



International
Labour
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UNHCR
The UN Refugee Agency



Handbook on social health protection for refugees

Approaches, lessons learned and practical
tools to assess coverage options

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The present handbook was developed jointly by the United Nations High Commissioner for Refugees (UNHCR) and the International Labour Organization (ILO), on the basis of the combined mandates, experience and expertise of both organizations. It aims at helping UNHCR and ILO staff to assess available options for the inclusion of refugees into national social health protection systems, to support the selection of a sustainable option and to plan for its implementation.

The handbook has been produced in the context of the partnership programme on “Improving Prospects for Host Communities and Forcibly Displaced Persons (PROSPECTS)” funded by the Government of the Netherlands. The partnership brings together the International Finance Corporation (IFC), the ILO, the UN Refugee Agency (UNHCR), the UN Children’s Fund (UNICEF) and the World Bank. The PROSPECTS partners are looking to work across humanitarian and development processes using social protection systems to provide predictable and sustainable support for displaced populations and host communities, beyond the short-term intent of international humanitarian assistance. The integration of refugees into national social health protection systems can provide sustainable and cost-effective solutions to move out of humanitarian assistance, particularly in protracted situations. The approach to strengthen social protection systems generally benefits both refugees and host communities. Solid social security systems act as strong economic and social stabilizers in the region and at the country level.

This document takes stock of approaches, successes, potential pitfalls and lessons learned for the extension of social health protection coverage to refugees. It is intended to provide staff in charge of public health, social protection and programming, as well as managers in country operations, with important considerations that should be taken into account when exploring options for including refugees in national social health protection systems.

The handbook was prepared by Olivier Louis dit Guérin, Heiko Hering, Shana Hoehler, Lou Tessier and Michael Woodman and benefited from the input of many colleagues from the ILO and UNHCR headquarters and field offices, including James Canonge, Samia Kazi Aoul, Maya Stern Plaza and Clara Van Panhuys.

Acronyms

ABND	Assessment-based National Dialogue
CBHI	Community-based Health Insurances
CBO	Community-based Organisation
CEACR	Committee on the Application of Recommendations and Standards
CNAM	Caisse Nationale d'Assurance Maladie
CRRF	Comprehensive Refugee Response Framework
ILO	International Labour Organization
ISPA	Inter-agency Social Protection Assessment Initiative
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
NGO	Non-governmental Organisation
NHIF	National Health Insurance Fund
OOPs	Out-of-pocket Payments
RAMA	Rwandaise d'Assurance Maladie
RFP	Request for Proposal
RMHF	Regional Mutual Health Fund
RSSB	Rwandan Social Security Board
SDG	Sustainable Development Goals
SPPOT	Social Protection Policy Options Tools
UHC	Universal Health Coverage
UNAIDS	Joint UN Programme on AIDS
UNHCR	United Nation High Commissioner for Refugees
UNICEF	UN Children's Fund
VAT	Value-added-tax
WFP	World Food Programme

Background and purpose of the handbook

The purpose of this handbook is to guide UNHCR public health and programme staff and ILO staff working on social protection at country level on the considerations and practical steps required to assess options for the inclusion of refugees in national social health protection schemes.

This handbook is based on a growing body of evidence that highlights the importance of social health protection and universal health coverage (UHC) in improving health status and in contributing to Sustainable Development Goals (SDGs), in particular targets under SDGs 1, 3 and 8 when it comes to reducing mortality and morbidity at all ages, reducing poverty, hunger and malnutrition and improving livelihoods. Social health protection is one tool that can be used as part of a wider health and social protection platform aimed at improving the health and socio-economic situation of refugees.

UNHCR has been using social health protection schemes as one of the options of improving access to health services and has pursued this in several countries with varying degrees of success. Since 2014, the ILO and UNHCR have been collaborating on the extension of social health protection to refugees.

On 1 July 2016, the ILO and UNHCR signed a new Memorandum of Understanding (MoU) to engender a new and deeper phase of collaboration between the two organizations in eight common priority areas, including the extension of social protection. The agreement focuses on long-term solutions for refugees and others displaced by conflict and persecution.

Many of the examples laid out in the present handbook are taken from joint assessments and technical support interventions carried out by the ILO and UNHCR since 2014. Those interventions were concentrated in West and Central African countries.

