Subsidized health insurance for the hard-to-reach

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

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Economic and Social Commission for Western Asia

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Background paper

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

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01
Executive summary

This study aims to contribute to the policy debate about universal health coverage (UHC) in the context of the Arab region. Specifically, it seeks to illuminate the design features of existing subsidized health insurance arrangements and to assess their importance for making progress towards the UHC goals. To this end, the study mobilizes a wide range of sources including findings from previous studies, regional and country case documentations, as well as time-series data extracted from different sources including the Global Health Expenditure Database (GHED) of the World Health Organization (WHO) and the data portal of the United Nations Economic and Social Commission for Western Asia (ESCWA). There are a number of interesting findings and key implications to be highlighted.

First, analysis of key indicators reveals that most Arab countries are making moderate to fast progress through the health financing transition, which reduces the burden of health spending on vulnerable groups and is indispensable for moving towards UHC. Despite this shift in health spending, the share of domestic public resources allocated to health remains relatively low (as compared to global and other regional averages), indicating that it is not a high priority in governments' budget allocations.

Second, the current subsidized arrangements appear to be inadequate to ensure full protection against vulnerability. This signals that there is a need to reconsider the institutional and organizational features of the current arrangements in order to strengthen their financial protection and service provision capacities. Results suggest that neither a policy providing free care for all nor a subsidization policy can be enough to succeed on its own.

Experiences from Arab countries and elsewhere show that subsidization policies can have little success unless effective targeting and monitoring mechanisms are put in place to ensure effective identification of the population eligible for subsidies. Ensuring adequate funding from multiple sources – rather than relying solely on government budget transfers – is equally important in order to maintain the provision of adequate and good quality health services and to compensate for revenues lost by health insurance schemes and public health facilities.

List of figures

02 Acronyms

AAAQ: Available, Acceptable, Affordable and of Quality

AMG: Assistance Médicale Gratitude

BIA: Benefit Incidence Analysis

CASNOS: Caisse Nationale de Sécurité Sociale des Non-salariés

CBHI: Community-based Health Insurance Scheme

CEBHI: Compulsory Employment Based Health Insurance

CHE: Catastrophic Health Expenditures

CNAM: Caisse Nationale d'Assurance Maladie

CIP: Civil Insurance Program

CNAC: Caisse Nationale d'Assurance Chômage

EGP: Egyptian Pound

FHF: Family Health Fund

GCC: Gulf Cooperation Council Countries

GDP: Gross Domestic Product

GGE: General Government Expenditures

GHE-D: Domestic Government Health Expenditures

GHI: Government Health Insurance

GNP: Gross National Product

HEF: Health Equity Fund

IHE: Impoverishing Health Expenditures

IMF: International Monetary Fund

MOH: Ministry of Health

MOEF: Ministry of Economy and Finance

MOSA: Ministry of Social Affairs

NSSF: National Social Security Fund

OECD: Organisation for Economic Co-operation and Development

OOP: Out-of-Pocket

OPT: Occupied Palestinian Territory

PoHE: Pooled Health Expenditures

PTES: Programme of Treatment at the Expense of the State

RAMED: Régime d'Assurance Maladie des Économiquement Faibles

RMS: Royal Medical Services

SCI: Service Coverage Index

SDG: Sustainable Development Goals

SHI: Social Health Insurance

SHIP: Student Health Insurance Program

THE: Total Health Expenditure

UHC: Universal Health Coverage

UNHCR: United Nations High Commissioner for Refugees

UNRWA: United Nations Relief and Works Agency for Palestine Refugees in the Near East

WHO: World Health Organization

03
Key messages

Moving beyond the status quo towards Universal Health Coverage would require most Arab countries to take the following actions:

01

Increase health expenditure, adjusted epidemiologically and demographically, to levels closer to conventional standards by increasing their public spending on health through social insurance funds, government agencies or other statutory pooled funding schemes.

02

Use domestic resources more efficiently and equitably by ensuring that additional resources for health are channeled through pre-paid and pooled arrangements to reduce reliance on direct OOP payments.

03

Mobilize additional resources to improve the quality of health-care delivery and contain the increased demand on health-care services.

04 Introduction

In their attempts to achieve the UHC target of the Sustainable Development Goals (SDGs) – service coverage (SDG indicator 3.8.1) and financial protection (SDG indicator 3.8.2) – many countries rely on government budget transfers to expand health coverage.

Such transfers are used either to subsidize the delivery of health services (supply-side subsidy), to reduce the deficits of the national health insurance programmes or to subsidize health insurance contributions for the "hard-to-reach" (demand-side subsidy). Regardless of the specific form that it may take, subsidization is generally used to expand health coverage to vulnerable groups of the population at reduced or no charge.[01] Eligible population groups may be defined on the basis of demographic or socioeconomic criteria (for instance, children, older persons, women, persons with disabilities and chronic diseases, the poor, refugees, informal sector workers, migrant workers, self-employed or unemployed individuals.[02] The subsidized health arrangements cover a range of mechanisms including premium subsidization; exemption from contributions; State-subsidized health insurance; subsidized coverage, medical assistance programmes; social safety net; premium tax credits and employer-sponsored insurance. What brings all of these mechanisms together is that they are all designed to serve those who are unable to get adequate public or private health coverage. Additionally, they are typically based on the notions of mutual aid, cross-subsidization and social solidarity.[03]

According to the World Health Organization (WHO),[04] budget transfers to health can help achieve three dimensions of UHC: breadth of coverage (extent of the population to be covered), depth of coverage (proportion of services to be covered) and height of coverage (proportion of costs covered or the level of financial protection of health coverage). However, it is less clear whether budget transfers will be used to subsidize the coverage of the hard-to-reach populations or to subsidize the service coverage for the more readily accessible populations.[05] The approach used by WHO is to specify the features of good institutional design of the budget transfers to health. These include: effective targeting of the poorest; providing full or very high subsidization of their contributions; integrating the subsidized participants enrolled and the contributors into the same pool to ensure the provision of a uniform benefit package and equal access to health services; lower or no co-payment rates for the subsidized; harmonization of different benefit packages and the creation of an integrated system with no opting out for the better-off.[06]

This study provides a general review of the subsidized health insurance arrangements for a select number of Arab countries on very different income levels. These countries also differ in terms of health expenditure level and financing mix as well as the structure and organization of their health systems.[07] Such differences evolved as a consequence of a mix of historical and institutional realities rather than as a result of deliberate policy choices,[08] While these variations enrich our analysis of subsidized health insurance

01 World Health Organization (WHO), 2010.

02 Abu-Zaineh and others, 2019, Vilcu and others, 2016, World Bank, 2019.

03 Ahmed, 2020.

04 WHO, 2017.

05 Ochalek, Manthalu, and Smith, 2020.

06 WHO, 2017, World Health Organization-EMRO, 2019.

07 Abu-Zaineh and Abul Naga, 2013.

08 Alami, 2017, Kronfol, 2012.

arrangements, undertaking a comparative analysis of national health systems using standard typologies (such as the dual classification Beveridge-style social health insurance system versus the Bismarckian style of national health service or the typology of Esping-Andersen distinguishing between liberal, conservative or social democrat welfare regimes) falls outside the remit of this study.

Specifically, this study explores the design features of the current subsidized arrangements across the Arab countries based on a specific set of criteria including entitlement and eligibility rules, enrolment process, sources of funding, level and structure of subsidy, content of the benefit package, cost-sharing mechanisms and regulatory structures and policy. It aims to identify design features and policies that can help accelerate progress towards achieving UHC and identifies the factors inhibiting the desired impacts of subsidized health insurance coverage from being achieved, such as unavailability or inaccessibility of quality health care services, high co-payment requirements or restricted benefit packages.

The first section outlines the methods and materials employed to assess the various aspects related to subsidized insurance arrangements. The second section assesses the key indicators of the health financing transition and the third section evaluates the critical institutional design aspects of the subsidized insurance arrangements. The fourth and last section concludes with some policy recommendations.

1. Study methodology

This study mobilizes a wide range of sources including findings from previous reviews and studies as well as regional and country case documentations. It also relies on time-series data extracted from different sources including the databases and reports of ESCWA and WHO (such as the Global Health Expenditure Database (GHED)), the National Health Accounts (NHA) reports and health country profiles, as well as national surveys. Descriptive statistics and charts are used to analyse temporal changes and compare the key variables with global averages, Arab region averages, other regional averages and averages of countries forming part of the Organization for Economic Cooperation and Development (OECD).

Regional and global averages are weighted averages. Average annual changes in health expenditures are calculated using the compound annual growth rate calculation method. Gross Domestic Product (GDP) and all health expenditures are reported in constant 2018 purchasing power parity (national currency measured per United States dollar) to control for differentials in currency exchange rates and price inflation, thus capturing nothing other than changes in volume of expenditures.

The study population includes 17 Arab countries, which differ in many aspects, particularly income levels and health expenditure levels. They are classified into three groups using the World Bank

income groups for the fiscal year 2020 (based on data for 2018): lower-middle income (LMI) countries (the Comoros, Djibouti, Egypt, Mauritania, Morocco, Sudan and Tunisia), upper-middle income (UMI) countries (Algeria, Iraq, Jordan and Lebanon), and high-income (HI) countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates).

