Webinar 3 Executive Summary

The P4H Network and Australian National University (ANU) have organised a webinar series to promote knowledge sharing and dialogue on Social Health Protection (SHP) for Migrant Workers and Their Families. The last of the three-part series, held on June 28, 2023, was moderated by ***John Ataguba***, Canada Research Chair in Health Economics at the University of Manitoba and had speakers from Colombia, Lebanon, and Rwanda and participants from across the globe. The first speaker, ***Lea Bou Khater***, Technical Officer from the ILO Regional Office for the Arab States, shared that in almost all of the Gulf Cooperation Council (GCC) countries, national private sector employees are covered by the national health protection system. In contrast, non-national private sector employees are covered by mandatory private health insurance. In Bahrain, Kuwait and Qatar, migrant workers historically have access to non-emergency care through the national health system which employers paid.

Nonetheless, these countries have all announced plans to transit to mandatory private health insurance, joining countries such as Saudi Arabia and the United Arab Emirates that shifted to private health insurance for migrant workers from 1999 and 2013, respectively. The shift to a private insurance model, which is premised on individual risk management, may lead to fragmentation and exclusion and does not align with social health protection standards of universality and solidarity-based financing. Lea also shared a mix-method study of Nepali migrant workers across the GCC countries that reported lower insurance coverage amongst those in low-income groups and amongst domestic workers.

The next speaker, ***Michelle Barliza Cotes***, Senior Health Financing Lead, presented the USAID Local Health System Sustainability Project findings. The project aims to include Venezuelan migrant populations and returned populations within the health system by working with key stakeholders. Migrant populations include both regular and irregular workers. For the former, the efforts include looking at social insurance mechanisms, and for the latter, the efforts include strengthening institutional capacities in areas such as legal support to guarantee emergency care at the local level. The three steps approach includes health enrollment promotion, strengthening effective access and establishing results-based financing by mobilising economic resources from the private sector to finance maternal care packages for pregnant women with irregular and pendular migration status. An example of results-based financing being explored is a pay-for-performance arrangement between a private sector payer, intermediary and verifier, and maternal health service public provider with the end goal of advancing SHP of pregnant women in Colombia.

We also had the privilege to hear from ***Regis Hitimana***, Chief Benefits Officer of the Rwanda Social Security Board (RSSB), who shared about the national insurance schemes in Rwanda, including community-based health insurance (CBHI) scheme for the informal sector and medical insurance scheme for the formal sector. The four types of migrants in Rwanda include internal migrants, external migrants, urban refugees, and refugees in camps. The RSSB has recently established a new provider payment mechanism for internal migrant workers who are nationals, using a capitation model that accommodates portability and reconciliation between primary health care facilities based on the cost per service utilisation.

External migrants must purchase public or private health insurance within a month of their arrival; however, informal workers without valid visas or permits cannot access the insurance schemes. For refugees in the camp, no insurance schemes are available; however, primary health care is free at the point of service. Since 2019, urban refugees can be covered by the CBHI scheme with premiums paid for them. Several challenges remain, including the lack of harmonised social protection systems within

the region, the informal sector not covered under current insurance schemes, and issues in targeting vulnerable households to benefit from subsidies.

Near the end of the webinar, ***Esabelle Yam***, P4H Country Focal Person and Regional Engagement Manager from the Australian National University (ANU), shared the outcome of a survey that was designed to collect feedback from respondents on areas of work essential in advancing SHP for migrant workers. The knowledge areas highlighted in the survey include the policies, processes and challenges in implementing SHP in different country and regional contexts, the regulatory frameworks and areas of gaps or non-compliance, the types of data needed to design evidence-based SHP policies, etc. To conclude the webinar series, ***Christine Phillips***, Professor in Social Foundations of Medicine from ANU, shared the key learnings from the webinar series. Firstly, although there are legal instructions, conventions and recommendations on SHP for migrant workers, such as the Global Compact for Migration, many labour migrants still have none or limited access to social protection in Asia. SHP policies across the world vary in coverage and are not gender-neutral. Following the journey of migrant workers to their destination countries reveals many challenges in accessing health services and financial protection. The inadequate SHP leads to income insecurity and inaccessibility to health, contributing to poverty and vulnerabilities, inequalities and ill health, which impact human capability and productivity.

To mitigate these impacts, SHP requires a multisectoral approach, with a role for non-governmental organisations in working with governments to identify and work on the gaps in providing SHP for migrants. The COVID-19 pandemic has also highlighted the impact of inadequate SHP on the vulnerabilities of migrant populations and provided opportunities for countries to learn and identify ways to enhance SHP. These lessons contribute to the collective knowledge in advancing SHP for migrant workers and their families. P4H Network and its members will continue collaborating to foster dialogue on key SHP and health financing issues to catalyse policy reforms towards UHC. Watch the webinar recording through this link: https://www.youtube.com/watch?v=MjfRTKi-0YQ&t=1239s and the Q&A at the end of this article.

