Policy brief

Subsidized health insurance for the hard-to-reach

# Towards universal health coverage in the Arab region: a first look

November 2021

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# Vision

ESCWA, an innovative catalyst for a stable, just and flourishing Arab region

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Committed to the 2030 Agenda, ESCWA's passionate team produces innovative knowledge, fosters regional consensus and delivers transformational policy advice.

Together, we work for a sustainable future for all.

Policy brief

# Subsidized health insurance for the hard-to-reach

## Towards universal health coverage in the Arab region

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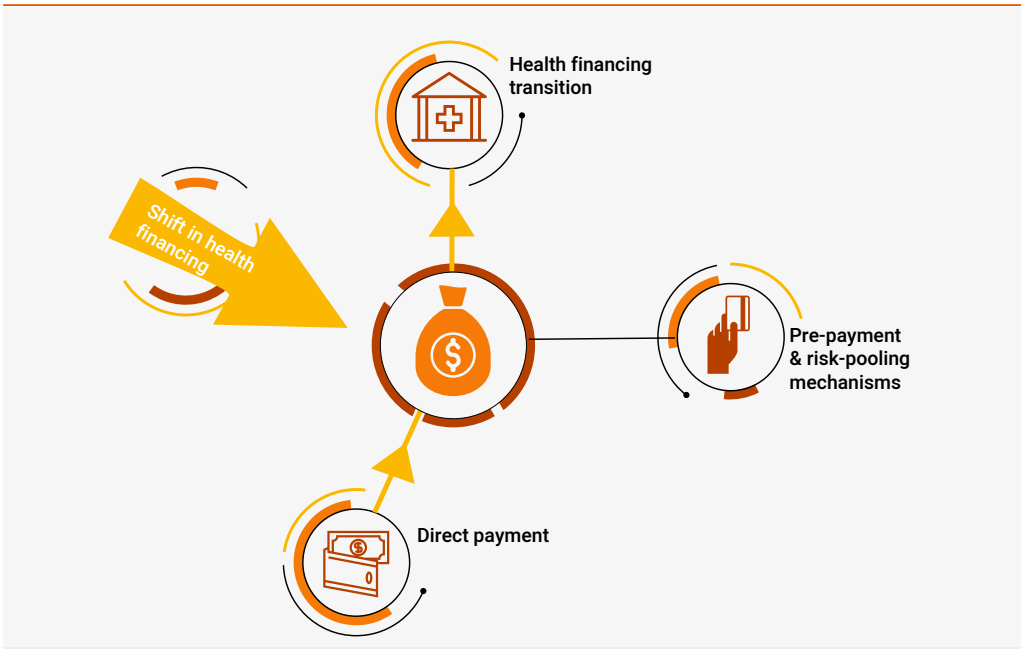
# Introduction

The COVID-19 pandemic has demonstrated the need to achieve universal health coverage (UHC) and to guarantee access to quality essential health services for all, as underscored by Sustainable Development Goal target 3.8. To reach UHC, countries increasingly opt for government budget transfers to health insurances to expand health coverage to **hard-to-reach** groups, such as informal workers, poor populations, persons with disabilities and those suffering from chronic diseases. The effective identification and enrolment of these groups in programmes that provide full, or near full, subsidization of health insurance contributions is necessary for governments to provide transfers to increase population and service coverage as well as financial protection.[1]

[1] This policy brief summarizes the main findings obtained through a review of publicly available information on subsidized health coverage arrangements in a selection of ESCWA countries and explores essential design and regulatory features of subsidized arrangements.

**Figure 1.** The health financing transition, explained




To achieve this, governments should aim for a **health financing transition**, where per capita health spending increases and **pre-financed risk-pooling** mechanisms from public resources replace **direct payments** from private sources at the point of health care delivery, especially direct out-of-pocket payments (OOP). **Health financing transition** is a necessary step towards UHC, it enhances **financial risk protection** by reducing the burden of health spending on vulnerable groups.