The paper utilizes a general analytical framework based on the three core functions of health financing: resource mobilization, fund pooling and purchasing.[09] Similar analytical frameworks have been implemented by previous reviews[10] to assess the impact of different health system reforms including government subsidization arrangements. The summary table on p.32 below presents the main components of the analytical framework, adapted from Vilcu and others, 2016.[11] This framework provides a taxonomy of the various institutional design features in relation to the main health financing functions (resource mobilization, risk-pooling arrangements and the purchasing decisions), which all have important implications for the progress towards UHC.

09 Kutzin, 2001, Gottret and Schieber, 2006.

10 Acharya and others, 2012, Tangcharoensathien and others, 2011, Bitran, 2014, Vilcu and others, 2016.

11 Vilcu and others, 2016.

12 Gottret and Schieber, 2006.

13 Abu-Zaineh and others, 2020.

14 Fan and Savedoff, 2014.

2. Health financing transition: key indicators in the Arab region

The level of public health spending and government budget transfers to health depends ultimately on the available fiscal space, defined as the extent to which a Government can provide additional resources for health without resorting to excessive borrowing or cutting spending on other sectors.[12] Fiscal space is at the centre of the current debate about the feasibility and sustainability of expanding health insurance coverage using various forms of subsidization.[13] Prerequisites to making progress towards UHC include increasing total health expenditure (THE) per capita and as a share of GDP by increasing their public spending on health (financed either through general tax revenues or payroll contributions). This involves channelling most of the increase in health spending through State and compulsory contributory schemes; this means increasing domestic government health expenditure (GHE-D) as a proportion of THE and of general government expenditure (GGE). Health funding through pre-payment and pooling mechanisms should therefore take the place of direct payments (direct out-of-pocket spending borne by households at the point of health care delivery) and non-pooled health arrangements (medical savings accounts). This shift in the health financing mix from ex-post mode of financing towards ex-ante risk-pooling mechanisms is referred to as the health financing transition required in order to move towards UHC.[14] When countries progress through the health financing transition, they are helping to reduce the burden of health spending on vulnerable groups. This section presents an indicator-based assessment of the key variables of the health financing transition in the Arab region during the last two decades.

A. Total health expenditure: how much do Arab countries spend on health?

Attempts have been made in some empirical studies to assess the amount by which countries need to increase domestic spending to achieve UHC. The International Monetary Fund (IMF), taking into account economic and demographic variables, estimates that developing countries should mobilize domestically an additional 2 to 8.3 percentage points of GDP for health spending by 2030.[15] For example, a study conducted by OECD[16] suggests that Morocco would need to increase the share of GDP allocated to health expenditure by 2.5 percentage points to reach 8.2 per cent of GDP in 2030. Certain Arab countries themselves proposed targets for increased domestic spending on health. For instance, Egypt committed 3 per cent of Gross National Product (GNP) to be allocated to health in order to move closer to the SDG 3 target by 2030.[17] However, reported figures on health spending (as a share of GDP and as a share of GGE) appear fairly disappointing as most countries seem to spend less than the global averages or even than their specified targets (figure 1 and figure 2).[18]

Figure 1 depicts the share of GDP devoted to THE in the Arab countries. In most of them, health appears to constitute only a small part of the economy. The latest available figures show that the average health expenditure as a share of GDP in the region is 5.3 per cent, which is much lower than the global average of 8.2 per cent and the average of Latin American countries, which is 7.7 per cent. It is only slightly higher than the average for sub-Saharan Africa (5 per cent), even though the Arab region has a much higher GDP per capita. There are large variations within the Arab region: Lebanon, Jordan and Tunisia spend 8.4 per cent, 7.8 per cent, and 7.3 per cent of their GDP on health, respectively, which is higher than other countries in the region, including those of the Gulf Cooperation Council Countries (GCC): Qatar (2.5 per cent), Oman (4.1 per cent), Bahrain (4.1 per cent), United Arab Emirates (4.2 per cent) and Kuwait (5 per cent). Although, there is no commonly accepted benchmark for the share of GDP that a country should allocate to health, a low share may indicate either limited fiscal space for health, a relatively young population, or a low priority for spending on the health sector. Such an interpretation may be a plausible explanation for LMI countries (e.g., Djibouti: 2.3 per cent, Egypt: 4.9 per cent) and UMI countries (Algeria: 6.2 per cent, Libya: 6 per cent), but hardly for the HI GCC countries.

Figure 2 compares the average annual change in the amount of resources spent on health per capita to the average annual change in GDP per capita in the Arab region during the period 2000-2018. In these countries, per capita health expenditure (at constant 2018 PPP) rose by an average of 3.1 per cent per year between 2000 and 2018 (an increase from $607 in 2000 to $1,059 in 2018) as compared with an average annual increase in the global average by 2.9 per cent (from $870 to $1,457), an average annual increase of 2.1 per cent in Latin America and 2.3 per cent in sub-Saharan Africa. These figures confirm that the per capita health expenditure in the Arab region increased at a faster pace than the global average and even the other regional averages included in the comparison, despite a lower average increase in GDP per capita (at constant 2018 PPP).

As the literature suggests that much of the variation in THE per capita is associated with variations in GDP per capita, the growth rate of THE per capita is expected to keep

15 Abu-Zaineh and others, 2020, Awawda, Abu-Zaineh and Ventelou, 2020, Gaspar and others, 2019.

16 Organization for Economic Co-operation and Development (OECD), 2020.

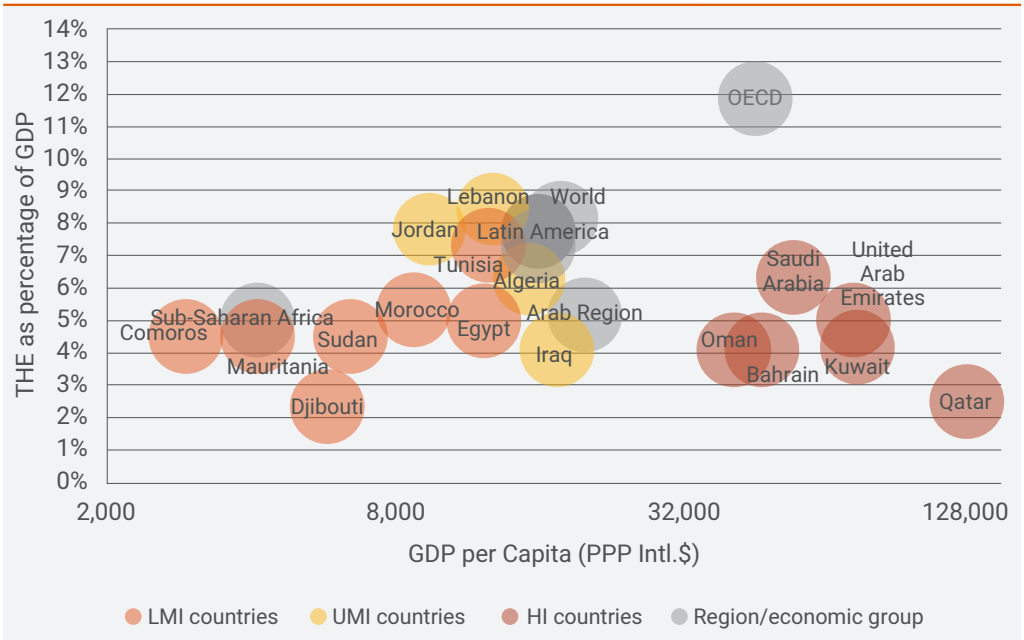
17 Mansour, 2013.

18 We did not find similar information on benchmarks for health spending in other countries in the region.

pace with income growth and to grow faster than GDP.[19] As illustrated in the shaded area of figure 2 above, in the majority of Arab countries the average annual increase in THE per capita was higher than the average annual growth of GDP per capita, the exceptions being the Comoros, Djibouti, Jordan and Lebanon.

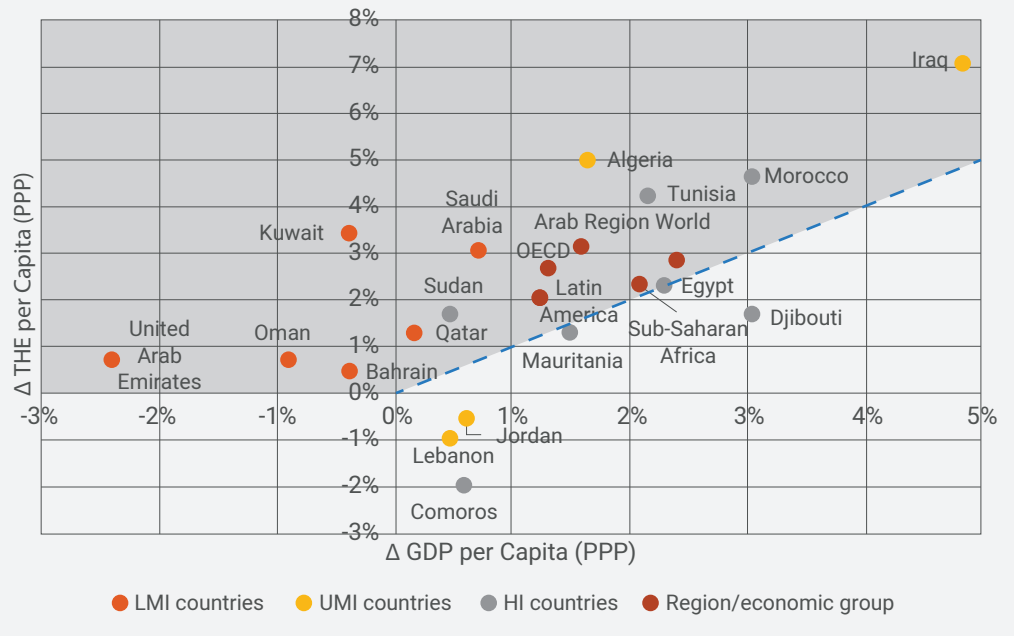
[19] Bander and others, 2020.