The situation of refugees' access to health varies from one country to another but overall, UNHCR and humanitarian partners face challenges to cover the health care needs of refugees, which include the challenge of sustaining significant levels of humanitarian funding in protracted situations and avoiding the creation or continuous operation of unsustainable parallel health systems for refugees.

UNHCR advocates that refugees access health services in similar ways to nationals, and that they experience equality of treatment, in line with international human rights instruments and equally embedded in ILO standards on social protection. Hence, where the provision of health protection for nationals is limited, options for refugees may also be limited.

It is, therefore, important to seek sustainable approaches to ensure refugees' access to health care, in line with the Global Compact on Refugees and national efforts to extend social protection. The inclusion of refugees in social health protection schemes feeds into the broader question of extension of social protection to the informal economy, which requires strategies aiming at gradual integration and closely aligning with programmes focused on economic integration.

If social health protection options are available in a country (i.e. national medical care service or social health insurance, see definitions in the following section), the inclusion of refugees

in the national health systems may improve access for refugees, reduce costs and avoid duplication of services. However, the health financing options in each country have to be understood to determine whether the use of an existing social health protection scheme will result in better health access for refugees.

UNHCR's mandate

UNHCR is the United Nations body mandated to lead and coordinate international action to protect refugees and work with governments to secure solutions. Its primary purpose is to safeguard the rights and wellbeing of refugees. This includes ensuring access to services, including health services. UNHCR's public health programmes are underpinned by universal human rights principles. The 1951 Refugee Convention states that refugees should enjoy access to health services equivalent to that of the host population (Article 23, Refugee Convention of 1951). The Universal Declaration of Human Rights of 1948 (Article 25) and Articles 11 and 12 of the International Covenant on Economic, Social and Cultural Rights also call for all people, including refugees, to enjoy the right to a standard of living adequate for the health and wellbeing of themselves and of their family, including food, clothing, housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond their control, as well as the right of everyone to enjoy the highest attainable standard of physical and mental health.

In this regard, UNHCR advocates for the inclusion of refugees in national health systems and encourages governments to allow refugees to access available health services, on a par with nationals. At first, there may often be barriers to accessing public services owing to cost, ineligibility of benefits from social protection services, exclusion from services or geographical location. The New York Declaration lays out a vision for a more predictable and comprehensive response to these crises, known as the Comprehensive Refugee Response Framework (CRRF) and is part of the Global Compact on Refugees affirmed by the UN General Assembly in 2018, calling for greater support to refugees and the countries that host them.¹

ILO's mandate

The ILO is a standard setting organization that promotes international labour standards adopted by its tripartite constituents (governments, employers and workers), develops policies and devises programmes as a means to promote decent work for all women and men. In particular, the ILO works with its constituents to promote the development of public social health protection systems and universal access to health care for all, including through the creation and improvement of countries' national social protection floors.

Social protection floors should guarantee access to essential health care, including financial protection and basic income security for all in need, as defined in the ILO Recommendation concerning national floors of social protection, 2012 (No. 202). Social protection floors guarantee a basic level of protection within comprehensive national social security systems aiming at progressively reaching higher levels of coverage. In addition to access to medical

¹ <https://www.unhcr.org/comprehensive-refugee-response-framework-crrf.html>

care and sickness benefits, the ILO's leading standard as regards social security, Social Security (Minimum Standards) Convention, 1952 (No. 102), includes seven other life contingencies for which all members of society may require protection along the life cycle,² as well as setting out a number of fundamental principles for good and sustainable governance.

The ILO strategy towards universal access to health care addresses the gaps in coverage and financial barriers through the development of efficient and effective public social health protection systems. This aims to ensure that persons in need will not face hardship and an increased risk of poverty because of the financial consequences of accessing essential health care and is directly relevant to achieving Sustainable Development Goals 1.3 on universal social protection and 3.8 on UHC.



Photo: Rwanda. Urban refugees in Kigali are enrolled in the national social health insurance scheme (contributions paid by UNHCR) which covers primary and secondary healthcare as per nationals.
©UNHCR/ Anthony Karumba

² Benefits for unemployment, old age, employment injury, family, maternity, invalidity and survivors.

Key definitions and principles

A detailed glossary is included at the end of this handbook (page 49).