Question and Answer:

1.The question is whether we can have private provision and public regulation, especially for countries with a very large private sector. Do you think we can have private provision and public regulation?

I think we should start by saying that globally, private health insurance has a minor role in health financing and it is generally used only as a complementary mechanism to national solidarity based financing systems. The issue here is that we are moving completely away from national solidarity based financing systems and focusing on providing this access only through private insurance. So this is the issue. Now to answer the question is that yes, there can be private insurance, but as I said in the last part of presentation. The role of the state as a guarantor is necessary to guarantee good mechanisms and to deliver and manage the social protection benefits. The role of the state is key.

2.Is the Rwandan government thinking about a government finance health insurance scheme to cover at least the poor and the vulnerable?

Yes. As I said in my presentation, this actually exists. The community-based health insurance is heavily subsidized by the government. Last year government subsidies were much more than contribution. 17% of the population identified as poor are completely 100% covered by the government. So maybe the difference from the question would be a separate scheme for the poor contributed by the government. The approach in Rwanda is to have them join the scheme and get the same benefit as someone who has means to contribute and pay by themselves, so they access the same service. And the other thing maybe I need to emphasize is that at the point of care they don't pay co-payment, and thus, access to care is free for the people identified as poor. Actually, it is creating a big problem where everyone is trying to remain in that status even if they have moved upwards. They don't want to lose that benefit. This is a big challenge in the targeting.

3. How is the Colombian government responding to the LHSS project objectives?

In Colombia, we have a good response in working with the Ministry of Health. It is very important to talk about it because with the temporary institute for migrant population, it is important to include the migrant population into the health system. Without these normative, the statistical indicator for enrollment will have the same results. And obviously all the activities for the objectives that I mentioned starting my presentation in Colombia are articulate fully with the Ministry of Health because it's very important to strengthening for the capacity of the health system, including the national level to achieve better results into the LHSS Columbia outcomes.

4. What is the long-term sustainability plan for Colombia after the external funding of the project is over?

When we start the plan for Colombia, we formulate the sustainability and transition plan with the different stakeholders that we are strengthening in Colombia. The purpose of this plan is strengthening international and local capacities to improve comprehensive healthcare for the migrant population. The idea is to generate strategies for the integration into the health system. But we need to buy the activities on different principles, for example, sustainability, quality, efficiency and solidarity. Because the idea is when the program ends, the different stakeholders can't continue with

activities that we promote with the technical assistance in Colombia. Now and each year we are monitoring the different milestones that we formulate in the transition and sustainability plan.

5. Historically the ILO has had a normative approach to social health protection on research and policy support. Research and policy support is appreciated but what countries need is implementation support beyond just policy support and research. Do you think it is time to get on the field and help the government to get things moving?

To be honest, we respond to the requests of the government when they need technical assistance. For instance, in the GCC, we have been requested to provide technical assistance or even to give technical opinion for certain countries regarding the attempts to move to private healthcare to mandatory employer funded healthcare. And to be honest, the aim of this research, if you look at the overall objectives, is to accompany these countries and their attempts of adjustments and reforms. So first I would say that we are starting from scratch with exploratory research on the topic that is the services of these countries. We have participated in several workshops and consultations and engagements to steer if you want these reforms to extent as possible towards the alignments with international social security standards. I think this is a key role that the ILO is playing in the region. The trend towards privatization is very tangible and often when we have these consultations with these governments there is a room for discussions around improvements and alignments of international social security standards.

6.Rawanda is a beautiful example of CBHI providing protection to a large number of people. But in the technical sense, we know that CHI has a sustainability problem. How do you feel about it?