Figure 1. Share of THE as percentage of GDP versus GDP per capita (PPP Intl.$) in the Arab region, as per the year 2018



Source: Calculated by ESCWA based on data from WHO-GHED and data portal of ESCWA (Accessed 11/11/2021).

Figure 2. Average annual change in THE per capita versus GDP per capita (constant 2018 PPP $) in the Arab region, years 2000-2018



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

B. Financial protection: is pooled health spending overtaking out-of-pocket?

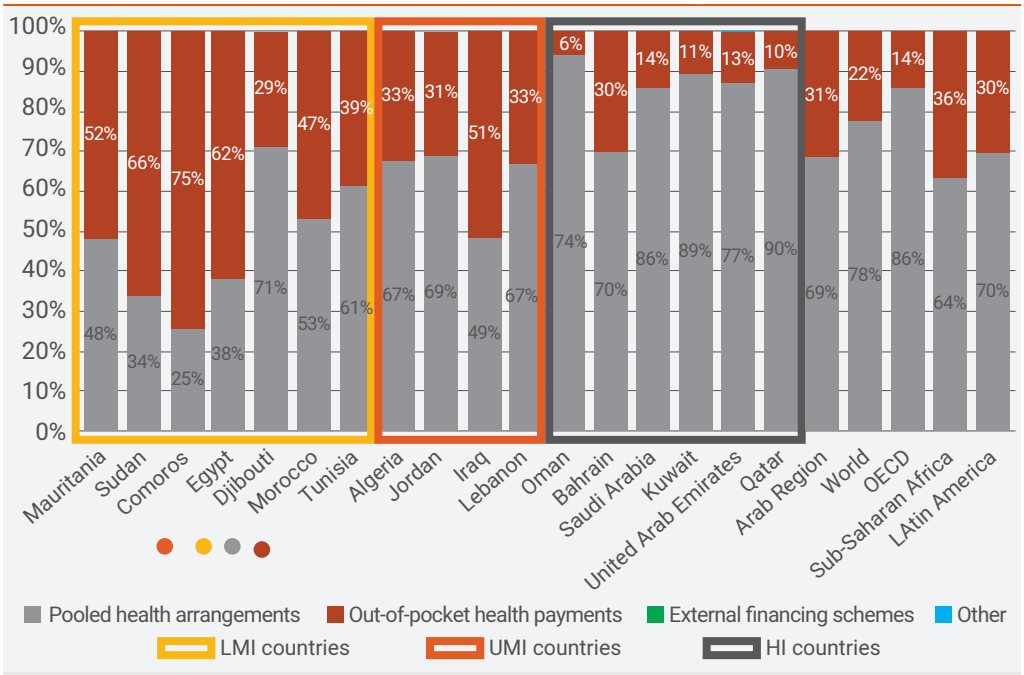
Financial protection (SDG indicator 3.8.2) is the ultimate goal of UHC and of the subsidized health insurance arrangements. Enhancing the financial protective capacity of the health system entails reducing the direct out-of-pocket expenditure borne by households at the point of health care delivery,[20] by increasing the proportion of pooled health expenditures (PoHE). Breaking down health expenditures for the year 2018 by type of financing scheme into pooled health arrangements, household OOP payments, external financing and other financing schemes (figure 3) reveals that the health financing mix varies across Arab countries. The share of OOP payments decreases as the income level increases. Thus, HI countries channel most of their health expenditures through pooled health arrangements, which include government, compulsory contributory and voluntary health insurance schemes.

Nevertheless, the share of PoHE in the Arab region (69 per cent) is lower than the world average (78 per cent) despite the fact that the regional GDP per capita is higher than the global average. On the other hand, the Arab region has a share of PoHE that is comparable to that of Latin America (70 per cent) and higher than that of sub-Saharan Africa (63 per cent).

To determine whether countries are moving through the health financing transition and how fast this shift is occurring, the average annual growth rates in pooled and OOP health spending have been plotted in figure 4 Whenever PoHE is growing faster than OOP payments, the pooled share of health spending increases, so that the country

[20] WHO and World Bank, 2020.

Figure 3. Health expenditures by financing scheme in the Arab region, as per the year 2018



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

progresses through the health financing transition. The shaded area of the diagram indicates which countries and regions are witnessing this transition, revealing different patterns:

- In the lower right quadrant of the diagram, PoHE is shown to be increasing while OOP payments are declining. Countries in this area are moving rapidly through the health financing transition, thus ensuring a higher level of financial risk protection. This development occurred particularly in Mauritania, notwithstanding its ranking as an LMI country, with OOP payments decreased on average by 0.9 per cent annually while PoHE increased on average by 5.8 per cent annually. Consequently, the pooled share of health expenditures grew from 22 per cent in 2000 to 48 per cent in 2018.

- In the lower triangle of the top right quadrant, both PoHE and OOP payments are shown to be increasing, but the former at a more rapid pace than the latter. Countries in this area are consequently passing through the health financing transition but more slowly than countries in the lower right quadrant. For example, in the Arab region, PoHE rose by an average of 3.6 per cent annually while OOP payments grew by 2.3 per cent annually. As a result, the share of PoHE out of THE grew from 64 per cent in the year 2000 to 69 per cent in 2018, which is considered faster than the world average for which the pooled share of health spending grew from 75 per cent in the year 2000 to 78 per cent in 2018.

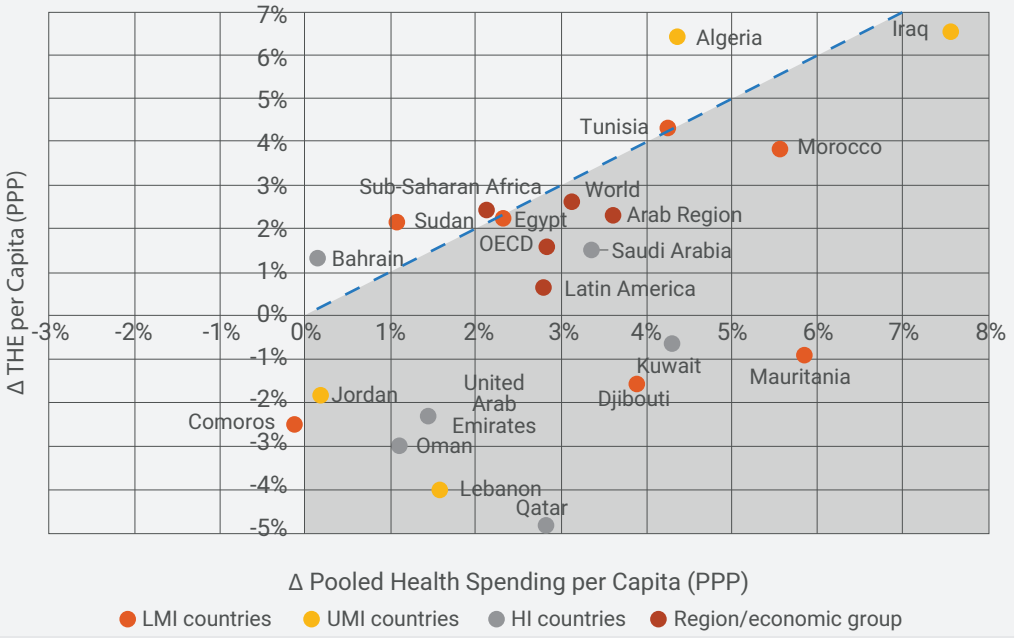
- In the upper triangle of the top right quadrant too, PoHE as well as OOP payments are shown to be increasing, but here the latter does so at a more rapid pace than the former. As a result, the pooled share of expenditure decreases, meaning that countries in this area are not making the health financing transition. In Algeria, for instance, PoHE grew by an average of 4.4 per cent annually, but since OOP grew even faster at 6.3 per cent annually, the share of PoHE out of THE decreased from 74 per cent in 2000 to 67 per cent in 2018.

- In the lower left quadrant, both PoHE and OOP payments are shown to have decreased. The only Arab country found in this area is the Comoros, where the pooled share of health spending increased (from 18 per cent in 2000 to 25 per cent in 2018) not because of an increase in PoHE, but because OOP payments declined annually at a faster rate than PoHE (-2.5 per cent decrease in OOP against -0.1 per cent decrease in PoHE). Since its THE has been decreasing (by an average of -2 per cent annually as shown previously in figure 2), the Comoros cannot be considered to be moving through the health financing transition.