Refugees

The 1951 Convention protects refugees. It defines refugees as persons who are outside their country of nationality or habitual residence, who have a well-founded fear of being persecuted because of their race, religion, nationality, membership of a particular social group or political opinion, and are unable or unwilling to avail themselves of the protection of that country, or to return there, for fear of persecution (see Article 1A(2)). People who fulfil this definition are entitled to the rights and bound by the duties contained in the 1951 Convention.

The number of forcibly displaced persons currently around the world is higher than ever before. By the end of 2019, more than 68.5 million people were forcibly displaced worldwide, of whom 25.4 million refugees had fled conflict or persecution. Once in their country of refuge, however, refugees and asylum-seekers often face challenges in accessing services and livelihood opportunities.

Social health protection

Social health protection designates a series of public or publicly mandated private measures to:

- i. Cover the cost of effective access to affordable health care services;
- ii. Income security to compensate for the loss of earnings in case of sickness.

A better health status allows individuals to work and generate income, which helps to break the vicious circle of ill-health and poverty.

Social health protection provides a rights-based approach to reach the objective of UHC. UHC means that all people can use the necessary health services, including prevention, promotion, treatment, rehabilitation and palliation of sufficient quality to be effective, and that the use of these services does not expose the user to financial hardship.³ Social health protection is firmly grounded in the international rights framework: the Universal Declaration of Human Rights, the International Covenant on Economic, Social, and Cultural Rights, the Social Security (Minimum Standards) Convention (No. 102), and the Social Protection Floors Recommendation (No. 202).

As part of the 2030 Agenda for Sustainable Development, the extension of social health protection contributes to two complementary goals:

- SDG 3.8 on UHC, which aims at ensuring access to health care without hardship;
- SDG 1.3 on universal social protection systems, including floors, which aims at ensuring income security across the life cycle.

³ https://www.who.int/health_financing/universal_coverage_definition/en/. Accessed May 24th 2020.

SDG target 3.8 encompasses two indicators, which look at the service coverage and the lack of financial protection in each country.

Box 1. UHC in the SDG framework

Target 3.8: Achieve UHC, 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.

Indicator 3.8.1: Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population).

Indicator 3.8.2: Proportion of population with large household expenditures on health as a share of total household expenditure or income.

Social health protection enables access to health services and financial protection in case of illness. Protecting people from the financial consequences of paying for health services out of their own pockets reduces the risk that people will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets, or borrow – destroying their futures and often those of their children.⁴ While several pathways can ensure the financial protection component of UHC, most countries reach it through mandatory or universal schemes. The extent of voluntary health insurance in health financing globally is small (World Health Organization, 2018). Mandatory schemes can be financed by taxes, social contributions or a combination of both, and can take various forms and names including social health insurance, national health insurance, a national health service, etc.⁵

Key international social security standards on social health protection include:

- [Medical Care Recommendation, 1944 \(No. 69\)](#)
- [Social Security \(Minimum Standards\) Convention, 1952 \(No. 102\)](#)
- [Medical Care and Sickness Benefits Convention, 1969 \(No. 130\) and Recommendation, 1969 \(No. 134\)](#)
- [Maternity Protection Convention, 2000 \(No. 183\)](#)
- [Social Protection Floors Recommendation, 2012 \(No. 202\)](#)

⁴ WHO. [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)).

⁵ ILO. 2020. "Towards universal health coverage: Social health protection principles." Social Protection Spotlight. Geneva: ILO. <https://www.social-protection.org/gimi/RessourcePDF.action?id=56009>.

Equality of treatment

ILO standards on social protection/social security promote equality of treatment of refugees. The situation varies greatly from one country to the other. Multiple difficulties are encountered for refugees to benefit effectively from such protection. The instruments mentioned in Box 2 are particularly relevant. Likewise, equality of treatment should imply effective access to the labour market for refugees. This is important when considering social protection coverage, because formal labour market participation is sometimes an entry point into the social protection system. However, in many countries, access to work permits may be restricted for refugees (by law or in practice).

