ON COVERING THE 'MISSING MIDDLE' for UNIVERSAL HEALTH COVERAGE (UHC)

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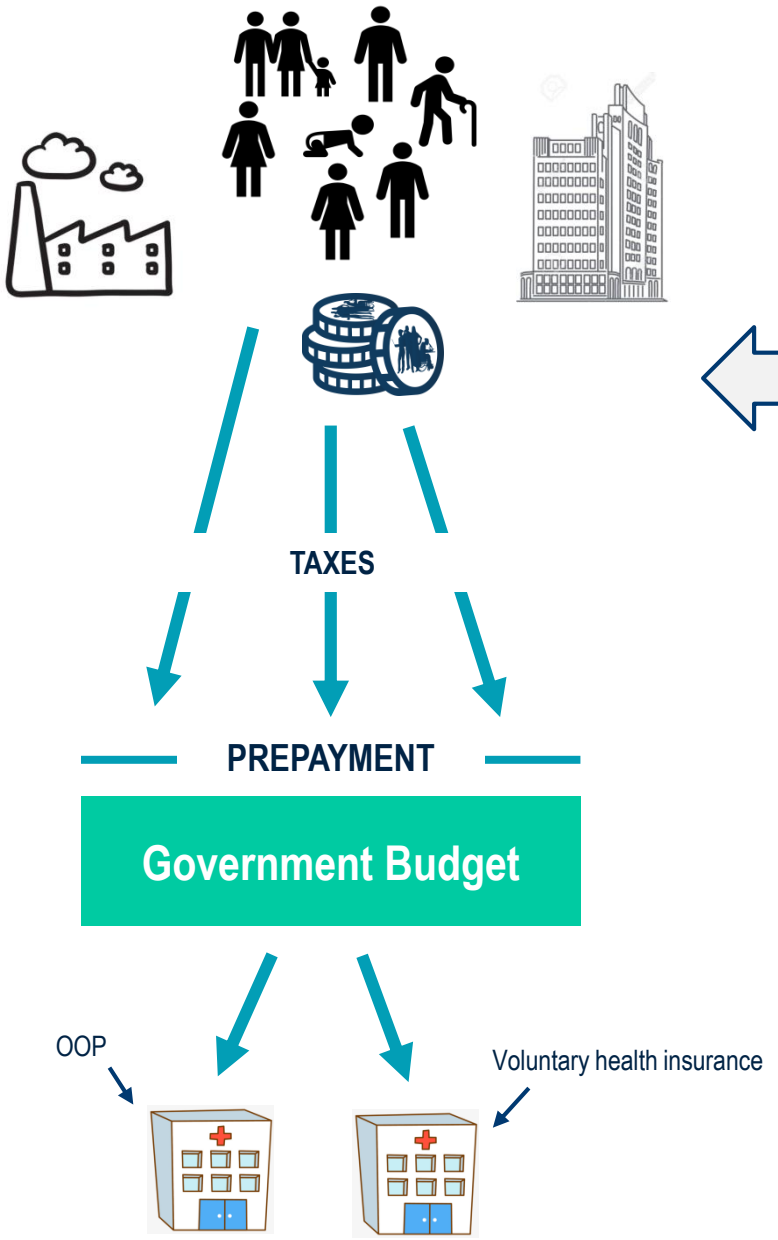
Outline