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

The level of health subsidization from government budget transfers depends ultimately on the share of GDP devoted to GGE and the share of the latter that is allocated to domestic government health expenditure (GHE-D). Consequently, we expect GHE-D (as a share of GGE) to be positively associated with GGE (as a share of GDP). As a rule of thumb, a GGE to GDP ratio lower than 15 per cent indicates very low fiscal capacity. Fiscal capacity would be considered low if that

Figure 4. Average annual change in pooled versus out-of-pocket health spending (constant 2018 PPP $) in the Arab region, years 2000-2018



Source: Calculated by ESCWA based on data from WHO-GHED (accessed 11/11/2021).

ratio falls in the range of 15 per cent to 20 per cent, low to medium in the range of 20 per cent to 25 per cent, medium in the range of 25 per cent to 35 per cent, medium to high in the range of 35 per cent to 45 per cent, and very high when that ratio is higher than 45 per cent. Meanwhile, the ratio of GHE-D to GGE is an indicator of the priority Governments give to health compared to other public spending.[21]

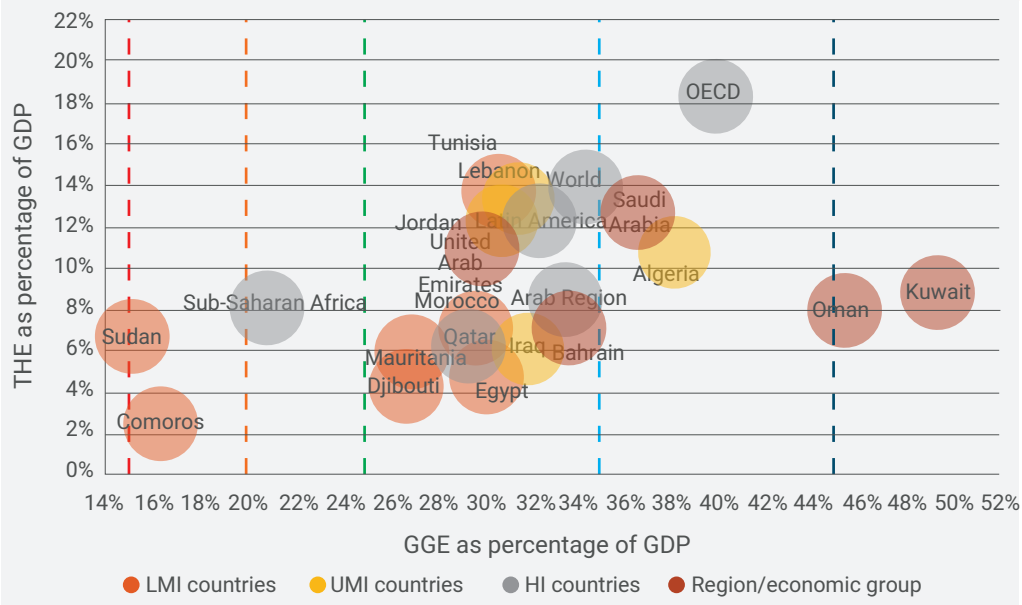
As shown in figure 5, GGE as a share of GDP is in the range of 25 per cent to 35 per cent for most of the Arab countries, indicating a medium level of fiscal capacity. The main outliers are, at one end, Kuwait and Oman (very high fiscal capacity) and, at the other, Sudan and the Comoros (low fiscal capacity). Although the Arab region has a fiscal capacity comparable to that of Latin America and to the world average, its level of public spending on health (GHE-D to GGE) is much lower: 8.5 per cent as compared to 12.3 per cent for Latin America and 13.8 per cent for the world. This indicates that Arab countries, in general, give low priority to health in their budget allocations.

Although we expect that the higher the GDP per capita, the higher the share of GHE-D to GGE, for a number of Arab countries this is not the case. Figure 6 reveals that the HI countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and United Arab Emirates) appear to have shares of GHE-D/GGE that are fairly comparable to those reported for some LMI and UMI countries. This might be due to the high contribution of oil and gas industry to the economies of GCC countries. Egypt and Iraq have relatively low shares of GHE-D/GGE compared to their level of GDP per capita. On the other hand, some Arab countries-notably Algeria, Jordan, Lebanon and Tunisia-appear to have higher shares of GHE-D to GGE than might be expected from their GDP per capita. Although the Arab region has a higher GDP per capita than Latin America and the world, its share of GHE-D to GGE is significantly lower,

[21] McIntyre and Kutzin, 2016.

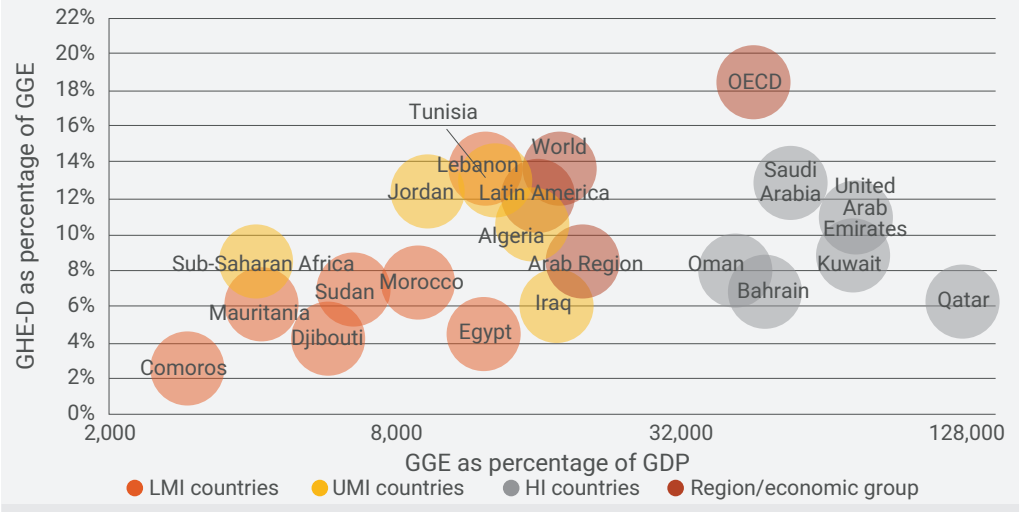
confirming the finding that Arab countries do not seem to prioritize spending on health relative to other forms of public spending.

Figure 5. GGE as a share of GDP versus domestic government health expenditure (GHE-D) as a share of GGE in the Arab region, as per the year 2018



Source: Calculated by ESCWA based on data from WH-GHED and ESCWA data portal (Accessed 11/11/2021).

Figure 6. GHE-D as a share of GGE versus GDP per capita in the Arab region, as per the year 2018



Source: Calculated by ESCWA based on data from WHO-GHED and ESCWA data portal (Accessed 11/11/2021).

3. Analysis of the main features of subsidized health arrangements in the Arab region

During the past decade, all countries reviewed here initiated a number of legal and institutional reforms of their health systems with a view to improving access to health care and achieving UHC. These included, inter alia, revising national health polices and legislation as well as reforming the health financing structure.[22] In many cases, the reforms included introducing or expanding coverage of subsidized health insurance but information regarding the implementation of these reforms is often limited: which are the groups eligible for subsidies and how are they identified? What are the criteria for enrolment in the expanded (subsidized) health coverage? How and by whom are the arrangements financed, and is there an element of risk pooling? This section seeks to resolve these and other issues, based on the available evidence.

A. Entitlement and eligibility: who is covered? Which groups are eligible for subsidies?

A review of the available literature reveals that despite every country in the region having made an explicit commitment to the right to health for all, the concept of entitlement has not yet been well defined. According to WHO,[23] universal entitlement means ensuring the delivery of essential health services to all strata of the population without causing financial hardship. This entails ensuring that no group, whether it be socioeconomic, demographic or geographic, is subject to exclusion or deprivation. However, entitlement does not necessarily imply effective (actual) coverage. While the former is usually taken to refer to de jure coverage, effective (de facto) coverage requires that health care services should be available, acceptable, affordable and of quality (AAAQ).[24] Significant discrepancies between de jure and de facto coverage have often been observed.[25]

Entitlement can differ markedly across countries depending mainly on how their health systems are organized and funded (universalism versus targeting; contributory versus non-contributory). In countries where social health insurance (SHI) programs exist, entitlement remains basically contributory and work-related[26] (membership is publicly mandated for designated population groups which are often defined on a professional basis). By contrast, countries relying primarily on tax-financed systems (also referred to as government-funded systems) offer a universal entitlement to free (or quasi-free) care based on citizenship and/or residence, independent of employment status. Both the SHI and tax-financed systems involve two forms of cross-subsidization: equity-subsidy between the better-off and the worse-off (through either differential premiums

22 Odoch and others, 2021 Saleh and others, 2014.

23 WHO and World Bank, 2020.

24 Mills and others, 2019.

25 Abu-Zaineh and Abul Naga, 2013.

26 Social contribution is defined as a payment to a health insurance scheme by the insured or by other parties on their behalf to ensure entitlement to a defined benefit package offered by the scheme. For instance, the Government can pay contributions on behalf of its employees or can receive contributions as the operator of a SHI scheme. Gottret and Schieber, 2006.

or progressive taxes) and risk-subsidy between the healthy (low-risk) and the unhealthy (high-risk).[27]

In the context of incomplete coverage of the population and services, however, these two forms of cross-subsidies tend to be highly constrained. As a result several countries have made an increasing push to enrol the uninsured groups in the formal risk pool and/or to establish an explicit entitlement to a specific benefit package of services covered under the national health system.[28] These reforms include opening voluntary enrolment to private sector employees, self-employed and informal workers based on their willingness and ability to pay; providing public subsidies to social health insurance schemes to enrol the poor; or subsidizing the premiums of certain vulnerable groups (demand-side subsidies) and/or public hospitals and health care providers (supply-side subsidies). While expansion of coverage has mainly been observed in countries where social health insurance plays an important role (with Tunisia and Morocco being the leading examples), supply-side subsidies apply mainly to countries with tax-financed systems.[29]

The presence of widespread labour market informality, high unemployment, a low level of economic participation (especially among women) and widespread poverty, coupled with weaknesses in government institutional capacity, hinder the development of universal entitlement systems of health insurance-based payroll contributions.[30] Several countries are therefore using public financing instruments – which are more broadly based than payroll contributions – to set up (non-contributory) schemes specifically targeting the vulnerable groups, with subsidized premiums being funded from general government budget, in addition to resources generated from the direct payroll tax/contributions for the contributory schemes.[31]

The populations eligible for subsidies typically consist of the vulnerable groups, broadly defined as consisting of those who may have inadequate access to health services and be further susceptible to catastrophic health expenditures and impoverishing health expenditure (CHE and IHE). These groups are usually identified on the basis of certain economic, demographic, geographic or other relevant criteria, including health status. The groups eligible for subsidies may therefore be specific demographic groups (children, the elderly and women), individuals with disabilities or some chronic diseases, the poor, the refugees, informal sector workers, migrant workers, the self-employed or unemployed persons.[32] Besides the targeted population, eligibility rules may further define the conditions of enrolment including the content of the benefit package, provider choice and payment method. Generally speaking, the broader the eligibility criteria, the higher would be the share of the subsidized population group in the total insured population and the higher the total population coverage rates.