# Impact assessment

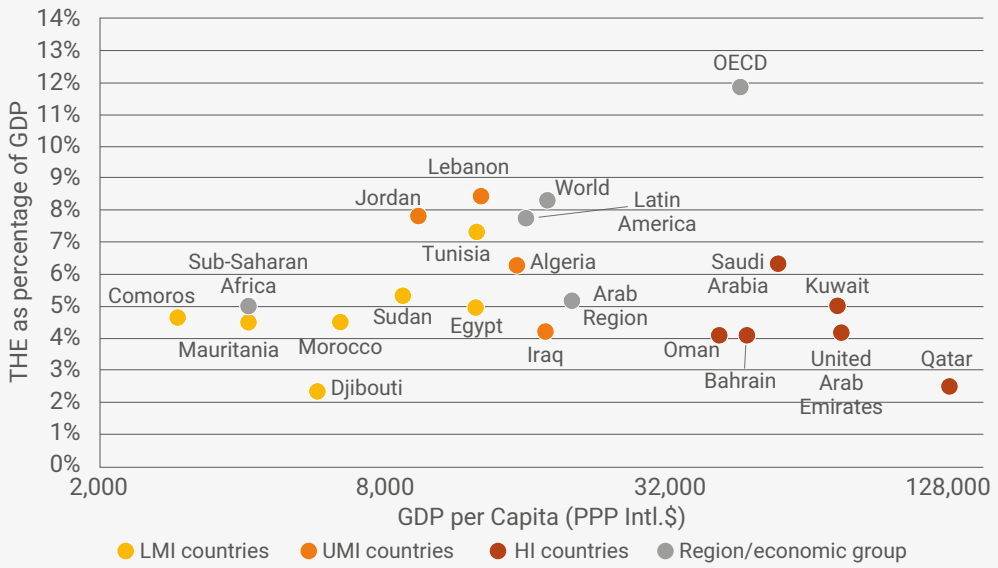
## How much do Arab countries spend on health?

An analysis of key indicators related to the health financing transition in the Arab region revealed that total health expenditure (THE) is relatively small in most Arab countries. In 2018, THE as a share of Gross Domestic Product (GDP) accounted for 5.3 per cent in the Arab region, which is lower than the global average of 8.2 per cent and the average in Latin American countries, of 7.7 per cent, even though the GDP per capita level (in PPP intl.$) in the Arab region is slightly higher than both the global and the Latin American averages.

Although there is no commonly accepted benchmark for the share of GDP that a country should allocate to health, a low share of GDP spent on health may indicate that this country either has:

- A limited fiscal space for health.
- A relatively young population.
- Low priority for spending on health.