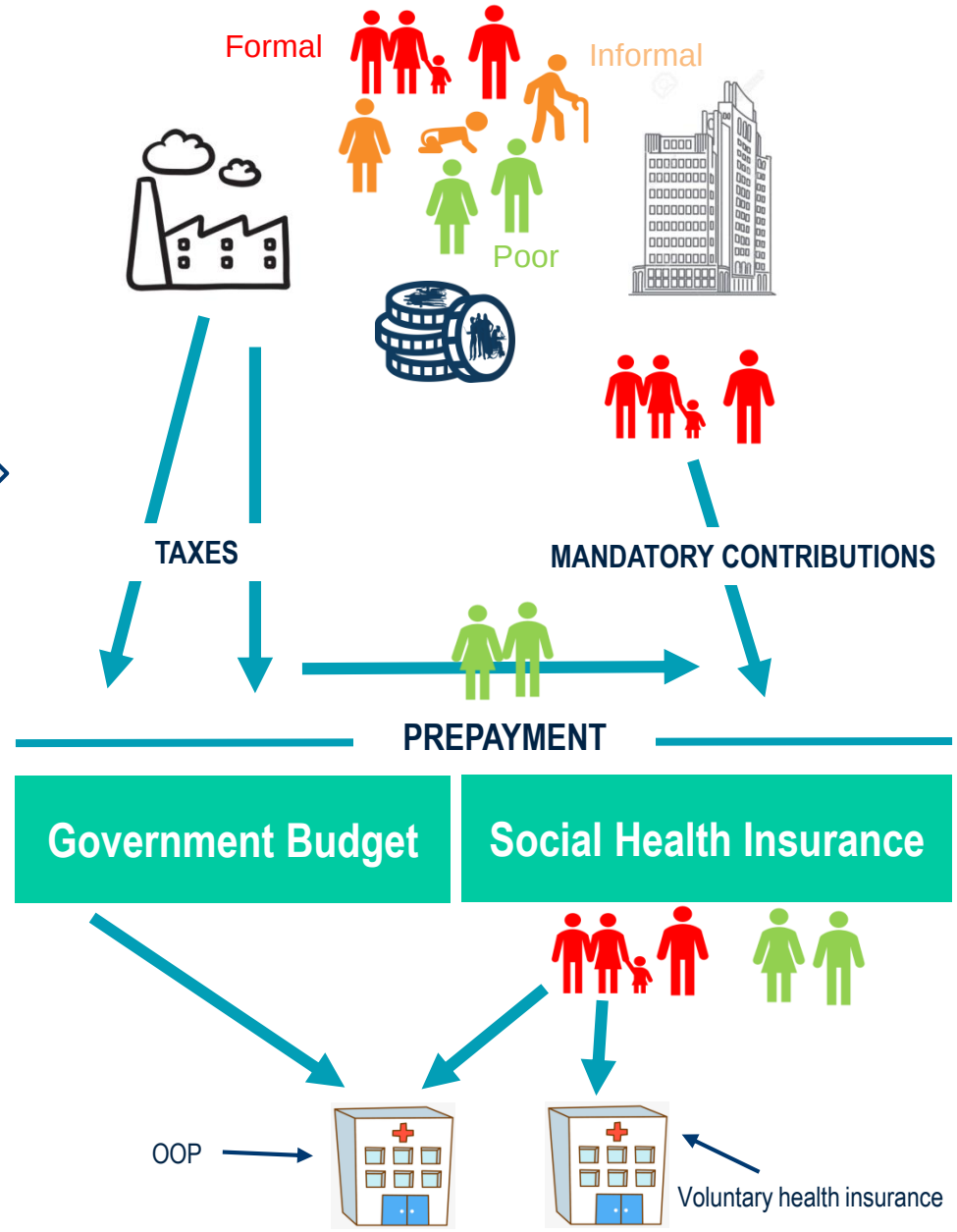
- Challenge of ‘missing middle’ common across developing countries using social health insurance (SHI) strategies for pursuing UHC.
- ‘Missing middle’ on paper may not be ‘missing middle’ in reality.
- ‘Missing middle’ challenge is basically linked to challenge of large and persistent levels of informality.
- Compulsion and subsidization key for UHC but mandating premiums difficult from informal sector; relying on voluntary enrollment for informal sector is recipe for disaster.
- Expanding tax-financed non-contributory coverage to the ‘missing middle’ and delinking contributions to entitlement are some options countries such as India could consider.