Results reported in the summary table below show that most of the Arab countries offer subsidized health coverage to the vulnerable groups either through the existing public (national) health systems or via separate insurance arrangements/ programmes specifically designed to target specific groups of the population. In Algeria, for instance, there are two separate schemes that cover the informal sector workers and the unemployed, namely, the national social security fund for non-wage earners – Caisse Nationale de Sécurité Sociale des Non-salariés – (CASNOS) and the national fund for the unemployed – Caisse Nationale d'Assurance Chômage – (CNAC).[33]

In Egypt, there are three separate State-subsidized funds/programmes: the Programme of Treatment at the Expense of the State (PTES) that caters for the uninsured vulnerable and women, the

27 WHO, 2010.

28 Mataria, Hajjeh, and Al-Mandhari, 2020.

29 Alami, 2017.

30 Abu-Zaineh and others, 2019 Kronfol, 2012.

31 Alami, 2017, Abu-Zaineh and others, 2019.

32 Vilcu and others, 2016. According to the World Bank (Silva, Levin, and Morgandi, 2012), the informal sector also includes the self-employed and those with casual, temporary and unpaid jobs.

33 Chouaidia and Laib, 2019.

34 Sieverding and Selwaness, 2012, WHO-EMRO, 2019.

35 International Labour Organization (ILO), 2018.

36 Halasa-Rappel and others, 2020.

37 WHO-EMRO, 2019.

Family Health Fund (FHF) that covers health-care services for the poorest and uninsured, and the Student Health Insurance Programme (SHIP) that targets schoolchildren.[34] Recently, Egypt implemented a new mandatory health insurance regime designed to benefit the entire population. Pensioners and widows will pay reduced contributions amounting to 2 per cent of their monthly pensions while the contributions of the most vulnerable will be entirely paid by the Government.[35]

In Jordan, there are several separate public and semi-public insurance schemes. These include the Civil Insurance Programme (CIP), which is a compulsory programme run by the Ministry of Health on a contributory basis for public sector employees, and the Royal Medical Services (RMS), which provides (non-contributory) health coverage for some services to the armed forces and their dependents. The Civil Insurance Programme provides subsidized health coverage for low-income households, the unemployed, the self-employed, informal sector workers, children under 6 years of age, persons aged 60 years and over, citizens residing in the least advantaged and most remote areas, families whose head of household has a disability of 75 per cent or more and families in which one member is an organ donor; blood donors also benefit from this health coverage.[36] The Royal Medical Services provide services at heavily subsidized rates to its affiliates, irrespective of their income level. In addition, Jordan provides a limited subsidized coverage to Syrian refugees while the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) provides fully subsidized coverage to the Palestinian refugees residing in the country.[37]

In Lebanon, recently unemployed formal private sector employees, the self-employed, the informal sector employees and the employer's family members working without a declared income are eligible for subsidized coverage provided by the National Social Security Fund (NSSF).[38] In addition, Palestinian and Syrian refugees residing in Lebanon benefit from subsidized health coverage offered by UNRWA and UNHCR, respectively.[39] In Mauritania, the poorest segments of the population in Dar-Naïm have subsidized health coverage provided by the Health Equity Fund (HEF).[40] Recently, the health insurance coverage through the Caisse Nationale d'Assurance Maladie (CNAM) was provided on a subsidized basis to 100,000 households benefiting from the cash transfer programme (TAAZOUR). In Morocco, disadvantaged groups can benefit from State-subsidized health coverage offered by a specific programme called the Régime d'Assurance Maladie des Économiquement Faibles (RAMED). Despite the reported success in covering about 82 per cent of beneficiaries living in poverty, previous studies revealed that the programme suffers from uptake problems due mainly to the poor quality of services and the cost of accessing these in practice.[41]

In Tunisia, the Assistance médicale gratuite (AMG) programme provides two discrete benefit packages to the poor (AMG-I) and the vulnerable (AMG-II). While this enables much broader coverage, previous studies have indicated that the effectiveness of AMG is undermined by the presence of some ad hoc criteria and regional quotas in addition to the extensive use of co-payments and user fees.[42]

In Palestine, there are different subsidized health insurance arrangements which are administered by the government health insurance (GHI) system and supported by various institutions. These arrangements serve different groups including unemployed individuals who are sponsored by the Ministry of Labour; poor families who are supported by the Ministry of Social Affairs; and Israeli political detainees and their families, whose coverage is fully subsidized by the Commission of

38 WHO-EMRO, 2016.

39 WHO-EMRO, 2019.

40 Waelkens, 2015.

41 Alami, 2017.

42 Abu-Zaineh and others, 2014.

Detainees' and Ex-Detainees' Affairs. In addition, since 2007, the Ministry of Health has provided fully subsidized health coverage to the Palestinians living in Gaza Strip and UNRWA has done the same for Palestinian refugees since 1948.[43] Latest figures indicates that about 78.3 per cent of the population in the West Bank and Gaza Strip are covered by the GHI system.[44] However, previous studies allude to the modest capacity of the current arrangements in providing adequate financial protection to the disadvantaged groups.

In the GCC countries, all citizens are, in principle, entitled to free or quasi-free health care services (including treatment abroad) which are mostly covered by the health authorities and other government agencies.[45] Recent regulatory reforms in some GCC countries (such as Saudi Arabia and Egypt) involve changes in risk pooling and the delivery of health services. These include participation of public sector employees in funding the insurance scheme and the private sector clinics in the delivery of services with demand-side subsidization of social contributions for the disadvantaged groups. The new government regulations separate the financing and provision of services across the health sector (except for the publicly managed fund). Private providers are able, together with their public counterparts, to provide services for payroll contributors (who pay up to 10 per cent of their salaries) as well as citizens eligible for subsidies. Participants can also choose their providers.[46] Oman and Bahrain have in addition implemented systems of free universal medical care for all citizens.

B. Targeting approaches

Most targeting systems employed to identify eligible individuals and households are based on the means testing principle or earnings-related social needs.[47] Other alternative targeting approaches are also being employed in the region (summary table below). The targeted groups are identified on the basis of either sociodemographic indicators such as nationality (e.g., SHI in Bahrain and the Compulsory Employment Based Health Insurance (CEBHI) in Saudi Arabia), geographical characteristics (e.g., HEF in Dar Naïm and Daman in Abu Dhabi), or employment status (e.g., CASNOS and CNAC in Algeria, Ministry of Health insurance in Jordan, NSSF in Lebanon and GHI in the West Bank and Gaza Strip). Recent reforms geared towards UHC undertaken in Egypt (under mandatory health insurance Law no. 2 of 2018) stated that the targeting criterion determining which families may be eligible for subsidies will be set by the Ministry of Social Solidarity, the Ministry of Finance and the Central Agency for Public Mobilization and Statistics.[48]

C. Enrolment process and type of affiliation

Enrolment modalities in the subsidized health insurance schemes can vary across the different schemes depending mainly on whether the scheme is voluntary or mandatory and on who undertakes the subscription process. Broadly speaking, two enrolment modalities can be identified. First, under voluntary schemes, individuals or households who would need a subsidy to be able to afford the premium contributions or to gain access to the

43 WHO-EMRO, 2015a.

44 WHO-EMRO, 2019.

45 Khoja and others, 2017.

46 Ibid.

47 Abu-Zaineh and others, 2019.

48 ILO, 2018.

services are called upon to play an active role. By contrast, the enrolment process under the mandatory schemes is usually managed by the public health authority, which contacts and enrols all individuals or households eligible for subsidies.[49]

With rare exceptions (notably the GCC countries), affiliation to, and enrolment in, subsidized health insurance schemes is undertaken on a voluntary basis (summary table below). This contrasts with enrolment in formal health insurance schemes which rely on mandatory earmarked payroll contributions and a clear link between these contributions and the right to a defined benefits package of services.[50] Although all Arab countries have committed to UHC, few countries have passed laws requiring a mandatory universal participation or opening enrolment provisions via implementing a subsidized mandatory-based health insurance programme (the new health insurance regime in Egypt being a notable exception).

The inclusion of "the-hard-to-reach" groups thus relies on their willingness to enrol and willingness to contribute to a proposed or an existing subsidized risk-pool scheme,[51] which has largely been realized through opening up affiliation on a voluntary basis to specific groups such as the self-employed and informal workers (as is the case of GHI in the West Bank and Gaza Strip); providing public subsidies to social health insurance systems to enrol the poor and vulnerable groups (the case of AMG in Tunisia), or subsidizing premiums for self-employed or informal workers (the case of Algeria).