Box 2. Relevant ILO instruments on equality of treatment and social protection

- The Equality of Treatment (Social Security) Convention, 1962 (No. 118): “The provisions of this Convention apply to refugees and stateless persons without any condition of reciprocity.” (Article 10.1)
- Migrant workers conventions: Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143) and Migration for Employment Convention (Revised), 1949 (No. 97) also include provisions relevant for refugees. According to the Committee on the Application of Recommendations and Standards (CEACR), the provisions of Convention No. 143 apply to all workers employed outside their home countries, including refugees. The Committee of Experts explicitly included refugees in the scope of application of Convention No. 97. Among others, Article 6 related to equality of treatment in respect of social security.
- ILO Guiding principles on the access of refugees and other forcibly displaced persons to the labour market, adopted in November 2016,⁶ Articles 19 and 22.⁷

The ILO promotes the development of bilateral social security agreements, which are agreements between social security institutions of different countries by which the portability of coverage and benefits is secured. However, social security agreements have limited relevance for refugees, owing to the difficulty of availing themselves of the protection of their home country. ILO staff should keep those elements in mind when supporting governments in the development of such agreements.

⁶ http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---migrant/documents/genericdocument/wcms_536440.pdf

⁷ Article 19: “Members should take steps to facilitate the portability of work-related entitlements (such as social security benefits, including pensions), (...) of refugees and other forcibly displaced persons between countries of origin, transit and destination.”

Article 22: “Members should adopt or reinforce national policies to promote equality of opportunity and treatment for all, in particular gender equality, recognizing the specific needs of women, youth and persons with disabilities, with regard to fundamental principles and rights at work, working conditions, access to quality public services, wages and the right to social security benefits for refugees and other forcibly displaced persons, and to educate refugees and other forcibly displaced persons about their labour rights and protections.”

Box 3. Bilateral and multilateral social security agreements

- The Maintenance of Social Security Rights Convention, 1982 (No. 157) specifies that bilateral or multilateral agreements should apply to refugees and stateless persons residing in the territory of one of the states (Article 4, Paragraph 3).⁸
- The Maintenance of Social Security Rights Recommendation, 1983 (No. 167) encourages states to extend bilateral and multilateral social security instruments to refugees and stateless persons resident in the territory of any member, with respect to several principles (Article 2).



Photo: Zambia. Refugees have access to the national health system at same level as nationals.

©UNHCR/ Enoch Kavindele Jr

⁸ Article 9: “...to beneficiaries who are nationals of a Member or refugees or stateless persons, irrespective of their place of residence.”

HIV-sensitive social protection

UNHCR and ILO, as co-sponsors of the Joint UN Programme on AIDS (UNAIDS), promote HIV-sensitive social protection systems that are inclusive of people living with, at risk of or affected by HIV in support of 2030 targets of eliminating HIV as a public health problem.⁹ This recognizes that social protection helps to:

- Address the multiple social determinants of HIV,¹⁰ thus contributing to reductions in new HIV infections, AIDS-related deaths and HIV-related discrimination;
- Address demand-side barriers to accessing HIV services, with the potential to improve prevention, treatment, care and support outcomes;
- Mitigate the social and economic impacts of HIV on people, provided such programmes are responsive to the needs of people living with, at risk of or affected by HIV.

Social protection assessment tools

With the adoption of ILO Social Protection Floor, 2012 (No. 202), a set of tools was developed to analyse the current situation of social protection and to identify and assess options for expanding and strengthening coverage. These tools include joint work of partner organizations of the Inter-agency Social Protection Assessment Initiative (ISPA) and, more specifically, on the methodology and Social Protection Policy Options Tools (SPPOT), based on assessment-based national dialogues developed by the ILO over several decades. The objective of these methodologies and tools is to support national dialogue processes and decision-making, regarding the priorities and reforms that should be undertaken in the countries concerned, to build a national social protection system and its financing options. They also aim to promote capacity-building for national actors and decision-makers.

The approach developed here draws on existing tools, with a specific focus on social health protection. It aims to formulate a strategy consistent with the maturity of the national protection system in each country, as well as to integrate the refugees into policies for extending and strengthening social protection.

⁹ Social protection: A Fast-Track commitment to end AIDS. Guidance for policy-makers and people living with, at risk of, or affected by HIV. UNAIDS (2018). https://www.unaids.org/sites/default/files/media_asset/jc2922_social-protection-fast-track-commitment-end-aids_en.pdf

¹⁰ Including poverty, income inequality, gender inequalities, stigma and discrimination, and social exclusion.