Challenge of 'Missing Middle' ↔ SHI Health Financing Systems

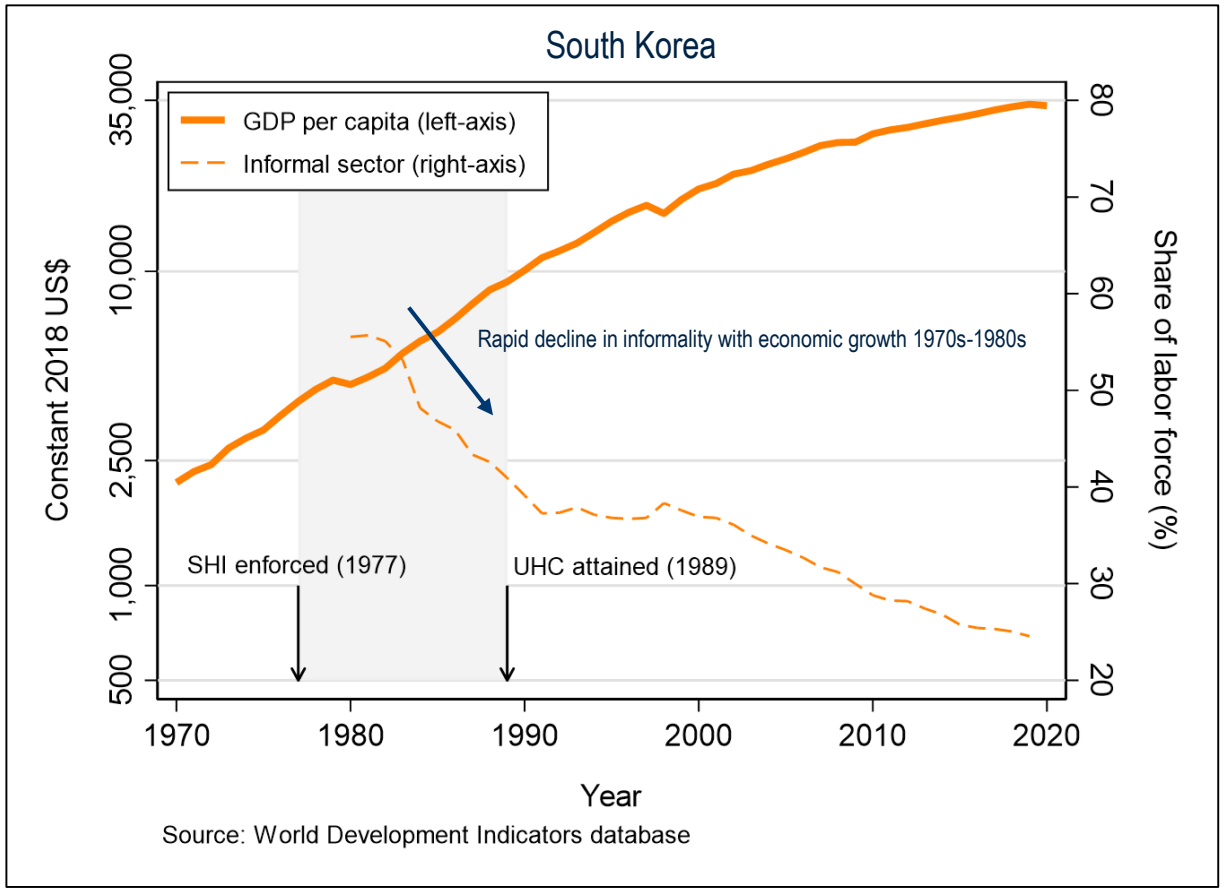


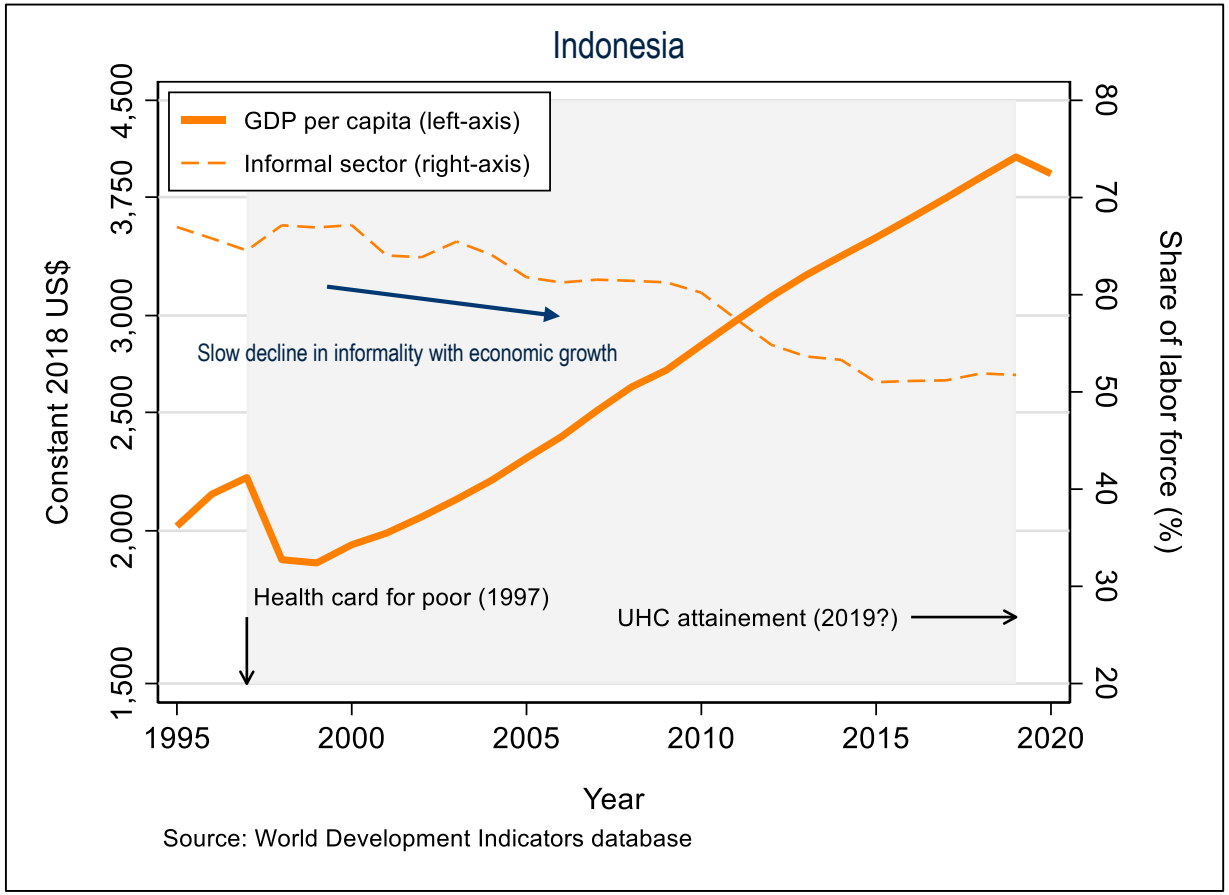
Tax financed health financing systems – Brazil, Malaysia, Sri Lanka -- UHC with universal entitlement

SHI financed health financing systems – Indonesia, Vietnam, Philippines -- UHC where contributions, self-paid or paid by government on behalf of beneficiaries, is linked to entitlement; difficult to collect mandatory contributions from informal sector



‘Missing Middle’ Challenge ↔ Persistent Informality





Burdensome regulations, high taxation, non-contributory social protection schemes, globalization/outsourcing-oriented supply-chains, weakening unionization, demographic pressures are some of the reasons hypothesized for persistence in informality in recent decades