Yes, definitely there is a very huge sustainability problem when you have already brought 90% of the population in this scheme. The next question is what do you give them? and what do you promise them? Second, we are transitioning from communicable diseases to noncommunicable diseases and having a double burden because we still have HIV, TB, malaria, mainly malaria. Probably, we have done well with HIV and TB. We are seeing a rising trend of noncommunicable diseases. Life expectancy is increasing rapidly. Now we are approaching 70% in the past year in the last census. So that means what? It means that the cost of care is expected to grow very quickly and rapidly, and it has already started. But the pace in which population income is growing is not following that trend. So first of all, what the government would have done very quickly to at least save the situation? We are thinking of increasing contributions from members. It was to look into beyond the subsidy for tertiary care. The government has already committed to cover tertiary care for everyone who is enrolled in healthcare. So they have been doing it in addition to covering the poor. Covering tertiary care to everyone who is in the scheme. So they give that, but in addition to that, but as I said in my presentation. We realize we need more resources. That's how innovative financing came up, including how can tax and direct tax based on consumption on key services, including transport, fewer telecommunication, motor vehicle inspection, traffic fines. All of these are contributing to the scheme, and you have seen bringing something actually closer to member contributions. So we are now matching the contribution number from those sources. But this is a discussion that will continue in the next will be members increase their contribution. Actually, I forgot to start with the other health insurance that contributes to the community-based insurance, 5% for private insurance and 10% for a public health insurance that we manage. So they contribute to the big pool (community based insurance) without expectation of any benefit. This has at least surprised the scheme for now, but we expect the trend to reverse if we don't increase the contribution from members.

7. This question is about enrollment in Rwanda, you talked about the poor community. So how does this scheme select the poorest and what are the criteria that are used to select beneficiaries as poor or vulnerable?

We have one government system for social protection, not for insurance, only for social protection. And that program is actually managed by another ministry that is in charge of social protection. They have different schemes to support vulnerable households. Some receive cash benefits, others receive jobs in order to get income, other receive small grants or small capital that they will pay back without interest. But in order to identify who gets what, the government has set up an identification system which is community owned. There is the list of criteria that is different from rural to urban because in rural you expect a good award standing households to have a land, some cattle, and so on. So they put those criteria to the community meetings and they decide this household belongs to this category and we use that. So it's a combination of objectivity and discussion and agreement in the community which also tends to be objective to a certain extent with always errors that we can see, but at least majority of the poor are identified through that system. Now the changes that are coming are how can we keep that system dynamic because people move upwards and downwards on regular basis and how can we also increase objectivity in that identification. We have integrated with all having one ID is actually one infrastructure that is helping this system. Now the government has connected to all systems and land. So authorities know my ID. They can know how much land I owned. They can know my salary. All these assets have been identified and connected through government systems. Even if the community thought I am poor, but for my assets, you can see in all the government systems suggest otherwise. Then the system would be adjusted accordingly. But people would be that will allow dynamism in the system, so to adjust for shocks that happen or movement upwards that can happen. If I buy land, I move from this category to another category because it's an indication that I'm better off. It's a challenge and it's not for health insurance only. It's for all the social protection systems in Rwanda.

8. They said decision making is very political, so how do we convince parliamentarians to use public money for migrants?

First, ILO is a tripartite organization. We don't only want to speak with the government, but also respect our tripartite essence, which is to speak to employers, governments, and workers. There are several issues such as this one. One example can be found in the recent policy paper on the end of service indemnity where we try to address the concerns than to speak about these issues. We also try to focus on several angles. This is kind of do a business case for the extension of social protection to migrant workers in the GCC. And this is key because the labor market is changing very fast in the GCC. This is accompanied by and reflected in the changes in the sponsorship system slowly. But it's mean legally at least is there. We need to accompany this by saying that social protection enhances decent work and enhances productivity, which is good for all the government, the worker, the employer. We have to say that social protection rights, including access to medical care is important to formalization and to reducing unfair competition, which is very important when we think about the nationalization of the labor market, which is an objective in these countries, we have to say also that it contributes to economic development and macroeconomic stability that equality of treatment, which is a central principle in social protection and solidifies social cohesion. I mean, these are several messages, but also a key message that these countries are embarking and reforms of their social insurance systems because of several weaknesses, even for their nationals. And the extension of social protection to migrant workers actually strengthens these national social protection systems. And this is a very young population. It's a big population. It really makes the social protection system very strong for all, for the government, for the employers, for the workers, and for the nationals. I mean, these are assets of, you know, overarching messages that are key of our dialogue with all our constituents, not with the governments.

9. Whether you can share, in your own opinion, any evidence of migrant workers are not abusing access to healthcare.

No, we don't Information now about the abuse of the healthcare system in migrants. We have a commitment to understanding the barriers for access. Of course, we have two kind of population that we want to talk. We have the enrolled population. They have the directly access to health care facilities, but the irregular pendular population that they demand services in Colombia. They come to Colombia only to receive services. For example, for 8% of the attention are concentrated in maternal care. Obviously, they come to Colombia to receive attention in the health facilities for their childbirth. That is the situation in Colombia. But obviously with the Ministry of Health, we are working to understand the system to have a better use of the system because migrant population and Colombian population are including in the same health system to have a good use to the health services and that's the situation. But obviously maybe in some cases, we can looking into it in the future.