Enrolment in the voluntary schemes depends on eligible beneficiaries being proactive as it is their responsibility to enrol themselves and to renew their membership regularly. Registration and renewal of membership often involve the payment of subscription and membership renewal fees, which is likely to discourage the poorest segments of the targeted population.

In Algeria, individuals who are identified or recognized as eligible may register and obtain a special card that allows them to benefit from health-care services provided by the different subsidized health insurance schemes.[52] In Jordan, individuals eligible for subsidized health insurance through the Ministry of Health must provide a valid identity document at the time of enrolment.[53] Individuals in Mauritania wishing to enrol in the HEF scheme can register themselves (as well as their dependents) whenever they wish.[54] In Morocco, different sectors, including the Government, actively participate in identifying the eligible individuals for the RAMED scheme.[55] In Tunisia, eligible individuals must submit a request to local health authorities to benefit from the medical assistance programmes.[56]

The registration process is rendered difficult in some of the subsidized schemes by the large number of potential beneficiaries, the complicated administrative procedures, the relatively high overhead costs as well as the delay between subscription and benefits – all of which may create disincentives for the poor to actively seek to join.

D. Financing arrangements: level of subsidization and structure of contributions

Some of the health insurance schemes are said to fully (or heavily) subsidize the premium contributions or the health-care services of those eligible to enrol (except for subscription fees in some cases). However, in many other schemes, eligible individuals who are willing to join the scheme are required to pay

49 Vilcu and others, 2016.

50 Mataria, Hajjeh, and Al-Manhari, 2020.

51 Makhloufi, Ventelou, and Abu-Zaineh, 2015.

52 Chouaidia and Laib, 2019.

53 WHO-EMRO, 2016.

54 Waelkens, 2015.

55 WHO-EMRO, 2015b.

56 WHO-EMRO, 2016.

contributions or user fees to benefit from the subsidized coverage or to use the subsidized services. Such rigid payment structure has been shown to have a regressive impact, increase the financial burden on the poor, create disincentives to seek care and reduce the cross-subsidization from the rich to the poor.[57]

As shown in the summary table below, examples of fully (or heavily) subsidized health insurance schemes include the HEF scheme in Mauritania,[58] the AMG in Tunisia[59] and some of the GHI arrangements in the West Bank and Gaza Strip.[60] Other health insurance schemes such as the SHI in Bahrain require (non-citizen) enrollees who work in private companies to contribute by an amount equals to $190 per year, while non-citizen enrollees who work in the public sector are fully exempted from these contributions.[61] The PTES scheme in Egypt requires enrollees to contribute at different rates depending on their employment status and other sociodemographic characteristics. For instance, the contribution rate for Government employees and eligible women stands at 1 per cent of their salaries, while it is 0.5 per cent for other individuals working in the public and private sectors. It is worth noting that employers partially sponsor their employees' coverage with a contribution rate ranging between 1.5 per cent and 4 per cent of employees' salaries.[62] As regards the Student Health Insurance Programme (SHIP), beneficiaries are required to pay a token premium of about EGP 4 per year (25 per cent of total premium) while the Government pays the remaining 75 per cent (about EGP 12 per beneficiary).[63]

As for the RAMED scheme in Morocco, households with a monthly income per capita of less than $34 are exempted from insurance contributions while households with monthly per capita income of $34–$68 can purchase insurance according to a sliding scale (the contribution is between $12 and $62 per year and person).[64]

Other insurance schemes require members to pay a lump sum such as the Zakat fund in Sudan where each family must pay a monthly contribution of 35 Sudanese pounds.[65]

Assessment of the subsidization arrangements elsewhere reveals the presence of two approaches that are commonly used to determine the amount of subsidy.[66] The first approach simply provides a fixed lump-sum transfer to the subsidized schemes, irrespective of the number of eligible beneficiaries. The second approach involves the transfer of per capita subsidy to subsidized schemes on behalf of each identified eligible beneficiary. The per capita subsidy can be determined using either estimations of future health expenditure per subsidized member, or on the basis of the contribution rate of enrollees, or through a bidding process that enables insurance providers to cover a target population group with a pre-defined benefit package of services.[67] Although the per capita subsidy approach has some advantages as compared to the lump-sum transfer, particularly in terms of setting a more predictable and needs-adapted subsidy transfers, there is still a lack of evidence concerning the implementation and effectiveness of these two approaches in the region.

E. Organizational arrangements of risk pooling

Organizational arrangements of risk-pooling schemes can be distinguished based on: (i) the organization in charge of the scheme (e.g., Ministry of Health,

57 Abu-Zaineh and others, 2014.

58 Waelkens, 2015.

59 Abu-Zaineh and others, 2014.

60 WHO-EMRO, 2015a.

61 WHO-EMRO, 2016.

62 Sieverding and Selwaness, 2012.

63 (Nandakumar and others, 1999.

64 (Ruger and Kress, 2007.

65 WHO-EMRO, 2016.

66 Vilcu and others, 2016.

67 Ibid.

SHI or social security organizations, voluntary private insurance, and community-based health insurance, CBHI); (ii) the source of funding (e.g., general budget revenues versus payroll mandatory contributions, voluntary non-contributory premiums) and (iii) the purchase of health-care services. In the Arab countries, these organizational structures often coexist for generating revenues and financing coverage. However, little information is available about the respective shares of these sources in financing the subsidized prepayments schemes or health-care services. It is therefore difficult to assess the extent of subsidies within the same risk pool, or across the different risk pools, as well as the direct subsidies through government budget transfers. However, the little available anecdotal and empirical evidence suggests that fragmentations, duplications and inefficiencies of the health systems can significantly limit the scope of subsidization within and across the risk pools.[68]

Results from this review reported in the summary table below show that the current subsidized health insurance arrangements are still far from flawless, with segmented or fragmented risk pools prevailing in many Arab countries. Separate fragmented or multiple pooling funds are found, for instance, in the case of the CASNOC and CNAC schemes in Algeria, PTES and SHIP in Egypt, HEF in Mauritania, RAMED in Morocco, the Zakat fund in Sudan, the AMG schemes in Tunisia and the Daman fund in Abu Dhabi. By contrast, in six countries included in this study, the subsidized health insurance plans are part of (or integrated into) the broader national fund pools. These mechanisms exist in the case of the SHI systems in Bahrain and Oman, the health insurance scheme run by the Ministry of Health in Jordan, the NSSF scheme in Lebanon, CEBHI in Saudi Arabia, as well as the different subsidized arrangements of the GHI scheme in the West Bank and Gaza Strip. Although debates continue about the most appropriate institutional design of the risk-pooling arrangements for expanding coverage to the entire population, the available evidence suggests that increasing the scope of risk pooling through integrating the existing local or group-based funds within a broader risk pool for both the subsidized and the contributors can significantly enhance distributional subsidies and equity.

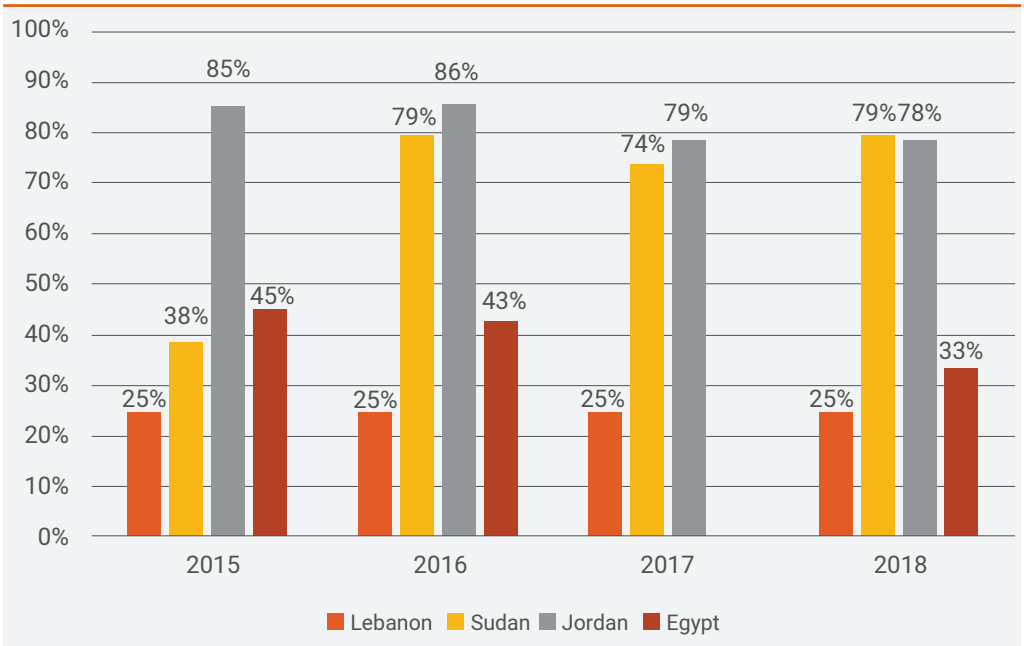
F. Financing source of the subsidized health insurance schemes

As shown in the summary table below, 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. Other subsidized insurance schemes are, however, co-financed by government revenues and the contributions of those enrolled in the schemes, such as SHI in Bahrain and Oman and AMG-II in Tunisia.[69] The Zakat fund in Sudan is co-funded by the Zakat Chamber and the national medical insurance fund scheme. Recent data obtained from the GHED shows that the shares of government transfers to subsidize social health insurance revenues can vary significantly across countries. As illustrated in figure 7, it is highest in Sudan (about 79 per cent in 2018), followed by Jordan (about 78 per cent in 2018). In Egypt, about one third of the subsidized health insurance revenues come from general

68 Alami, 2017.

69 WHO-EMRO, 2016.

Figure 7. Government subsidies to social health insurance (SHI) as a share of SHI in Arab countries



Source: WHO-GHED (Accessed 11/11/2021).

government revenues transfers. The share of government subsidization of the social health insurance revenues is even lower in Lebanon and Morocco (about 24.5 per cent and 0.2 per cent in 2018, respectively).

