

Universal health coverage as a crucial pillar for social protection



Photo: The International Federation of Red Cross and Red Crescent Societies (IFRC) and health personnel of the Tunisian Red Crescent unload medical supplies donated by the Spanish Red Cross at the IFRC Base Camp near the Libyan border. By Victor Lacken / IFRC, 2011

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Acronyms and abbreviations

BPJS	Badan Pengelola Jaminan Kesehatan
CHE	current health expenditure
CNAM	Caisse Nationale d'Assurance Maladie
CRT	Tunisian Red Cross
GDP	Gross Domestic Product
GRCS	Ghana Red Cross Society
ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
ILO	International Labour Organization
JKN	Jaminan Kesehatan Nasional
LEAP	Livelihoods Empowerment Against Poverty
NCDs	non-communicable diseases
NHIA	National Health Insurance Authority
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
OECD	Organisation for Economic Co-operation and Development
OOP	out-of-pocket
PHC	primary health care
PMI	Palang Merah Indonesia
SDGs	Sustainable Development Goals
SLRCS	Sri Lanka Red Cross Society
UHC	universal health coverage
UNGA	United Nations General Assembly
VAT	Value Added Tax
WHO	World Health Organization

1. Introduction

Social protection is a set of policies and programmes designed to reduce and prevent poverty and vulnerability throughout a person's life cycle (ILO, 2017). Universal health coverage (UHC), which embodies the right of all people to quality, accessible, affordable and available health services, is considered a key pillar of social protection systems. Social protection and UHC work to improve the lives and well-being of individuals by providing financial protection against health-related risks such as illness and disability. Increasingly, the importance of UHC and social protection have been explored in the context of climate change as its impacts are expected to further strain both systems.

The International Federation of Red Cross and Red Crescent Societies (IFRC) has been scaling up its work on universal health coverage since 2018, recognizing that UHC aligns closely with IFRC's commitment to act in the interests of the most vulnerable and alleviate human suffering (IFRC, 2022a). At the same time, IFRC has recognized social protection as a crucial pillar of investment to increase people's resilience to climate change in the most vulnerable countries (IFRC, 2022b). Given the prioritization of social protection and UHC within the International Red Cross and Red Crescent Movement, it is useful to explore how the two approaches can benefit from each other and leverage each other's strengths to reach those most in need.

This brief aims to provide health and social protection actors and practitioners with an overview of the role of UHC as an important pillar for social protection. It highlights important features and characteristics of UHC using case studies from Tunisia, Sri Lanka, Ghana and Indonesia to better convey how universal health coverage can contribute to building resilient social protection systems. This may also be useful to inform the programmes of civil society organizations as well as non-profit organizations such as the IFRC's National Societies.

2. Methodology

The objectives of this brief are to: 1) provide an overview of the role of UHC as a crucial pillar of social protection; and 2) outline how it can support vulnerable individuals to cope with health-related risks. The following research questions were developed:

- How have countries integrated universal health coverage into their social protection systems?
- What are the strategies and policies in place to ensure vulnerable individuals have access to quality healthcare?
- What lessons can be derived from countries who have linked their universal health coverage approaches into social protection?

To achieve these objectives, country case studies were sourced. A report from the Organisation for Economic Co-operation and Development (OECD) 'Towards universal social protection: Lessons from the universal health coverage initiative' (2019) was used as a key resource and a snowballing technique was applied to identify other relevant literature. This technique was supplemented by searches on Google to find grey literature linking UHC and social protection; and was followed by a secondary, more targeted search of the following terms within PubMed Central and BMJ Open, as well as the World Bank and World Health Organization repositories.

Table 1. Search terms used

1	Operator	2
Universal health coverage		Social protection
OR		OR
universal health care		shock responsive social protection
OR		OR
universal healthcare	AND	social protection floor
OR		OR
SDG 3.8		social assistance
OR		OR
SDG 3.8.1		social welfare
		OR
		welfare
		OR
		social safety net
		OR
		social insurance

A total of 40 countries with UHC principles integrated in varying degrees into their social protection systems were included in the analysis. The examples captured represented a wide spectrum of country examples with UHC, including two examples from low-income countries, 18 countries classified as lower-middle income countries, 14 upper middle-income countries, and six high-income countries. An extensive list of countries with explicit links between UHC and social protection are available in the Annex.

The case studies included in this report are Tunisia, Sri Lanka, Ghana and Indonesia. Tunisia and Sri Lanka were selected as noteworthy case studies due to the comprehensive health services provided, equitable access for vulnerable communities, political commitment to UHC, and positive health outcomes. To contrast these examples, Ghana and Indonesia were selected to assess system challenges such as financial constraints, lack of health service providers and inadequate health infrastructure.

This brief will provide a summary of UHC, illustrate the relationship between universal health coverage and SP, then delve into case studies from countries that have attempted to integrate UHC and social protection, followed by a set of key lessons related to the integration of social protection and UHC as derived from the case studies.

3. Understanding UHC

Health is recognized as a basic human right, and UHC is commonly acknowledged as a vehicle for attaining that right (Eozenou *et al.*, 2023). Universal health coverage aims to provide all individuals with access to adequate essential health services in a timely manner without having to incur financial hardship (WHO & World Bank, 2018; L4UHC, 2020; Chaudhuri *et al.*, 2022). It has three essential dimensions: equitable access, quality healthcare, and financial protection (IPU & WHO, 2022; Rim & Tassot, 2019; Yanful *et al.*, 2023; Chaudhuri *et al.*, 2022).

- **Equitable access** to services ensures all individuals can access the full spectrum of services provided without any discrimination or prejudice based on income, religion, gender, ethnicity and/or other factors. Equitable access also extends to

geographic accessibility, availability of health resources to provide essential health services, and access to health literacy.

