RESYST
RESILIENT & RESPONSIVE HEALTH SYSTEMS

EXPANDING HEALTH COVERAGE FOR THOSE OUTSIDE THE FORMAL SECTOR

AUGUST 2013

TOPIC OVERVIEW | Financing research theme

This brief outlines different options for providing financial protection to those outside the formal sector. Drawing on evidence from sub-Saharan Africa, it highlights the challenges to both voluntary and mandatory health insurance schemes in providing universal health coverage. Finally the brief considers alternative "innovative" funding options including special taxes and levies.

Health systems in many low and middle-income countries are funded primarily through out-of-pocket (OOP) payments. These are one of the most inequitable forms of health financing; they act as a barrier to access, contribute towards household poverty, generate little revenue, and promote perverse incentives, bureaucracy and corruption.

In recognition of the devastating consequences of OOP payments, many countries are now considering how to provide universal health coverage, where all citizens have access to appropriate promotive, preventative, curative and rehabilitative services at an affordable cost. Achieving universal coverage requires resilient and responsive health systems, where domestic resources constitute a large share of health care funding.

A particular challenge in achieving universal coverage is in providing coverage for people outside the formal employment sector, e.g. those who work in the informal sector, are unemployed or are not economically active. Many African countries have large populations who are poor and unable to afford financial contributions to the costs of health care, or who are working for unregistered or small enterprises from whom it is difficult to collect employer or employee insurance contributions.

Key points

- There are significant challenges to using contributory mechanisms to cover those outside the formal sector; low membership means small risk pools, schemes are only able to offer a limited package of services, and often require OOP payments.
- Even for mandatory schemes, countries face challenges in collecting contributions from the informal sector.
- In countries where CBHI schemes have been successful, they are part of a national financial strategy that receives government support with strong legislative, technical and regulatory frameworks.
- To achieve universal coverage there is a need to heavily subsidise services for the poor and vulnerable groups, mainly through tax funding, and in some cases a combination of tax and donor funds.
- Additional health financing agreements such as innovative funding approaches, offer a real alternative to contributory schemes, and need to be further explored before countries commit to implementing health insurance schemes that have limited capacity to offer adequate financial protection to their members.

Funding mechanisms for extending health coverage to the informal sector

There are several mechanisms for extending health coverage to the informal sector (Figure 1). These can be contributory schemes, where members' payments are pooled together and then used to purchase a package of health services, or non-contributory schemes that rely on domestic taxes or external

Figure 1. Types of funding mechanisms

Mechanism	Type	Examples
Contributory mechanisms	Voluntary health insurance contributions	Community Based Health Insurance schemes (e.g. the Community Health Fund in Tanzania).
	Mandated health insurance contributions	For example National Health Insurance (Ghana, Rwanda); formal sector schemes (National Hospital Insurance Fund in Kenya and National Health Insurance Fund in Tanzania.
Non-contributory mechanisms	Direct and indirect taxation	Special taxes earmarked for health include VAT (Ghana), levies on companies (Gabon), taxes on tobacco and alcohol products (Thailand).
	External sources	Donor funds, currency transaction levies.

sources of funding. Special taxes such as "sin taxes" on alcohol or tobacco, or levies on mobile phone use, collectively known as "innovative funding mechanisms" are an area of growing international interest with regards to financing health systems.

To what extent do contributory schemes provide financial protection?

Community based health insurance schemes
Community based health insurance (CBHI) schemes have been implemented in several countries to address barriers related to user fees, and many have focused on covering those outside the formal sector. However, the evidence from sub-Saharan Africa shows that CBHI schemes offer limited financial protection. They cover only a fraction of the target population (between 1 and 10%) with the exception of settings where they form part of a wider national health financing agreement, e.g. Rwanda and Ghana. Further, the voluntary nature of these schemes, with many employing agents to go door-to-door to encourage households to join and to collect annual contributions, can lead to high collection costs and low net revenue.

The types of health services covered through CBHI schemes are limited, mainly covering some aspects of inpatient services at public or faith-based facilities. Few schemes offer comprehensive coverage, with almost all requiring members to fund a large share of treatment costs through OOP payments, which can be catastrophic.

The limited evidence on the equity of CBHI schemes for those outside the formal sector suggests that they are highly regressive, with the poorest populations paying a higher proportion of their income than relatively wealthy groups.

Challenges facing CBHI schemes in Africa

- Extreme poverty makes premiums unaffordable
- Exemptions for the poor are non-existent or do not work effectively
- Limited understanding of health insurance among community and health professionals
- Percieved low quality of care in accredited facilities
- Lack of trust in the integrity of insurance organisations
- Unofficial payments for health services
- Weak managerial capacity
- Poor technical design leading to fraud, adverse selection and cost escalation
- Lack of legal structures and government support

Mandatory or social health insurance schemes
Although there are relatively few mandatory health insurance schemes in Africa, experience suggests that in countries where they do exist, coverage can be relatively high compared to CBHIs, but still far below universal coverage (55% in Ghana, 73% in Rwanda). Low membership has been reported even in settings where people are legally required to belong to health insurance schemes, mainly because of problems associated with enforcement.

Many mandatory insurance schemes focus on covering formal sector workers, and contributions by this group are usually progressive. However, in some countries that also require informal workers to pay for health insurance, contributions for this group are regressive.

Options for innovative financing

In order to generate additional funds for health care from non-contributory sources, some countries are beginning to focus on innovative taxes, which are easy to collect, especially if there is a large informal sector. Taxes include levies on large and profitable companies, a financial transaction tax or a tourism tax. These so-called Robin Hood taxes target more wealthy populations and redistribute wealth.

Figure 2. Examples of innovative taxes and levies

Country	Type of tax	Revenue
Gabon	10% tax on mobile phone operators, 1.5% levy on post-tax profits of companies that handle remittances	$30 million in 2009 towards NHI
Zambia	Levy of 1% on all gross interest earned in any savings or deposit accounts	$3.9m in 2009 towards HIV treatment
Ghana	2.5% national health insurance levy added to VAT	Pays for almost 75% of NHI scheme

With the impact of the global recession being felt in many donor countries, it is increasingly important to find predictable and sustainable external sources of financing for health care. Examples of external sources include air-ticket levies, mobile phone voluntary contributions and a currency transaction levy which has the potential to raise the greatest amount of money globally.

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This brief is based on RESYST Working Paper 2 **Providing financial protection and funding health service benefits for the informal sector: evidence from sub-Saharan Africa** written by Jane Chuma, Stephen Mulupi and Diane McIntyre

RESYST is funded by UKaid from the Department for International Development. However, the views expressed do not necessarily reflect the department's official policies.

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