**Figure 2.** THE as a share of GDP vs. GDP per capita (in PPP intl.$) in the Arab region, 2018



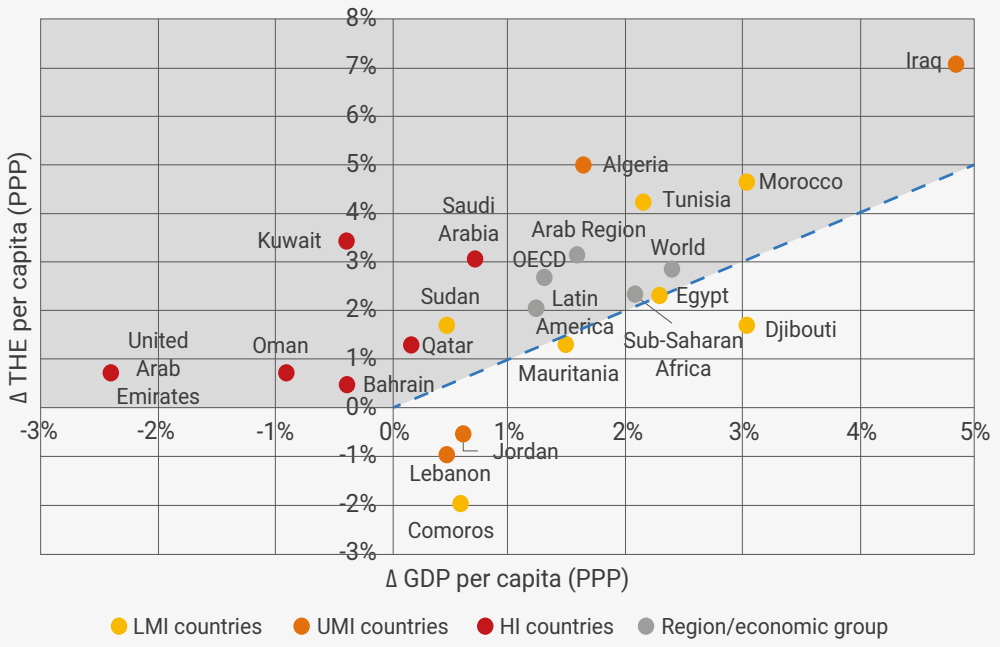

**Source**: Calculated by the United Nations Economic and Social Commission for Western Asia (ESCWA) based on data from the World Health Organisation's (WHO) Global Health Expenditure Database (GHED) and ESCWA's data portal (Accessed 11/11/2021).

**Note:** Lebanon is classified in the present study among upper-middle-income countries because data refer to the pre-economic crisis period. It has since been reclassified by the World Bank among lower-middle-income countries, https://data.worldbank.org/country/LB.

Health spending ideally grows faster than GDP per capita. In most Arab countries, the average annual increase in health spending has been higher than the economic growth average over the period 2000-2018 (as shown by countries in the shaded area in figure 3).

Moreover, health expenditure per capita in the Arab region has been increasing at a higher rate than the global average and even other regional averages (Sub-Saharan Africa) despite the slower economic growth.

**Figure 3.** Average annual change in THE per capita vs. GDP per capita (constant 2018 PPP $) in the Arab region, 2000-2018

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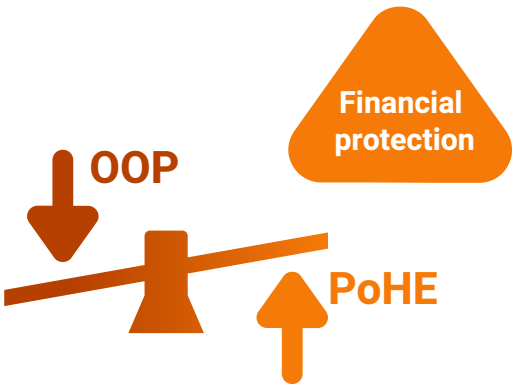
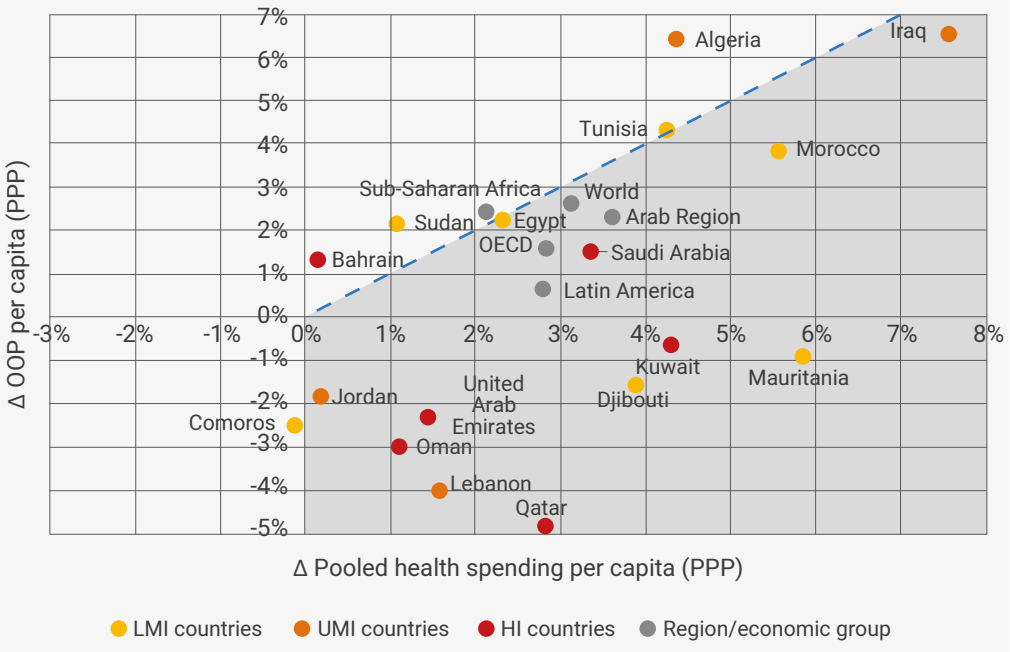
## Financial protection: is pooled health spending overtaking OOP?