G. Benefit package design: the scope of health services covered

The scope of health-care services covered by the subsidized schemes tends to vary significantly across countries, from a generous package to all beneficiaries (including outpatient and inpatient care at all levels as well as essential medicines list for both the subsidized and the contributors) to a restricted package (covering mainly primary and some secondary health care services). Results reported in the summary table below show that most of the schemes cover a rather limited benefit package of health services. In many cases, however, beneficiaries are offered "a negative list" of services – i.e., a benefit package that covers all available services except for a number of specified services such as treatment for a list of chronic conditions, organ transplantation and so on.

For instance, in Algeria, coverage includes preventive and curative medical health care services.[70] In Bahrain and Oman, the SHI system covers only primary health care services for expatriates while citizens are in addition entitled to secondary and tertiary treatments at all public hospitals inside and outside the country.[71] In Egypt, members of the PTES scheme are entitled to tertiary treatment at all public hospitals inside and outside Egypt[72] while the FHF scheme covers only primary health care services.[73] In Iraq, all

70 Chouaidia and Laib, 2019.

71 WHO-EMRO, 2016.

individuals have access to primary health care services, provided free of charge in public facilities.[74] The NSSF scheme in Lebanon covers a more generous set of health-care services that includes medications, medical consultations, hospitalization, radiology and maternity care services, but the informally employed and self-employed are excluded from these benefits.[75] The Health Equity Fund in Mauritania covers almost all health-care expenditure for the poor including a list of essential drugs for chronic conditions, outpatient care and hospitalization fees.[76] The benefit package of the RAMED scheme in Morocco is standardized and includes hospitalization, ambulatory care and drugs.[77] The AMG schemes in Tunisia cover different benefit packages with a negative list of services that includes all health-care services in public hospitals except for specific treatments, drugs and implantable devices such as knee prostheses and ocular implants.[78] Similarly, the Palestinian GHI scheme covers a standardized benefit package that includes inpatient and outpatient services provided in public health facilities (except for specific treatments and medications) with referral to private health sector and abroad being applied in some cases. The compulsory scheme (CEBHI) in Saudi Arabia also provides a generous standardized benefit package for all members which allows them to seek care in both public and private health care facilities.[79] In other schemes such as Daman in Abu Dhabi, individuals are able to choose either public or private health-care providers.[80] Furthermore, in some countries that rely more heavily on tax-funded health systems (such as Iraq, Algeria and Palestine), some health services are directly subsidized and covered by the Ministry of Health (or the public authorities in place), with cost-sharing mechanisms being in place (e.g., user fees or co-payments at the point of health care delivery).

The scope of health services covered is vital to ensuring adequate financial protection and access to the health care needed by the subsidized vulnerable groups of the population. This requires not only a clear definition of all the services included in the benefit package but also that the benefit package should be standardized for the contributors and the subsidized groups. The little available evidence suggests that the risk-pooling arrangements in place do not always ensure adequate access and financial protection for vulnerable and disadvantaged groups. This is due not merely to incomplete coverage of the targeted population, but also in part to the limitation of benefit packages and/or the presence of differential packages for contributors as opposed to the subsidized population. Furthermore, the persistence of relatively high OOP expenditure in many countries is an indication of the failure to pool the significant private resources which would be required to extend the effective coverage of risk-pooling arrangements.

H. Cost-sharing mechanisms

The extent and type of cost-sharing mechanisms is another crucial aspect that needs to be considered in the assessment of subsidized health coverage.[81] These mechanisms include various forms of non-reimbursable payments such as user fees or charges for publicly provided services, co-payments, co-insurance and deductibles for health insurance

72 Ibid.

73 WHO-EMRO, 2019.

74 Ibid.

75 Kukrety and Al-Jamal, 2016.

76 Waelkens, 2015.

77 Ruger and Kress, 2007.

78 WHO-EMRO, 2016.

79 Ibid.

80 Ibid.

81 Vilcu and others, 2016.

programmes. In low- and middle-income countries, decisions on the cost-sharing mechanisms have often been motivated by the need to mobilize additional resources for health, improve the quality of services, and to prevent excessive use of services.[82] Several studies have shown, however, that the implementation of cost recovery policies can have significant deterrent effects on the overall utilization of health care services by the poor.[83]

Data on cost-sharing mechanisms in the Arab region are scarce, but the available literature suggests that user fees remain widespread and can account for a fairly substantial share of total health financing. In addition, some studies allude to the proliferation of informal user fees that are often used to make up for major shortfalls in public financing and provision of health-care services. Nonetheless, the extent of cost sharing can vary significantly across the different countries. For instance, SHIP in Egypt covers up to 70 per cent of outpatient drugs and all the costs of inpatient care and chronic diseases.[84] Available data on the HEF scheme in Mauritania reveal that about 30 per cent of the hospitalization costs are covered by HEF while the remaining cost is paid for by the hospital fund run by the Ministry of Social Affairs. However, a decrease in the degree of financial protection that is provided by the HEF scheme has been attributed mainly to the increase in the cost-sharing co-payment rates recently introduced to tackle the problem of moral hazard.[85]

In Palestine, GHI members are required to co-pay for many services such as laboratory tests and imaging services and medications obtained from private health facilities are not reimbursed. In Tunisia, previous studies indicate that the heavy use of cost-sharing mechanisms (namely co-payments and user charges) significantly decreased the depth of service coverage and resulted in large proportions of the population having shallower coverage, especially for some expensive inpatient care and medications.[86]

I. Coverage rates of the populations eligible for subsidies

While some of the subsidized health insurance schemes in the Arab region appear to reach significant shares of the targeted population, others cater to only a tiny proportion of the eligible population and potential beneficiaries (summary table below). For instance, virtually full coverage of the population targeted for RAMED has reportedly been reached in Morocco[87] while about 41.8 per cent of expatriates are reported to be covered by the SHI scheme in Bahrain.[88] By contrast, only 16 per cent of informal sector employees are reported to be covered by the NSSF scheme in Lebanon.[89] The Zakat fund in Sudan covers about 1.4 million poor families, as reported in 2015.[90] The population coverage rates of other subsidized insurance schemes remain very low, however. This is the case of the AMG-I and AMG-II schemes in Tunisia where only 8 per cent and 16 per cent of the targeted populations are reported to benefit from these subsidized schemes.[91] There is a lack of reliable data on the effective coverage rates of the populations eligible for subsidies in the Arab region.

82 Waelkens, 2015.

83 Alami, 2017.

84 Nandakumar and others, 1999.

85 Waelkens, 2015.

86 Makhloufi, Ventelou, and Abu-Zaineh, 2015, Abu-Zaineh and others, 2014.

87 WHO-EMRO, 2015b.

88 WHO-EMRO, 2019.

89 WHO-EMRO, 2016.

90 Ibid.

91 WHO-EMRO, 2016.

Analysis of the main features of the subsidized health insurance schemes in the Arab countries

Country	Social protection system (Targeted population)[a]	Entitlement[a]	Subsidized health insurance schemes	Eligibility and enrolment rules to subsidized schemes	Percentage of the vulnerable population covered	Contributions
Algeria	Comprehensive	Statutory/ regulatory (de jure)	CASNOS and CNAC[g]	Informal sector[g] Unemployed[g]		
Bahrain	Comprehensive[b]	de jure[b]	SHI[b]	Expatriate[b]	41.8% of expatriates[k]	$58 per year for citizens and $190 for non-citizens. Expatriates working in the public sector are exempted from fees[b].
Egypt	Very limited statutory	de jure[b]	PTES[b] FHF[k]	Vulnerable groups who are not covered by other insurance programmes[b] Vulnerable women[e]		Government worker: Employee (1% of salary), employer (4%). Public and private sector workers: Employee (0.5%), employer (1.5%). Vulnerable women (1% of annual income)[e]
Iraq	Limited statutory	de jure[b]	--	--	--	--
Jordan	Limited statutory		MOH, UNRWA[b]	The individual (informal sector) seeking coverage must have a valid ID and cannot be covered under any other schemes[b].		
Kuwait	--	--	--	--		

