribution across socioeconomic groups of the burden of financing and the benefits of using health services; these analyses should provide a detailed description of the context and the policy process, so that policymakers can understand what is likely to work in different settings.
- Further research can provide insights into how contributory models can be made both compulsory and progressive, to enhance redistribution between the healthy and the sick, and between the better off and the poor.
- Contributory mechanisms may offer opportunities for decentralised management and local accountability, but may limit possibilities for redistribution and increase administration costs. What are these trade-offs in practice, and in different settings?

“Rwanda’s ability to cover a large section of the informal sector is impressive, in particular in organising informal workers to enrol into the scheme and to pay the subsidised premium. However, there remain outstanding questions about the cost of the premium, about how to increase utilisation and how to ensure high quality services.” - Dr Pujiyanto, University of Indonesia, Indonesia.



» Optimizing the health service purchasing function

- Purchasing is a key element of health financing, yet little is known about how to do it more effectively. Much more evidence is needed about how to bring strategic purchasing principles into all health financing systems, including how to define benefit packages, how to select providers who will deliver quality services, and how to pay providers to encourage equity, quality and efficiency.
- Countries have been experimenting with specific elements of the purchasing function through, eg, introduction of a capitation mechanism in Ghana, case-based payment in Tanzania, and pay-for-performance in many African settings. As well as stronger evidence about the effectiveness of these approaches, researchers should also consider the intermediate processes by which they operate, and how they interact with the broader health financing system.

» Finding the right balance between centralised and decentralised functions

- Greater centralisation is necessary to ensure the efficiency of certain processes, such as risk-pooling; but decentralisation can promote local solutions, accountability and responsiveness. What country experiences can provide lessons about which functions to decentralise, and which to retain at central level?

» Working with other sectors

- Ensuring that the poorest have access to essential services may require novel approaches to identification and targeting. What lessons can be drawn from the experience of other social services, such as social welfare and social protection, agriculture, water and sanitation?
- How can broader social protection strategies address the multiple needs of the poorest in a comprehensive way?

» Understanding the informal sector

- The make-up of the informal sector varies enormously across countries, ranging from the very poor and marginalised, through to self-employed professionals. A better understanding is needed of the composition of the informal sector in specific settings, including formal and informal organisations through which contributions or taxes may be levied.

Publications

- › **Providing financial protection and funding health service benefits for the informal sector: evidence from sub-Saharan Africa** by Jane Chuma, Stephen Mulupi, and Diane McIntyre. RESYST Working Paper 2; 2013

A review of the literature on domestic pre-payment funding mechanisms in relation to three dimensions of universal coverage: population coverage, service coverage and cost coverage.

- › SHIELD (Strategies for Health Insurance for Equity in Less Developed Countries) project outputs including:

- **Progress towards universal coverage: the health systems of Ghana, South Africa and Tanzania** by Anne Mills, Mariam Ally, Jane Goudge et al. *Health Policy and Planning*; 2012 27 (Suppl 1): i4-i12

The first of a series of papers that critically evaluate existing inequities in health care financing and provision in Ghana, South Africa and Tanzania and the extent to which health insurance mechanisms (broadly defined) could address financial protection and equity of access challenges.

- **Equity in financing and use of health care in Ghana, South Africa, and Tanzania: implications for paths to universal coverage** by Anne Mills, John E Ataguba, James Akazili et al. *The Lancet*; 2012. Vol. 380, Issue 9837, Pages 126-133.

This research paper measures the progressivity of health-care financing mechanisms, catastrophic spending on health care, and the distribution of health-care benefits in Ghana, South Africa and Tanzania.

- › **Taskforce on Innovative International Financing for Health Systems. More money for health, and more health for the money: final report.** Geneva: International Health Partnership; 2009.

Final report from the taskforce sets out its recommended actions for raising additional resources for health including through innovative financing options.

- › **Towards Universal Health Coverage: An Evaluation of Rwanda Mutuelles in Its First Eight Years** by Chunling Lu, Brian Chin, Jiwon Lee Lewandowski et al. *PLoS ONE*; 2012 7(6): e39282. doi:10.1371/journal.pone.0039282

This research paper evaluates the impact of Mutuelles on achieving universal coverage of medical services and financial risk protection between 2000 and 2008.

- › **Social protection in health: the need for a transformative dimension** by Joris JA Michielsen, Hermen Meulemans, Werner Soors, et al. *Tropical Medicine & International Health*; 2010 15(6), 654–8

This editorial argues that social protection in health needs to address the structural determinants of health-related social vulnerability.

- › **Community Health Insurance and Universal Coverage : Multiple paths, many rivers to cross** by Werner Soors, Narayanan Devadasan, Varatharajan Durairaj and Bart Criel. World Health Report (2010) Background Paper, 48.

This background paper examines community health insurance in six LMIC - Senegal, Mali, Ghana, Rwanda, China and India in relation to three dimensions of UHC - population coverage, service coverage and financial coverage.

Research projects

› RESYST: Expanding fiscal space through improved tax collection in Kenya, Nigeria (Lagos State) and South Africa

RESYST is conducting 3 case studies of countries/states that are recognised as having successfully increased general tax revenue by strengthening their tax administrative systems. The research will document how each country has increased general tax revenue and its impact on financing public services, especially health care. The research was carried out in 2013 and results are expected in 2014.

<http://resyst.lshtm.ac.uk/research-projects/case-studies-improving-tax-collection>

› RESYST: Investigating the purchasing arrangements for health care financing systems in LMIC

RESYST and the Asia Pacific Observatory on Health Systems and Policies are collaborating to investigate the purchasing arrangements for health care financing systems in 10 LMIC - China, Indonesia, India, Kenya, Nigeria, the Philippines, South Africa, Tanzania, Thailand and Vietnam.

Starting in 2014, each country will carry out case studies of existing purchasing mechanisms using a common protocol. The aim is to assess the performance of health care purchasers and identify factors that influence their performance.

<http://resyst.lshtm.ac.uk/research-projects/multi-country-purchasing-study>

› Health Inc: Financing health care for inclusion

The Health Inc. research project is a collaborative research project between London School of Economics (LSE) Health (project coordinator), the Institute of Tropical Medicine in Antwerp, Tata Institute of Social Science in Mumbai, Institute of Public Health in Bangalore, the Centre for Research on Social Policies in Senegal and the Institute of Statistical, Social and Economic Research in Ghana.

The research explores how social exclusion restricts access to health services despite the launch of recent social health protection programmes and how social health protection can be increased. Research has been conducted in Ghana, Senegal and the Indian states of Maharashtra and Karnataka. The project is a European Commission-funded project, on a grant from the 7th Framework Programme. It started in 2011 and will continue until the end of 2014.

<http://www.healthinc.eu>

› Documenting the Community Based Health Insurance Experience in Rwanda

The overall objective of this study is to document the CBHI experience in Rwanda. The research methodology includes a desk review as well as key informants' interviews. The review includes surveys of CBHI beneficiaries and uninsured households to examine: the financial effects on individuals and households, the impact of new premium schedules, barriers to access to care, utilization of selected services (preventive and curative care), and factors facilitating or impeding enrolment to CBHI. An analysis of secondary data from national surveys, Rwanda Demographic Health Survey (RDHS), and Integrated Living Conditions Survey (EICV) will also be done.

More information: Dr James Humuza (UR/CMHS/SPH), email: humuzajames@gmail.com

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