Financial protection (SDG indicator 3.8.2) is the ultimate goal of UHC and subsidized health insurance arrangements. Enhancing the financial protective capacity of the health system entails reducing the direct OOP payments borne by households by increasing the proportion of pooled health expenditure (PoHE).

Whenever PoHE grows faster than OOP payments, the pooled share of health spending increases, indicating that the financial protective capacity of the health system is improving (as shown by countries in the shaded area of figure 4).

**Figure 4.** Average annual change in PoHE per capita vs. OOP per capita (constant 2018 PPP $) in the Arab region, 2000-2018




**Source**: Calculated by ESCWA based on data from WHO's GHED (Accessed 11/11/2021).

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Arab countries are considered to be progressing through the health financing transition whenever they would be positioned inside the shaded areas of both figures 3 and 4, which indicates that they are witnessing an increase in per capita health spending and an improvement in financial protection.

## How large is the fiscal capacity? How much of it is allocated to health?

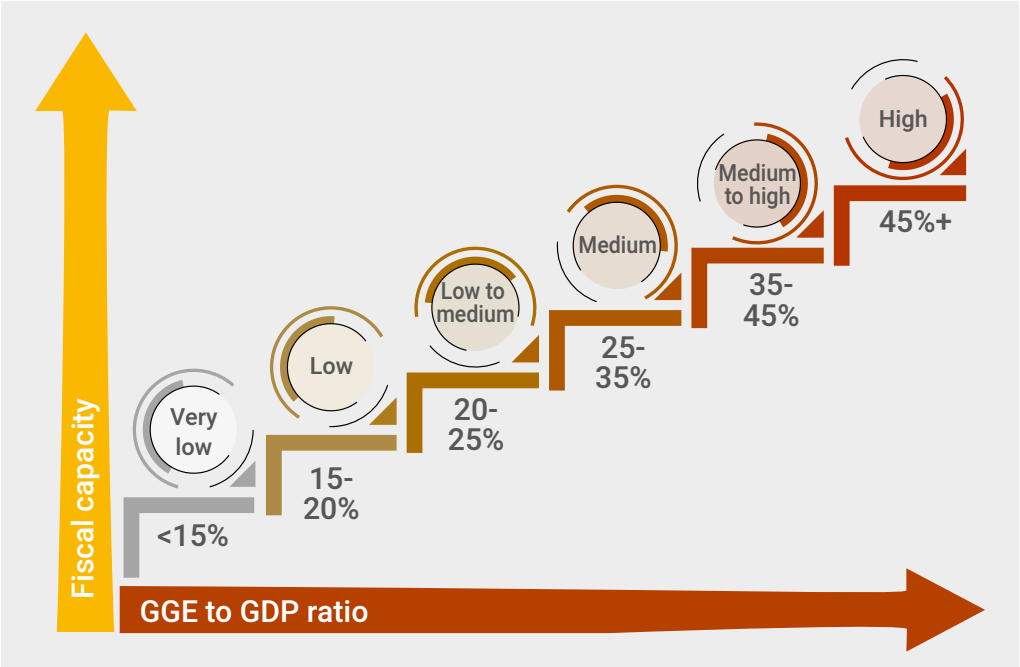
The available fiscal space is a main determining factor for potential and sustainable expansion in health insurance coverage through various forms of subsidization. Moving towards UHC requires – among other prerequisites – an increased public spending on health (channelled through social insurance funds, government agencies or other statutory schemes). This frequently involves increasing the share of domestic government health expenditure (GHE-D) of THE and thereby of general government expenditure (GGE) – ideally without resorting to excessive borrowing or cutting spending on other sectors.

As a rule of thumb, a country's fiscal capacity can be assessed through the ratio of GGE to GDP. The higher the ratio, the higher the fiscal capacity.

The GHE-D to GGE ratio is also an indicator of how much a priority a government considers financing health compared to other items of public spending.