- **Quality healthcare** refers to the quality of services provided with consideration to patient satisfaction, as well as the quality of services implemented and whether technical guidelines are followed. Additionally, it implies that healthcare does not compromise the patient's well-being and desires.
- **Financial protection** allows individuals to access quality healthcare without incurring financial debt or facing financial barriers.

In 2015, under the Sustainable Development Goals (SDGs) of the United Nations 2030 Agenda for Sustainable Development, 193 Member States adopted SDG 3 on Good Health and Well-being along with SDG 3.8 to, "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (UNGA, 2015). The SDG indicator for universal health coverage (SDG 3.8.1) has increased by more than 50 per cent from 45 points on a 100-point scale in 2000 to 68 in 2019, demonstrating growth in the number of people receiving quality healthcare globally without incurring catastrophic out-of-pocket expenses for health (WHO, 2023a; Yokobori *et al.*, 2023).

The harsh realities of out-of-pocket expenditure

Globally, out-of-pocket (OOP) expenditure accounts for 16.4 per cent of current health expenditure (CHE) (WB, 2023). OOP impacts not only low-income countries, such as Nepal whose OOP expenditure makes up a significant 54.2 per cent of CHE, but also high-income countries, such as Portugal where OOP expenditure is 27.8 per cent of CHE (*ibid*).

High levels of OOP expenditure can be a barrier in accessing healthcare, especially for low-income households. This, in turn, may exacerbate inequality as the poor spend more of their income on health services, potentially leading to disparities in health outcomes as individuals decide to forego treatment due to financial strain. Financial protection is a key pillar within UHC to ensure individuals are not incurring high levels of debt or catastrophic OOP in order to access healthcare.

Climate change poses significant risks to the undermining of global health and public health gains, exacerbating existing inequalities and creating new health risks such as increased heat stress, or the spread of infectious diseases (Machalaba *et al.* 2021). Climate change also indirectly worsens the social determinants of health by increasing poverty. Cyclical losses and additional expenses resulting from extreme weather events along with the slow degradation of productive livelihoods that are dependent on a stable climate, entrench people in poverty. This further reinforces the need for individuals and households to rely on negative coping strategies, often necessary in the short-term for acute needs, but which make people worse-off in the long run. Therefore, climate change represents an additional poverty trap, defined as a "self-reinforcing mechanism, which causes poverty to persist" (Azariadis & Stachurski, 2005).

As such, integrating UHC and social protection with consideration to climate risks is essential to mitigate the impacts of climate change and enhance resilience (Salas & Jha, 2019). This is especially important for countries that have the lowest rates of UHC, yet are the most vulnerable to climate change (*ibid*).

4. Understanding social protection

Social protection is a portfolio of policies and programmes aimed at reducing poverty, inequality and vulnerability (Costella *et al.*, 2022). Social protection programmes can be either contributory, which means that they are financed by contributions from employees and/or employers and specific to pre-agreed contingencies (e.g., old age, unemployment, employment injury, maternity/paternity, sickness, etc.); or they can be non-contributory, which require no direct contribution from beneficiaries or employers to receive benefits. This can be in the form of UHC, cash transfers or guaranteed work (ILO, n.d.). Additionally, the implementation of labour market policies that set standards for decent working conditions and minimum wages are also forms of social protection. Social protection programmes, and especially cash transfers with 'plus' or complementary components, have shown considerable positive impacts on health and well-being (Little *et al.*, 2021). 'Plus' components are additional to the actual benefit (e.g., cash transfers), and can range from mandatory health training or vaccinations to routine health checkups.

There is a growing evidence base demonstrating that social protection has been influential in reducing poverty rates and inequality, as well as advancing health and education infrastructure, thereby facilitating the economic development of countries (OECD, 2018).

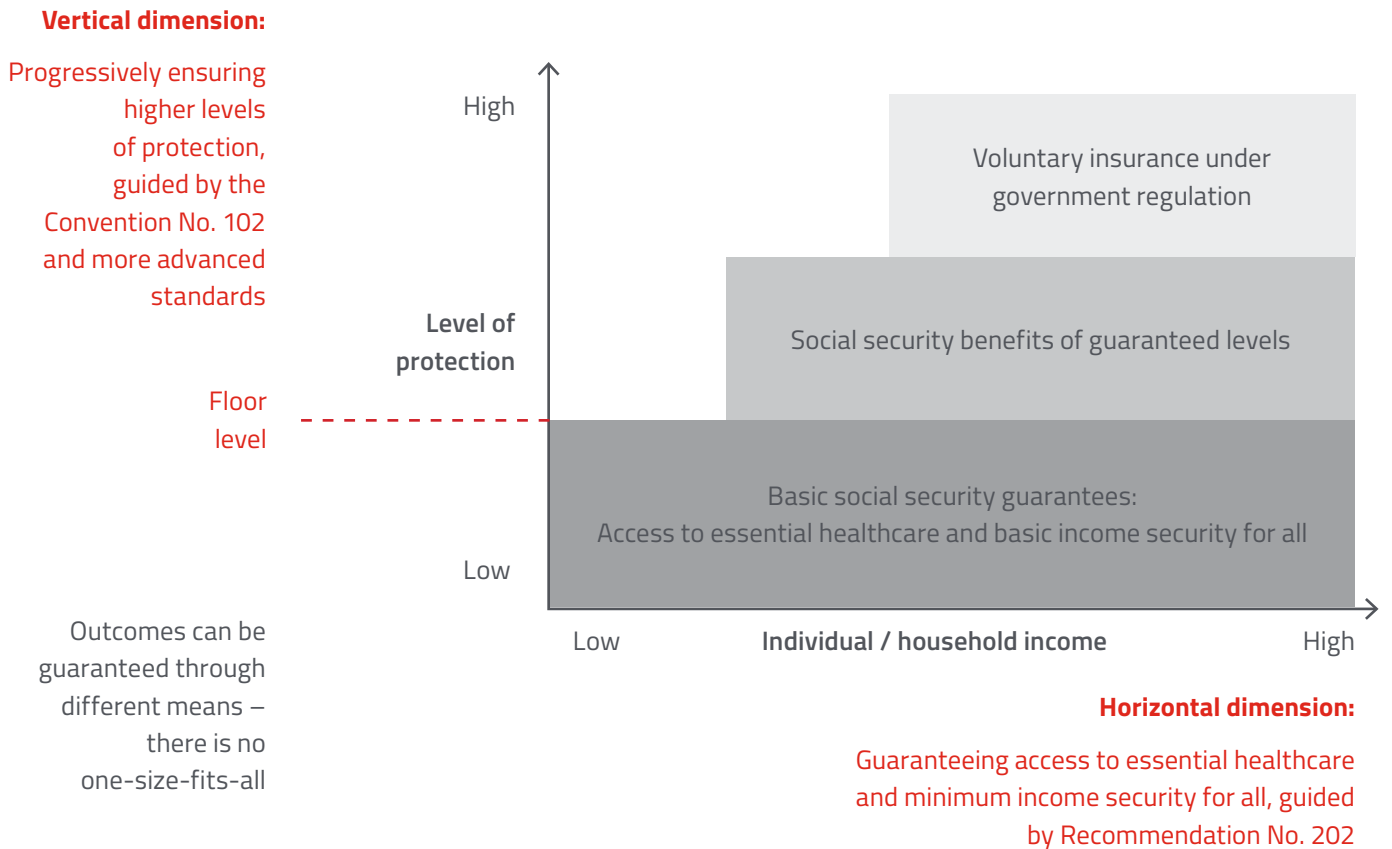
5. Relationship between universal health coverage and social protection