Lebanon	Semi-comprehensive		NSSF[b] UNRWA[k]	Unemployed, self-employed, informally employed or, those having undeclared income[b]	16% of the covered population belongs to the informal sector[b]	Contributions are calculated as a function of the minimum wage[b] The contribution to the fund is 23.5% of the wage, with 21.5% borne by the employer and 2% by the employee[h].
Libya	Limited statutory	UHC declared in 2009	--	--	--	--
Mauritania			HEF[i]	The poor who are unable to subscribe to the mutual health organization[i]	The poorest of the poor in the department of Dar Naim[i]	Free[i]
Morocco	Semi-comprehensive	Mandatory health insurance in formal sector	RAMED[a]	Poor (30% of population)[a]	99% of the target population[c]	Free if monthly income per capita is less than $34[g]
Oman	--	--	--	--	--	--
Qatar	--	--	--	--	--	--
Saudi Arabia	--	--	CEBHI[b]	Expatriate employees[b]	--	
Somalia	--	--	--	--	--	--
Sudan			Zakat (Charitable) fund[b]	Poor families[b]	1.4 million poor families (2015)[b]	35 SDG2 (Sudanese pound)
Syrian Arab Republic	Limited statutory	de jure	--	--	--	--

Tunisia	Comprehensive	Mandatory health insurance; UHC on political agend[a]	AMG AMGI, AMGII[b]	AMG I: economic criterion (individual income not exceeding the poverty line), or social criteria (individual's inability to work, poor living conditions, lack of family support, disabilities and chronic illnesses). AMG II: (individuals must be non-affiliated and ineligible for social security, and annual family income must be less than or equal to the minimum wage)[b]	16 per cent is covered by AMG II, 8 per cent is covered by AMG I (2013)[b]	AMGI: Free AMGII: Based on income and family size[f]
United Arab Emirates			Fragmented health insurance[b] National Health Insurance (Daman)[b]	Daman: residents in Abu Dhabi[b]		
State of Palestine		National Health Plan mentions equity	Ministry of Health, Ministry of Labour; Ministry of Social Affairs; Commission of Detainees' and Ex-Detainees' Affaird,[k]	The unemployed, the poor; Israeli detainees, ex-detainees and their dependents[d]	177,000 family (2013)[d]	Free[d]
Yemen	Limited statutory	--	--	--	--	--

[a] Alami, 2017.
[b] EMRO, 2016.
[c] EMRO, 2015b.
[d] EMRO, 2015a.
[e] Sieverding and Selwaness, 2012.
[f] Abu-Zaineh and others, 2014.
[g] Chouaidia and Laib, 2019.
[h] Kukrety and Al-Jamal, 2016.
[i] Waelkens, 2015.
[g] Ruger and Kress, 2007.
[k] EMRO, 2019.

4. Discussion: the way forward

This study set out to provide a general critical review of the various subsidized health arrangements in a set of Arab countries. It aimed to identify the most important institutional and organizational design features of these arrangements and evaluate their implications for the progress towards UHC.

Our analysis attempted to scrutinize the critical features and factors that might inhibit the subsidized health arrangements from achieving the desired impacts. This was done using a general analytical framework for assessing the current practices and design features against a set of good institutional design features or best practices as regards entitlement and eligibility, enrolment process, sources of funds, level and extent of subsidization, types and content of benefit package, cost-sharing mechanisms as well as the regulatory structures.

Analysis of key aggregate indicators reveals a moderate to fast progress through the health financing transition (viz. the increase in per capita total health spending and the substitution of pre-paid and pooled financing for direct out-pocket-payments) over the last two decades, though with important variations across Arab countries that can be attributed mainly to differences in their contexts, economies and structures of their health financing systems. The health financing transition, one of the prerequisites to achieving UHC, increases financial risk protection by reducing the burden of health spending on vulnerable groups. Overall, the analysis shows that health systems in the Arab region are under-financed, and that it will be possible to mobilize additional resources for health. The level of subsidization to health depends mainly on Governments' fiscal capacity as well as the available fiscal space. Although the fiscal envelope – total government spending to GDP ratio – reflects a medium and medium to high fiscal capacity for most Arab countries, the share of resources allocated to health from all domestic resources and from national budgets remains relatively low. This indicates a low priority for health in Governments' budgets, i.e. a narrow fiscal space for health despite the availability of fiscal capacity. Moving beyond the status quo towards UHC would require many Arab countries to:

- Increase health expenditure, adjusted epidemiologically and demographically, to levels closer to conventional standards by increasing their public spending on health,
- Use domestic resources more efficiently and equitably by ensuring that additional resources for health are channelled through pre-paid and pooled arrangements to reduce reliance on direct OOP payments.
- Mobilize additional resources to improve the quality of health-care delivery and contain the increased demand on health-care services.

The current subsidized health arrangements (whether through direct subsidization of demand-side or indirect subsidization of supply-side) appear inadequate to fully insure against catastrophic and impoverishing health expenditure. This is mainly due to the restricted benefit packages imposing a negative list or annual limitation for health spending per household or per capita, but also to the extensive use of co-payments and co-insurance, deductibles and user fees that account in many schemes for a substantial share of total health financing. This signals the need to reconsider the current role and structure of health systems in order to

strengthen their financial protection and service provision capacities.

Some implications for future reforms of the design of subsidized arrangements emerging from our analysis of the main features of the current arrangements are worth highlighting. First, results suggest that neither a full subsidization ("free care for all") policy nor a partial subsidization policy can be sufficient on its own. The lesson drawn from experience is that subsidization policies can have little success unless effective targeting and monitoring mechanisms are put in place to ensure, first, identification of the portion of the population eligible for subsidies. Ensuring adequate funding from multiple sources – rather than relying solely on government budget transfers – is equally important in order to maintain the provision of adequate and good quality health services and to compensate for revenues lost by health insurance schemes and public health facilities.

Second, the success of subsidized health coverage also depends on the effectiveness of the targeting mechanisms used to identify the population eligible for subsidies and to deliver services to the targeted populations. As shown in the analysis, while most of the subsidized arrangements implement some criteria to identify their potential beneficiaries, many of these criteria do not explicitly and properly apply a means-tested benefit approach (by relying, for instance, on a measure of household-adjusted equivalent expenditure or a need-earning assessment) to actually identify and reach out to the targeted groups. The means-tested benefit approach has been shown to be effective in bridging the significant gaps between de jure and de facto coverage rates of the population.

Third, employing more effective targeting mechanisms alone would not achieve the desired outcomes unless other effective measures are taken into account with respect to enrolment processes, benefit packages and cost-sharing mechanisms. Currently, the State plays a passive role transferring the subsidy to the pooled funds on behalf of the potential or actual beneficiaries. The latter are required to play an active role applying for, and initiating, the entire enrolment process to be able to benefit from the subsidized scheme. Today, however, a growing body of literature shows that a more active role needs to be played by the State (public health authorities) in the enrolment process, thereby reaching the vulnerable groups of the population who may otherwise be discouraged by the complicated administrative procedures.

Fourth, another key issue for future reforms of health insurance arrangements concerns the design of the benefit package, including the type of services and providers. The entitlement to a benefit package has often not been appropriately conceptualized and defined in many of the health insurance schemes assessed in this study. Indeed, although many of these schemes are said to offer universal coverage of services (an all-inclusive package), in practice, this implies a negative list of services, with an annual expenditure cap per household being imposed in some cases. But given that financial protection (SDG indicator 3.8.2) is the ultimate goal of all subsidized health arrangements, it is increasingly argued that a more financially protective benefit package can be attained by covering services that are mostly associated with catastrophic and impoverishing health expenditure. This would also require an active role in purchasing, with the purchaser regularly compiling and analysing relevant epidemiological and actuarial data on the beneficiaries.

Fifth, determining the level of subsidy is equally important for the design of effective and adequate subsidization arrangements. Although little is known about the methods that are used to

calculate the amount of subsidy in the Arab countries, the available literature indicates two approaches: a fixed lump-sum transfer and a per capita subsidy to the subsidized schemes or providers. The latter approach, involving estimates of expected health expenditure per beneficiary or through a bidding process to design a defined benefit package, provides a criterion for better determining the level of subsidy and cost sharing that may vary across and within the subsidized risk pools and the population groups eligible for subsidies.

Although the analysis undertaken in this review employed a broad analytical framework to analyse a wide range of sources, some practical limitations must be acknowledged which resulted mainly from the lack of detailed information and reliable data on a number of key indicators such as the ratio between revenue and expenditure, the level and direction of cross-subsidization within and between risk pools, the premium contributions of different vulnerable groups, the level of subsidies provided by the Government, the sliding co-payments for different health care services as well as the detailed benefit package covered by each of the schemes.

Future research should rely on microdata from nationally representative surveys to make a full analysis of the impact of various subsidization arrangements as regards the financial protection and the health-care utilization patterns of the groups eligible for subsidies. Benefit incidence analysis of the different targeting and subsidization mechanisms is also required make a full evaluation of the distributional aspects of these schemes which hitherto remain very much neglected or sidestepped by the empirical studies conducted in the region. A benefit incidence analysis makes it possible to assess how well the overall subsidized health insurance arrangements are performing with respect to the distribution of health care. In addition, it allows the identification of which individuals receive what benefits from Government subsidy. It would be also useful to explore further the potential presence of ex-post moral hazard (excessive use of health-care services) that may be induced by subsidized health services, and the different approaches that can limit such behaviours on the part of both the demand side and the supply side.

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This study aims to contribute to the policy debate about universal health coverage (UHC) in the context of the Arab region. Specifically, it seeks to illuminate the design features of existing subsidized health insurance arrangements and to assess their importance for making progress towards the UHC goals. To this end, the study mobilizes a wide range of sources including findings from previous studies, regional and country case documentations, as well as time-series data extracted from different sources including the Global Health Expenditure Database (GHED) of the World Health Organization (WHO) and the data portal of the United Nations Economic and Social Commission for Western Asia (ESCWA). There are a number of interesting findings and key implications to be highlighted.

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