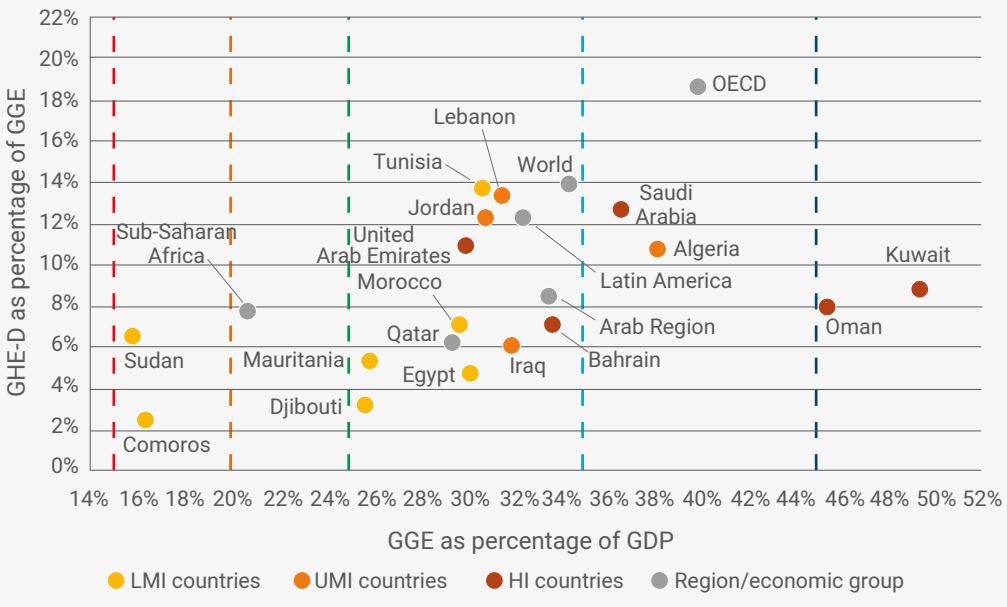
For most Arab countries, the share of GGE to GDP is in the range of 25-40 per cent, indicating medium to high levels of fiscal capacity.

**Figure 5.** Fiscal capacity assessment




Although the average fiscal capacity in the Arab region is comparable to both the average in Latin America and to the global average, the level of public spending on health (GHE-D to GGE) in the Arab region is much lower: 8.5 per cent, compared to 12.3 per cent for Latin America and a global average of 13.8. This indicates that health is not a high priority in the budget allocations of most Arab countries.

**Figure 6.** GGE as a share of GDP vs. GHE-D as a share of GGE in the Arab region, 2018

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# Key features of subsidized health arrangements in the Arab region

### Entitlement and eligibility

- Those who are eligible for subsidies are typically vulnerable groups – those who may have inadequate access to health services and can be susceptible to further catastrophic and impoverishing health expenditures.
- Most Arab countries offer subsidized health coverage to the vulnerable groups either through:
  - Existing public (national) health systems, or
  - Separate insurance arrangements/programmes, specifically designed to target specific groups of the population.


### Targeting of beneficiaries

- Most targeting approaches employed are based on:
  - *Means-testing* (i.e. wealth online or wealth + income) or
  - *Earnings-related* (i.e. income only) social needs.
- Targeted groups are identified based on:
  - Socio-demographic indicators.
  - Geographical groups.
  - Employment status.

**Enrolment process and type of affiliation**

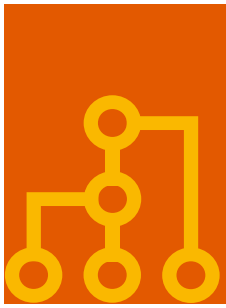
- Affiliation to, and enrollment in, subsidized health insurance schemes is undertaken on a voluntary basis (with rare exceptions, notably the GCC countries and Egypt).
- Registration procedures disincentivizes the poor (and other vulnerable groups) from actively seeking to register.

**Registration process rendered difficult by:**

- Overcrowded registration offices.
- Overly complex procedures.
- Delay between subscription and benefit transfer (e.g. up to 6 months).

**Financing arrangements**

- Health insurance financing arrangments subsidize fully or heavily either.
  - the contributions, or
  - the health care services.
- Other financing arrangements require eligible individuals to pay contributions or enrolment-fees to benefit from the subsidized coverage.
  - Such contribution measures would disincentivize vulnerable groups, especially the poor, from joining subsidized schemes.