The objectives of UHC are aligned with the aims of social protection, as social protection works to provide individuals with financial protection from vulnerabilities throughout their life. UHC complements social protection via the following pathways (IPU & WHO, 2022):

- **Financial protection and poverty reduction** by improving health outcomes, improving productivity due to a healthier population, and increasing economic opportunities in the healthcare sector. This, in turn, can increase households' saving capacity through the more equitable use of government resources and the reduction of catastrophic financial expenses.
- **Promotes gender equality and women's empowerment** by ensuring access to quality essential healthcare services, including maternity care, for women and girls.
- **Strengthens the State's capacity to respond** to health crises such as epidemics and pandemics. This can be further facilitated through social protection tools such as registries and delivery mechanisms.

In 2012, the International Labour Organization (ILO) institutionalized the role of UHC in social protection through the adoption of the Social Protection Floors Recommendation (No. 202). This provides guidance on how to build a comprehensive social protection system, specifically through the establishment of basic income security for families with children, the unemployed, the elderly and people living with disabilities, along with the commitment to provide essential healthcare (including maternity care) for all (see Figure 1) (ILO, 2012).

Figure 1: Social Protection Floors Recommendation (No. 202) (ILO, 2012)



The recommendations provide a foundation for social protection and encourages a vertical expansion towards additional social protection provisions based on budgetary allowances (*ibid*). To streamline the definition of access to essential services, the ILO identified the following criteria: availability of services, accessibility of services, acceptability in the country context, and decent quality (*ibid*).

In essence, the World Health Organization (WHO) suggests that UHC can be improved by reorienting health systems using a primary health care (PHC) approach, which recommends that the full range of quality services and products needed for health and well-being are delivered close to an individual’s environment (WHO, 2023a). As social protection systems in many countries target the end beneficiaries and provide support (e.g., cash, food packets, counselling) at the local level, it aligns in principle with bringing services and assistance to one’s vicinity, with the vision of increasing coverage, financial protection and equity.

In the context of a changing climate, the role of UHC in supporting individuals’ coping with climate-related hazards is vast. Here, social protection can be leveraged for the dual objectives of development and humanitarian response (Yokobori *et al.*, 2023). The features of shock responsive social protection, where traditional social protection programmes and mechanisms are temporarily adapted to respond to short-term shocks, can be utilized during crises for the scaling and targeting of health services (*ibid*).

6. Case studies

The following case studies provide insights into the experiences of implementing UHC as part of the social protection system in four countries. Tunisia and Sri Lanka provide insights into what progress towards comprehensive and equitable health services could look like, while Ghana and Indonesia depict how different challenges exist despite commitment towards universal healthcare. The countries were chosen based on the availability of comprehensive information on UHC during desktop research as well as the active role of the country's Red Cross Red Crescent National Society in the healthcare system. In each country example, the role of Red Cross Red Crescent National Societies in the provision of healthcare activities has been highlighted to demonstrate the potential role of civil society organizations in supporting and enhancing national healthcare efforts.

6.1 Tunisia



The Republic of Tunisia, the northernmost country in Africa, has a total population of 12.4 million people (UN, 2023). As a lower middle-income country, Tunisia witnessed a noticeable increase in the poverty rate due to the Covid-19 pandemic. In 2024, the poverty rate is projected to be 17.1 per cent based on the national poverty line (Statista, 2023). The Tunisian healthcare system, often lauded as one of the most developed in North Africa, is a blend of public and private healthcare services.

The Constitution of Tunisia enshrines the right to healthcare in Article 38 by guaranteeing preventive healthcare and treatment for every citizen and ensuring the safety and quality of health services. Upholding the principle of universality, it also guarantees free healthcare and seeks to provide social assistance for those without means (Republic of Tunisia, 2014). The Ministry of Public Health is primarily responsible for health affairs in the country, while the Caisse Nationale d'Assurance Maladie (CNAM or the National Health Insurance Fund), is the non-administrative institution responsible for providing a basic health insurance coverage for the whole population (Republic of Tunisia, 2004). In 2018, Tunisia signed the UHC2030 – Global Compact (WHO, 2019), which solidified Tunisia's commitment to work together with other partners of the Global Compact in accelerating progress towards universal health coverage by the 2030. According to the UHC Index in 2017, UHC in Tunisia stood at 65 per cent (WHO, 2018).