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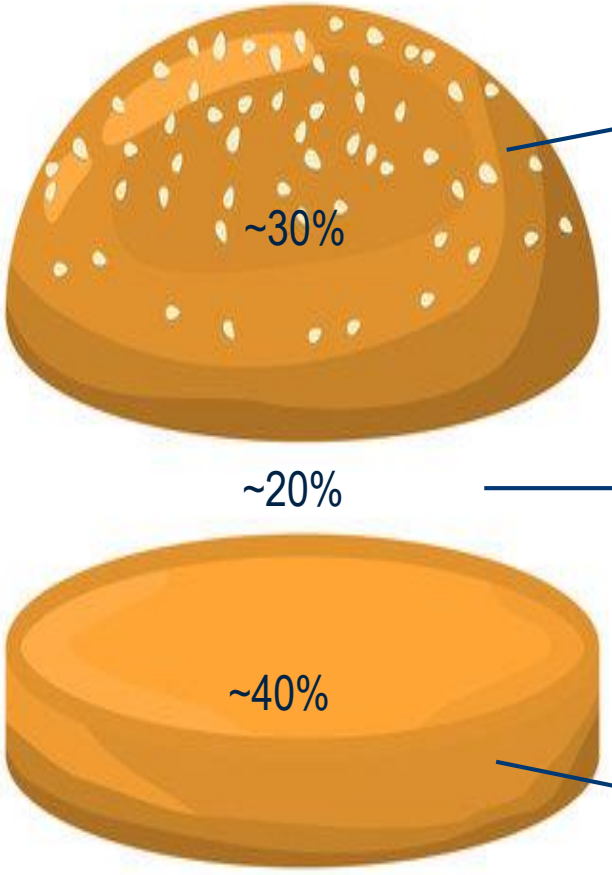
‘Missing Middle’ on Paper ↔ ‘Missing Middle’ in Reality

JKN: Indonesia’s SHI scheme, administered by BPJS Kesehatan



Top covered

- Tax-financed or compulsory insurance schemes for public sector employees (& dependents)
- Compulsory insurance schemes for formal private sector employees (& dependents)

‘Missing middle’

- Non-poor informal/self-employed workers (& dependents)
- Often low take-up of (subsidized) voluntary insurance & adverse selection problems

Bottom covered

- Tax-financed schemes for the poor and other indigent groups (& dependents)

Reasons for low take-up among non-poor informal: lack of information, underestimation of probability of getting sick, low risk aversion, perceptions of low quality of care, inability to afford premiums, limited impact on OOP

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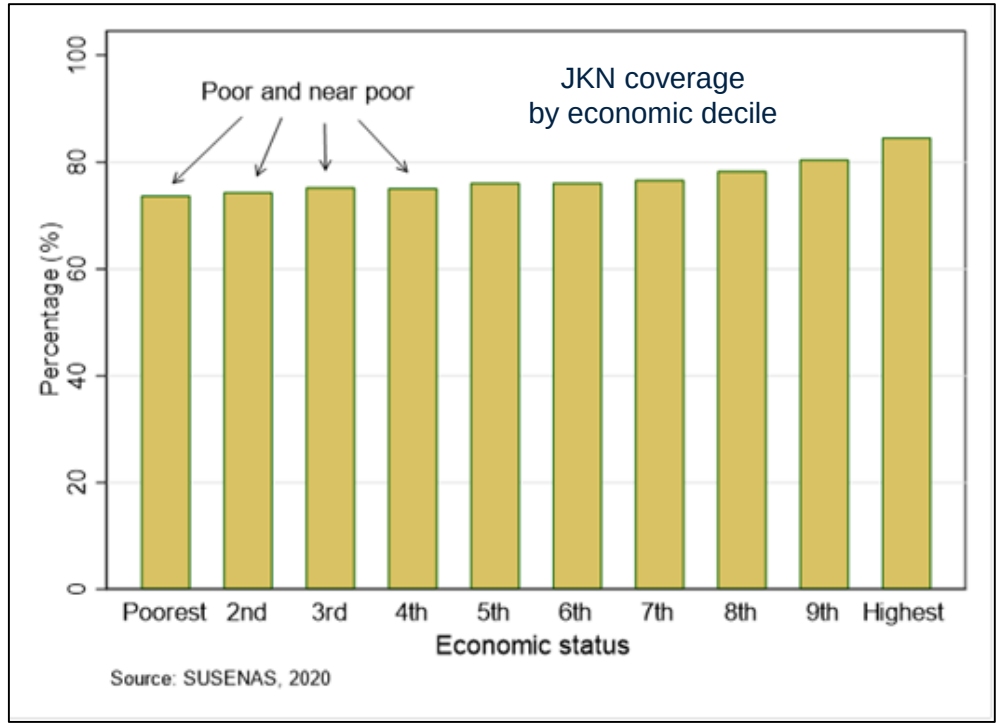
Jabatan	: Marketing Manager	Periode	: April 2016