**Organizational arrangements of risk-pooling**

- Separate fragmented or multiple-pooling funds prevail in many Arab countries.
- Fragmentations, duplications and inefficiencies of the health systems can significantly limit the scope of subsidization within and across the risk-pools.

**Financing source**

- The major source of financing of most of the subsidized health insurance schemes in the Arab countries comes from direct transfers from general government revenues.
- A limited number of subsidized insurance schemes are co-financed by government revenues and enrollee contributions.

**Benefit package design**

- Risk-pooling arrangements in most Arab countries do not always ensure adequate financial protection and access to health care for subsidized vulnerable groups. This is in part due to:
  - Restricted benefit package.
  - Differential benefit packages for contributors and subsidized groups.
- Persistence of relatively high out-of-pocket expenditure in many countries is an indication of the failure to pool the significant private resources required to extend the effective coverage of risk-pooling arrangements.

**Cost-sharing mechanisms**

- User-fees and co-payments/co-insurance are widespread in the Arab region and sometimes account for a fairly substantial share of total health financing.
- This can have significant deterrent effects on the overall utilization of health care services by the poor.

**Cost-sharing arrangements**

- Have a regressive impact.
- Increase financial burdens on the poor.
- Create disincentives to seek care.
- Reduce cross-subsidization from the rich to the poor.

**Coverage rates of the subsidy-eligible populations**

- A number of subsidized health insurance schemes in the Arab region appear to reach significant shares of the targeted population.
- Other schemes cover a small proportion of the targeted population.

# Key messages

| | |
|---|---|
| **The analysis showed that health systems in most Arab countries are under-financed** | Despite medium to high fiscal capacities in most Arab countries, the share of resources allocated to health remains relatively low. |
| | This indicates a low priority for health in government budgets despite the availability of fiscal capacity. |
| **Moving beyond the status quo towards UHC requires** | Increasing public spending on health.[2] |
| | Using domestic resources more efficiently and equitably by financing prepaid and pooled arrangements to reduce reliance on direct OOP payments. |
| | Mobilizing additional resources to improve the quality and accomodate for the increased demand on healthcare services. |
| **Current subsidized health arrangements are inadequate as full insurance against catastrophic and impoverishing health expenditures** | Restricted benefit packages with exceptions on specific services and/or annual limitations on financial coverage. |
| | High cost-sharing mechanisms despite subsidized health insurance contributions. |

2 Part of total health expenditure channelled through social insurance funds, government agencies or other statutory schemes.

# Policy response

## **Effective targeting and monitoring mechanisms** should be put in place to identify eligible populations

- The explicit and proper application of a means-tested benefit approach (e.g. measuring household adjusted-equivalent expenditure) to identify and reach out targeted groups.
- The means-tested benefit approach can be effective in bridging the gap between *legal* and *effective coverage*.

## Ensure **adequate funding from multiple sources**, rather than to rely solely on central government budget transfers

- Practical options can be:
  - Sub-national tax financing to maintain health care infrastructure.
  - Co-contributions by beneficiaries.
  - Tax-payrolls.
  - Sin taxes.
  - Charitable organizations (e.g. Zakat).

## **Public health authorities** should have a more **active role in the enrollment process**

- This will help capture vulnerable groups who may otherwise be discouraged by the complicated administrative procedures.
- Some examples of an active role include:
  - Opening enrolment provisions via implementing a mandatory subsidized health insurance program.
  - Public health authorities to contact and enroll all subsidy-eligible individuals or households.

## **Redesigning benefit packages,** including the type of services and providers

- A more financially protective benefit package can be attained by covering services that are mostly associated with catastrophic and impoverishing health expenditures.
- Avoid negative list of services (e.g. service exceptions) with annual expenditure cap per household or high cost-sharing.

## Determining the **level of subsidy**

- Two approaches: a *fixed lump-sum transfer* and a *per capita subsidy* transferred to the subsidized schemes or providers.
- A per capita subsidy approach provides a criterion for better determining the level of subsidy and cost-sharing that may vary across and within subsidized health insurance schemes and subsidy eligible population groups.

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