CNAM implements the basic health insurance scheme through three types of coverage, with all insured persons obliged to choose a preferred coverage type: a) public care channel managed by public health structures; b) private care channel provided by a doctor chosen by the insured person; and c) reimbursement system where services are provided by public and private sectors and the payment for the resulting costs are subsequently reimbursed to the patients by the fund. Contributions to CNAM are made by both employees and employers, ensuring a steady source of funding. These are systematically deducted from the wages of active workers, the income of self-employed workers and the pensions of retirees (CNAM, 2023). Additional schemes exist for workers, covering accidents at work or occupational illnesses (e.g., work accidents, stress disorders).

The Tunisian healthcare system has made significant strides in establishing UHC through a combination of policies and strategies aimed at making the system equitable, participatory and efficient (Salman, 2017). The Government’s commitment to ensuring that every citizen has access to essential healthcare services has led to the establishment of an extensive network of public hospitals and clinics, with 2,157 primary health centres and 108 hospitals; a second level of care with 31 regional hospitals; and third level with 27 university hospitals and nine specialist centres (Giusti *et al.*, 2023). These institutions offer a wide range of medical services, from primary care (e.g., general sickness, flu) to specialized treatments (e.g., haemodialysis or blood purification), and are funded through a combination of general taxation and social insurance contributions.

In 2012–2014, a large-scale consultation process – the *Dialogue Sociétal pour la Réforme du Système de Santé* (Societal Dialogue for Health System Reform) – was initiated by the Government with its citizens to inform policies on a range of health topics. The second phase of the consultation process was launched in 2017, and the third phase in 2019 (WHO, 2019). This consultative process included different formats such as regional meetings on health, open mic sessions, focus groups, citizen’s jury, thematic working groups and national health conferences. These activities encouraged participation from the public, health and thematic experts, non-governmental and civil society organizations, marginalized and vulnerable groups, and analysed their needs and proposed solutions for improving the Tunisian health system. In 2021, it ultimately resulted in the official adoption of the National Health Policy 2030 (ben Mesmia *et al.*, 2023). According to a study conducted among Tunisian regional hospital directors, decentralization of the healthcare system in Tunisia is expected to reduce the inequities between the different territories in terms of access to services and their availability, the quality of the provided services, and optimization of health outcomes (Giusti *et al.*, 2023).

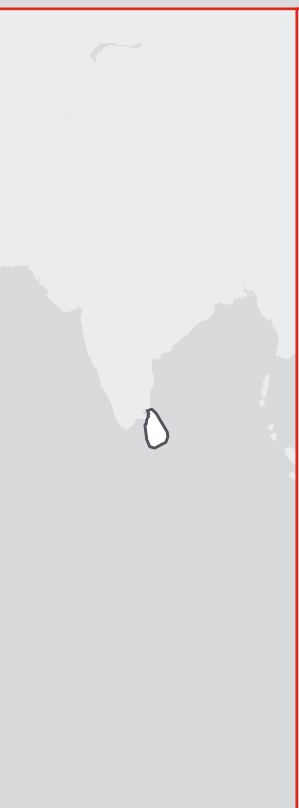
National Society’s role: The Tunisian Red Crescent (CRT) plays a significant role in supporting the achievement of UHC in Tunisia through its humanitarian and healthcare activities. The CRT participates and contributes to the social dialogue processes alongside the national-level health platform; operates healthcare centres and mobile clinics; and offers mental health and psychosocial support to vulnerable and underserved populations; as well as providing immediate medical care and relief assistance to affected populations during disasters (e.g., during Covid-19) (IFRC, 2022c).

Existing challenges: While Tunisia has been making substantial progress in achieving UHC in the country, the ageing population along with a rise in non-communicable diseases (NCDs) are expected to increase the burden on the healthcare system. Newly graduated health professionals are facing high unemployment rates, and this is expected to lead to a ‘brain drain’ as they shift to the private sector and foreign countries (WHO, 2018).

Notable features:

- **Societal dialogue and stakeholder consultations:** The societal dialogue process created an enabling condition for UHC where citizens were encouraged to participate and raise concerns related to their healthcare rights and needs.
- **Decentralization improving regional healthcare access:** The decentralized healthcare system contributes directly to UHC as it enables improved access to health services and increases the distribution of health services’ supply across Tunisia.

6.2 Sri Lanka



Sri Lanka is a lower-middle income country located in the Indian Ocean with a population of over 22 million people (Rajapaksa *et al.*, 2021; World Bank, 2022). Internationally, the country is recognized for its high-impact and low-cost UHC model, which had provided institutionalized free primary health care since the early 1950s and has since expanded towards more comprehensive UHC since 2014 (Rajapaksa *et al.*, 2021; UNICEF, 2021). Healthcare policies are passed by the Cabinet of Ministries and supplemented by a parliamentary Sectoral Oversight Committee on Health to ensure that health is integrated across all relevant policies, including social protection (Rajapaksa *et al.*, 2021). In 2020, the country spent 4.07 per cent of its gross domestic product (GDP) on healthcare services, which is more than the South Asian average of 3.05 per cent of GDP; however, this falls behind the average health expenditure of all middle-income countries of 5.62 per cent (World Bank, 2023). Funding for the UHC system consists of tax and non-tax revenue, domestic borrowing and international assistance. In 2015–2021, foreign assistance averaged 5.3 per cent of the health budget (UNICEF, 2021).