INFORMASI	PENDAPATAN		PENGURANGAN	
Year to date	Gaji Pokok	6,000,000	PPh21	87,959
April - 2016	Tunjangan Jabatan	0	BPJS Ketenagakerjaan	397,512
	Tunjangan Komunikasi	125,000	BPJS Kesehatan	350,250
	Tunjangan Transportasi	880,000	Koperasi	0
	THR	0		
	Bonus	0		
	Lembur	0		
	BPJS Ketenagakerjaan	647,262		
	BPJS Kesehatan	280,200		
	TOTAL PENDAPATAN	7,932,462	TOTAL PENGURANGAN	1,435,721
			PENDAPATAN BERSIH	6,496,741

Mandatory payroll contribution

Payslip ini dicetak menggunakan HR system, tidak membutuhkan stam atau tanda tangan.



Compulsion & Subsidization ↔ UHC

Many countries have sought to collect revenue from nonpoor informal workers in exchange for health insurance coverage. None of them has managed to collect a significant amount of resources, where significance refers to the share of the contribution relative to the costs of coverag

The results suggest limited opportunities to raise voluntary health insurance enrollment through information campaigns and subsidies, and that these interventions exacerbate adverse selection.

The difficulties that developing countries today are experiencing in extending coverage to nonpoor informal sector workers and in raising contributions from them point towards a long and frustrating road to universal coverage under SHI.

The Challenges of Universal Health Insurance in Developing Countries: Experimental Evidence from Indonesia's National Health Insurance*

Abhijit Banerjee
Amy Finkelstein
Rema Hanna
Benjamin A. Olken
Arianna Ornaghi
Sudarno Sumarto*

May 2021

POLICY RESEARCH WORKING PAPER 6893

Effects of Interventions to Raise Voluntary Enrollment in a Social Health Insurance Scheme

A Cluster Randomized Trial

Joseph J. Capuno
Aleli D. Kraft
Stella Quimbo
Carlos R. Tan, Jr.
Adam Wagstaff

So, What Can Countries Do For Covering the 'Missing Middle'?

Abandoned SHI financing

- Brazil, UK, Norway, Denmark, Greece, Portugal, Italy, Spain abandoned SHI, made entitlement universal and general tax-financed.

Extend fully-subsidized SHI coverage to non-poor informal sector

- Thailand gave up trying to collect contributions from non-poor informal sector, extended non-contributory general tax-financed SHI coverage to entire informal sector (~75% of population). Indonesia and Vietnam have slowly expanded fully-subsidized coverage beyond the poor to the near-poor and other vulnerable groups.

Universalize specific services or services in specific types of facilities

- Chile has a defined guaranteed service package for everyone regardless of insurance status.

Delink contributions to entitlement

- Russia, Kazakhstan use diversified revenue sources – mandatory contributions, health taxes, general taxes – to provided universal entitlement regardless of employment status.

Key Take-Away Messages

Developing countries following SHI financing for making progress towards UHC face an oft-insurmountable challenge of collecting contributions from non-poor informal sector

Challenge is compounded by large and persistent levels of informality in recent decades; informality has been stagnant or decreasing slowly, evidence that COVID-19 has resulted in higher informality (and poverty)

Growing global evidence that partial subsidization of contributions, information campaigns, etc. are not cost-effective strategies and do not make a significant dent towards UHC, can even exacerbate problems due to adverse selection

Generally non-contributory more successful than contributory strategies for making progress towards UHC with large informality, but even so design and careful implementation remain key, including aspects related to governance and service delivery