Sri Lanka’s public health system boasts a range of health services, including free service delivery, and encompasses approximately 95 per cent of inpatient care services and 50 per cent of ambulatory care, with the remaining services requiring a fee (Rajapaksa *et al.*, 2021). In cases of emergencies, ambulance services are free (*ibid*). Additionally, the Government takes on the expenses for prescribed medication and tests (*ibid*). Though the poor are not explicitly targeted, the UHC system is pro-poor and indirectly aimed at reducing poverty as it strives towards equitable access to quality services across the population (Rajapaksa *et al.*, 2021). This is evidenced through the reduction of financial barriers to health service-uptake by the poor by ensuring hospitals and clinics are located close to communities, with greater emphasis on preventative care linking education and nutrition interventions (Rajapaksa *et al.*, 2021; Kumar, 2019).

National Society’s role: To supplement the efforts by the national Government, the Sri Lanka Red Cross Society (SLRCS) works with the Ministry of Health to implement community-based activities for health promotion, preventing NCDs, facilitating blood donations, and, in some cases, providing emergency healthcare, such as first-aid services during conflict and natural disasters, through its network of volunteers (SLRCS, n.d.). The SLRCS provides these services during emergencies, including disasters. More recently, it has completed training programmes for volunteers across six tsunami-affected districts to provide psychosocial support (*ibid*).

Existing challenges: Despite the strengths of this system, there is still a need for increased Government investment into the country’s health system, especially with an ageing population and predicted rise of NCDs (Chapman & Dharmaratne, 2018; UNICEF, 2021). Furthermore, with increases in privatized health services and healthcare actors shifting to the private sector, there are uncertainties surrounding the sustainability of the system (Smith & Witter, 2004).

Notable features:

- **Institutionalization of health objectives across various sectors:** The Sectoral Oversight Committee on Health works to ensure the seamless integration of health information into all relevant policies, including those related to social protection, to encourage policy coordination and collaboration to meet health-related objectives.
- **Achievement of pro-poor objectives:** The country’s UHC is pro-poor and designed to improve the well-being of economically vulnerable individuals and communities, thereby applying the universal health coverage principles of equity and financial protection.

6.3 Ghana

The healthcare system in Ghana has evolved significantly over the years, marked by a series of reforms and improvements since the country's independence from the colonial rule in 1957. The most significant development in Ghana's healthcare system was the establishment of the NHIS (National Health Insurance Scheme) in 2003 with the goal of providing access to healthcare services for all residents of Ghana. It is a social health insurance programme that covers a wide range of medical services, including community-based health planning and services and emergency care as well as access to maternity homes, health centres, clinics, hospitals and pharmacies. By offering comprehensive coverage, the NHIS has significantly expanded access to healthcare services for a large portion of the population (NHIS, n.d.).

One of the key principles of UHC is ensuring financial protection for individuals and families. The NHIS helped to achieve this by reducing the financial barriers to accessing healthcare premiums in 2012 (Alhassan *et al.*, 2016). Children, pregnant women, persons with disabilities, 'indigent' persons (core poor) and the elderly are exempt from paying contributions, making healthcare more affordable and preventing catastrophic healthcare expenses (NHIS, n.d.). According to 2016 estimates, 60 per cent of those enrolled in the NHIS were exempt from paying premiums (Alhassan *et al.*, 2016).

Ghana's NHIS is funded through a combination of sources: a) the National Health Insurance Levy (NHIL), which is a 2.5 per cent levy on goods and services collected under the Value Added Tax (VAT); b) 2.5 percentage points of Social Security and National Insurance Trust (SSNIT) contributions per month; c) return on National Health Insurance Fund (NHIF) investments; d) a premium paid by informal sector subscribers (NHIS, n.d.).

Ghana offers a unique example of integrating social protection with universal health coverage: In 2011, the Ministry of Gender, Children and Social Protection (MoGCSP) collaborated with the National Health Insurance Authority (NHIA) to enrol beneficiaries in the 'indigent' category in the Livelihoods Empowerment Against Poverty (LEAP) programme. LEAP waives all NHIS fees including those for card processing, premiums and renewals. Additionally, while pregnant women were not initially included under LEAP, the LEAP eligibility criteria were later expanded to include poor households with pregnant women or children under 12 months of age (Palermo *et al.*, 2019). The expansion of eligibility criteria was to reach households with young children suffering from malnutrition, who were previously not covered by LEAP (Otieno *et al.*, 2022). Both these initiatives were successful in increasing the enrolment of vulnerable communities to the NHIS (Palermo *et al.*, 2019).

Existing challenges: Despite the interventions in place, the healthcare system faces challenges in low coverage rates, indirect cost and politicization. Of exempt groups, 60 per cent have been brought under coverage; but, of the whole population, overall, 60 per cent is still not covered by the NHIS. Annual registration and renewal of membership to the NHIS results in indirect costs for the beneficiaries, posing financial barriers for economically vulnerable individuals. The programme has also been criticized for being politicized through strategic appointments of NHIS officials and the allocation of NHIS funds (Kipo-Sunyehzi *et al.*, 2020).

National Society's role: The Ghana Red Cross Society (GRCS) plays a vital role in supporting the goal of UHC in Ghana by improving healthcare access, emergency response, and community health promotion through vaccination drives and campaigns, psychosocial support services, medical screening and the distribution of first-aid kits (GRCS, 2022; GRCS, 2021).

Notable features:

- **Taxation for health insurance subsidies:** The Ghanaian health insurance scheme receives funding from the NHIL, which comprises the 2.5 per cent levy on goods and services collected under VAT. As this is pre-decided and institutionalized, it acts as a sustainable stream of finance and demonstrates the country's commitment to providing UHC for its people.
- **Consistent integration between social protection and healthcare agencies:** In 2011, the MoGCSP collaborated regularly with the NHIA to enrol beneficiaries of the LEAP programme for health insurance. This form of coordination is central to achieving integrated systems.

6.4 Indonesia



Indonesia is a lower-middle income country located in Southeast Asia with a population of 273 million people (World Bank, 2021). Its mandatory health insurance scheme is administered through the Jaminan Kesehatan Nasional (JKN). Launched in 2014 and managed by the social security organizing agency, Badan Pengelola Jaminan Kesehatan (BPJS), it provides accessible health services across the nation (Nugraheni *et al.*, 2020). JKN is a mandatory programme for all inhabitants of Indonesia through individual and employer contributions (Mahendradhata *et al.*, 2017). The BPJS is monitored by the National Social Security Council which also designs social protection policies (Prabhakaran *et al.* 2019). Under the Presidential Regulation No. 82 (2018), JKN provides health insurance to all citizens and eligible foreigners to access primary health care and emergency care as well as secondary and tertiary health services, based on referrals from public system doctors (Nugraheni *et al.*, 2020). To increase the enrolment of low-income individuals and those in the informal sector, JKN has established subsidized rates for monthly contributions for this population dependent on the level of care required (Prabhakaran *et al.*, 2019). The subsidized rates require a relatively lower contribution for enrolment (*ibid*). In 2019, the Indonesian Government subsidized the insurance contributions of almost 50 per cent of the population, with the informal sector predicted to make up a large segment (*ibid*). Although this national health insurance is in place, private insurance continues to play a major role in the overall healthcare system (*ibid*).

Existing challenges: Though health spending as a percentage of GDP continues to rise – from 3.1 per cent in 2012 to 3.4 per cent in 2020, it is much below the average of low- and middle-income countries of 5.61 per cent (World Bank, 2023). In 2017, the OOP expenditure was 60 per cent (Mahendradhata *et al.*, 2017). Since its launch in 2014, the JKN has faced challenges with a rising deficit and weak implementation; particularly in achieving its pro-poor objectives (Nugraheni *et al.*, 2020). Enrolment is hindered through the requirement of ID cards and proof of residence that are not easily accessible to all (Prabhakaran *et al.*, 2019; Nugraheni *et al.*, 2020). Despite being mandatory, there is a lack of enforcement of individual contributions from informal sector workers (Prabhakaran *et al.*, 2019). As such, informal members who would be the most impacted by OOP expenditure, suffer the greatest financial hardships from health spending (Mahendradhata *et al.*, 2017; Prabhakaran *et al.*, 2019).

Moreover, adverse selection implies those who are ill will be more likely to provide contributions, which leads to a greater strain on the pooled resources and undermines risk pooling and subsidization (Mahendradhata *et al.*, 2017). This has overall implications for the sustainability of the scheme. However, the Government has expressed a commitment to putting forward policies and actions to adapt enforcement strategies to enrol more informal workers and effectively manage contributions (Prabhakaran *et al.*, 2019).

National Society's role: Historically, the Indonesian Red Cross Society or Palang Merah Indonesia (PMI) has contributed actively to national public health policies with responsibilities to deliver emergency public health responses during disasters using its vast network of volunteers and experts (PMI, 2016). The PMI implements a community-based health and water sanitation programme across six targeted regions (*ibid*). Through this programme, the elderly are supported through social welfare activities; health education is provided to vulnerable communities; and blood service drives are conducted across the country (*ibid*).

Notable features:

- **Integrated governance arrangements:** Universal health coverage is managed and implemented by the country's Social Security Organizing Agency to prevent fragmentation and duplication across the healthcare and social protection systems.

7. Key learnings

Based on the earlier case studies, the following section provides key learnings for public sector officials and Red Cross Red Crescent National Societies seeking to integrate social protection and universal health coverage.

- 1. Legal framework and constitutional guarantee enables using social protection for UHC:** The integration of UHC and social protection requires a legal framework and constitutional guarantee to acknowledge and legally recognize social protection as a policy and programmatic option that can help to achieve UHC as a right of all citizens. Tunisia's constitutional guarantee of health coverage emphasizes health as a fundamental right. Once there exists a legal framework that guarantees access to healthcare, social protection can be recognized as an option in supporting access and coverage, by updating national health policies and frameworks.
- 2. Leveraging and building on existing social protection systems offers a concrete entry point for UHC:** One of the primary steps in establishing UHC through social protection is to build on existing social protection systems through collaboration between healthcare and social protection agencies, as Ghana does, to enrol beneficiaries of social protection programmes onto health insurance schemes. Health insurance schemes could expand their eligibility criteria to include social protection beneficiaries such as households with pregnant women or young children, who may not be covered by systems which primarily cater for the formally employed.
- 3. Pro-poor approaches should underpin social protection and UHC:** As seen in Ghana and Sri Lanka, overcoming barriers to accessing healthcare for poor groups is crucial to addressing and preventing the negative impacts of income poverty on health outcomes. Countries seeking to integrate UHC and social protection could adopt a stepped approach by prioritizing healthcare access for the most vulnerable and income-poor groups, who are often targeted by social protection programmes.
- 4. Sustainable financing mechanisms are a prerequisite for social protection to promote UHC:** A long-term financing strategy that taps into different sources for a social health insurance fund is essential to progressively increase coverage and improve the quality of healthcare without creating a financial burden on people. As seen in the Tunisian example, this can be done through a diversified mix of funding sources, including a percentage coming from social protection contributions made by employees, employers and enterprises. For countries where financing is a bigger challenge, a tax-funded social health insurance system could be set up initially, with minimal voluntary contributions from the absolute poor, and subsidized rates for low-income and informal sector workers to reduce financial barriers (as seen in Indonesia). Additional sources such as international climate funds that can finance projects to improve social health insurance governance systems and mechanisms could also be considered.

- 5. Long-term planning against future risks enables integrated healthcare and social protection systems:** Countries are currently facing several challenges, including the impacts of climate change and ageing populations. To adequately offer protection against such risks, healthcare and social protection systems would benefit from conducting climate risks and impact assessments; using this information to strengthen systems to be able to adapt, scale up and be flexible when such risks arise. This would enable countries to anticipate and prepare – just as Sri Lanka predicted its demographic shift so was able to allocate resources to address the rise of NCDs and an ageing population.

How can risk-informed planning enable UHC and social protection in practice?

In a country with an ageing population, where risk assessments predict an increase in the number of heatwaves affecting elderly people, social protection systems would benefit from adding a flexible design component that enables elderly people to withdraw cash from their pension funds during heatwaves to meet their immediate needs, such as the increased costs of electricity or the purchase of fans. Health systems equipped with the same risk assessment information could prepare awareness messages or health services directed at the elderly who are members of the pension fund.

- 6. Existing/new social protection benefits could consider a 'plus' package of healthcare services:** Social protection systems that are currently operational could seek to integrate 'cash plus' components relevant to the health risks faced by the population being targeted. Where social protection programmes have conditionalities to receive benefits (e.g., mandatory school attendance), UHC-related conditionalities (e.g., regular health checkups/vaccinations/clinic visits) could also be taken into consideration. However, it is important to ensure that conditionalities do not create barriers for beneficiaries in accessing the programme (e.g., accessing distant clinics to fulfil eligibility may act as a demotivation); and, as such, are carefully designed to be relevant for the region/community targeted.

Additional example: These findings from Tanzania's 'cash plus' model show how healthcare objectives were integrated within the Government's Productive Social Safety Net programme targeting youth, and resulted in improved mental health and knowledge of sexual and reproductive health while increasing access to healthcare services.

- 7. Monitoring and evaluation of the gains from integrating social protection and UHC is needed:** Where countries are using social protection systems for achieving healthcare objectives, rigorous monitoring and evaluation assessments are necessary to enable other countries to learn from challenges and successes. The case study countries presented in this report could be studied further to evaluate the effectiveness of integrating social protection and healthcare objectives and systems.
- 8. National Societies can support UHC goals and linkages with social protection:** Red Cross Red Crescent National Societies in most countries are currently involved in providing healthcare to people in many ways, including mobile clinics, community health programmes, counselling services and psychosocial support. To further enhance the intersection of UHC and social protection, National Societies could help in three ways: a) registering social protection

beneficiaries onto national health insurance schemes and increasing uptake (especially for those schemes that are voluntary); b) supporting people in accessing health subsidies provided by social protection agencies through messaging and campaigns; and c) targeting social protection beneficiary categories for healthcare support for their own programming.

8. Conclusion

The integration of social protection and UHC, as exemplified by the four country case studies (Tunisia, Sri Lanka, Ghana and Indonesia), holds promise for achieving sustainable development and climate adaptation goals. Integrating social protection and UHC reinforces the notion that access to healthcare is *a fundamental human right*. It enshrines this right in national constitutions, emphasizing its importance for the well-being of citizens. This integration *prioritizes equity*, ensuring that healthcare services are accessible to all, regardless of socio-economic status. It reduces disparities in healthcare access, promoting social inclusion. By *reducing financial barriers* to healthcare, it shields individuals and families from catastrophic health expenses, thereby enhancing financial stability and reducing poverty rates.

Social protection and UHC goals integration contributes directly to Sustainable Development Goal (SDG) 3 by promoting UHC access, reducing maternal and child mortality, and combating disease. By shielding individuals from health-related financial burdens, this integration aligns with SDG 1's objective of poverty reduction. It also supports SDG 10 by addressing health inequalities and ensuring equitable access to healthcare services.

Through this integration, access to essential healthcare services for marginalized and vulnerable people can be enhanced. In turn, comprehensive care prevents OOP expenditures and protects citizens from health-related economic shocks and income poverty, reducing pressure on existing social protection systems. The decentralization of healthcare services helps to address regional disparities and tailor healthcare to regional needs. Engaging communities, healthcare workers and agencies in consultative processes similar to Tunisia's Societal Dialogue for Health System Reform, offers an inclusive way of involving stakeholders and citizens to inform healthcare policies and reforms and promote preventive care, early intervention and a focus on overall public health.

Despite the potential gains, ensuring long-term financial sustainability can be challenging, particularly with changing demographics and healthcare needs. Avoiding political influence and maintaining fair resource allocation is essential to prevent the misuse of healthcare systems. Additionally, enforcing contributions and ensuring the inclusion of all eligible individuals poses implementation challenges.

In conclusion, the integration of social protection and UHC is not only crucial for improving healthcare access but also for advancing the SDGs and addressing climate and development challenges. It presents a path towards more equitable, resilient and sustainable societies, where healthcare is a fundamental right and a cornerstone of progress. Policymakers should embrace this integration as a powerful tool for achieving broader societal and environmental objectives.

Glossary

Catastrophic expenses: Catastrophic health expenditure refers to out-of-pocket (OOP) payments for healthcare services which surpass the threshold of households' income or ability to pay for the services (Liu *et al.*, 2019). The WHO defined this threshold as 40 per cent of the households' net income after expenditure on subsistence needs (*ibid*).

Communicable diseases: Communicable diseases are illnesses that can be transmitted between humans or other vectors such as mosquitos and ticks (Modjadji, 2019). Examples of communicable diseases include tuberculosis, COVID-19, dengue and malaria (*ibid*).

Non-communicable diseases (NCDs): Non-communicable diseases are long-term conditions that cannot be passed on to others through contact such as heart conditions, obesity and cancer (Modjadji, 2019).

Out-of-pocket (OOP) expenditure: Out-of-pocket expenditure refers to payments made directly by households to access healthcare services or goods using their income or savings (World Bank, n.d.). OOP payments are made immediately during the purchase of health services or goods (*ibid*).

Poverty rate: The poverty rate is a percentage of individuals whose income is below the poverty line (OECD, 2021).

Primary health care: Primary health care is a system of community-oriented healthcare aimed at preventing illnesses and promoting healthier lifestyles (WHO, 2023b).

Risk pooling: Risk pooling is an approach to distribute the financial risks that may be associated with accessing healthcare, especially during times of uncertain need (Smith & Witter, 2004). This approach transfers risks to the pool of members rather than it being borne individually (*ibid*).

Social protection: Social protection is a set of policies and schemes aimed at reducing poverty, inequality and vulnerability throughout a person's life cycle (Costella *et al.*, 2022).

Subsidization: Subsidies are social assistance benefits provided to individuals or households based on a categorical assessment to keep the prices of goods or services low and increase the access of poor or vulnerable individuals (Browne, 2015).

Universal health coverage: Universal health coverage is a healthcare approach aimed at providing all individuals with access to decent health services without incurring financial hardship (WHO & World Bank, 2018).

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Annex

Table 1 showing Universal Health Coverage across countries with explicit links to social protection

Country	Programme name	Programme objectives/ description	Links to SP (registries, etc.)
Burkina Faso	Universal Health Insurance Scheme: Régime d'Assurance Maladie Universelle (RAMU)	Universal health coverage in Burkina Faso aims to ensure universal access to a basic health package. Everyone except national forces is expected to contribute through the payment of a premium.	This premium is heavily subsidized for the poor through Government funding; formation of a planned unified registry for health and SP interventions.
Morocco	Assurance Maladie Obligatoire (AMO) & Regime d'Assistance Medicale (RAMED)	AMO is a mandatory contributory health insurance scheme for the formal sector complemented with a non-contributory basic health coverage scheme (RAMED) for the informal sector.	Mutual Health is managed by the National Social Security Fund and the National Fund for Social Welfare Bodies
Ghana	National Health Insurance Scheme (NHIS)	The NHIS is a social intervention programme introduced by the Government to provide financial access to quality healthcare for the residents of Ghana.	Ghana's Livelihood Empowerment Against Poverty (LEAP) beneficiaries receive premium waivers for NHIS.
Tunisia	National healthcare	More than 80 per cent of the population is covered by a healthcare mechanism; either through mandatory contributions (CNAM) or a non-contributory programme for poor households.	Contributions are waived for households identified as poor.
Pakistan	Sehat Sahulat Programme (SSP) / Health Facility Programme	To provide accessible healthcare for all residents.	SSP covers families under the poverty line and earning less than USD 2.00 / day or scoring 32.5 on the National Socio-Economic Registry (NSER).
India	National healthcare	The healthcare system works to ensure universal access to healthcare.	Ayushman Bharat or PM-JAY, financed by taxes, is aimed at low-income communities to get free services at private clinics
Sri Lanka	National healthcare	The country has had free and universal health coverage policies since the early 1950s.	Universal health coverage is implicitly pro-poor because better off segments of the population tend to opt for private care due to less waiting time.

Country	Programme name	Programme objectives/ description	Links to SP (registries, etc.)
Maldives	Husnuvaa aasandha ("Aasandha")	All citizens are covered through the social health insurance.	Administered by the National Social Protection Agency under the Ministry of Health.
Thailand	Universal Coverage Scheme	Every citizen is entitled to a variety of preventive, curative and palliative health services across his/her life cycle.	The ILO social protection floor informed the development of this healthcare infrastructure.
Samoa	National healthcare	Provides accessible healthcare for all.	UHC is part of the Strategy for the Development of Samoa (SDS) 2016/17–2019/20 to provide better quality of life for everyone.
Mexico	Seguro Popular	The federal Government aims to increase health services through voluntary, universal insurance.	Seguro Popular was adopted to address the unequal distribution of resources in the public health services.
Colombia	Sistema General de Seguridad Social en Salud (SGSSS)	All citizens are part of one of two schemes – a contributory plan for individuals with contributory capacity or a non-contributory scheme for informal workers and low-income individuals.	The SISBEN, a social protection registry, is used to identify the poorest households for the non-contributory scheme.
Costa Rica	Caja Costarricense de Seguro Social (CCSS)	Universal health coverage in Costa Rica was created based on three pillars: <ol style="list-style-type: none"> 1. increasing population coverage; 2. increasing availability of solidarity financing mechanisms; and 3. increasing the services covered to provide comprehensive health services to everyone across the country. 	The social security institution is responsible for universal health coverage in Costa Rica
Argentina	National healthcare	The healthcare system has three schemes: <ol style="list-style-type: none"> 1. a contributory social security which covers 57 per cent of the population; 2. a private health insurance system that also operates on a contributory basis, covering 5.1 per cent of the population; and 3. free healthcare to all, but mostly used by the uninsured, who make up 37.9 per cent of the population. 	Provides a separate programme for the poor as identified by the Government.

Country	Programme name	Programme objectives/ description	Links to SP (registries, etc.)
Germany	National healthcare	Health insurance is mandatory in the country through statutory health insurance (SHI) or private health insurance (PHI), with 88 per cent and 10 per cent enrolment, respectively. The remainder is covered through special schemes for military personnel. It is estimated that 0.1 per cent of the population do not have health insurance due to either administrative hurdles or financial constraints.	Health insurance in Germany is codified in the Sozialgesetzbuch (SGB) or social security code. The SGB also outlines unemployment insurance, pensions for widows and people living with disabilities, and social care.
Canada	Medicare	Canada has 13 publicly funded provincial/territorial health insurance plans through the Canada Health Act with the majority of primary and tertiary health services covered to reduced barriers to healthcare.	Coverage of prescriptions is extended to recipients of social assistance programmes in the provinces/territories .



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