Introduction: A stepwise approach for the assessment and selection of options for the health coverage of refugees

In each context, a stepwise approach should be taken to assess the options and feasibility of including refugees in national social health protection schemes. The five steps proposed below may feed existing processes to extend coverage at national level, depending on each country context:

Figure 1: Steps for assessing the feasibility and possible inclusion of refugees in national social health protection



This handbook was designed with the objective of UNHCR and ILO staff working jointly on this issue. An “assessment team”, ideally a joint team at country level, which can call on external social health protection support from ILO and UNHCR regional bureau and headquarters when required, should undertake the stepwise approach.

The first two steps should be undertaken by country level UNHCR public health and programme staff, in collaboration with ILO staff working on social protection. When facilitating a social protection assessment-based national dialogue (ABND), or when using the inter-agency social protection diagnosis tools (for example SPOTT), ILO staff should take into account the results of steps 1 to 3 and include refugees and other displaced persons in their analysis.

Steps 1 and 2 help to set the scene and identify where the country stands in terms of existing mechanisms for health coverage, and more specifically, current coverage of the refugees. Specialized technical expertise on social health protection is often required for Step 3, where a deeper analysis of the possibilities of integrating refugees within existing public coverage options is conducted, with the aim of formulating concrete costed recommendations. Step 4 mobilizes the results of steps 1, 2 and 3 to contribute to a consultation process and advocacy strategy. The last step aims at preparing for the implementation of integrating refugees within a social health protection scheme. The ILO staff working on social protection have the mandate and access to a network of experts that could be mobilized for this purpose.

Step 1: Identify available coverage mechanisms in the country

Key messages

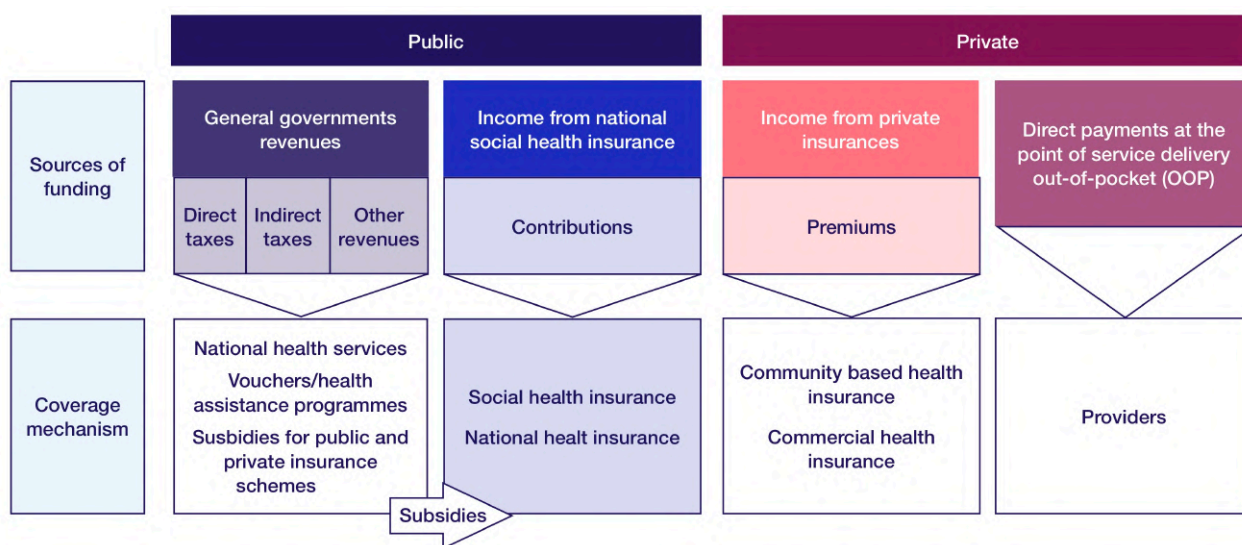
- Different mechanisms exist to cover health care costs and improve effective access to affordable health care services. They are not all equivalent in terms of effectiveness of the coverage they provide or with regard to their equitability.
- It is crucial to be able to understand those mechanisms, identify them, and know which ones are best adapted to the objective of UHC.
- In most cases, a country will present a combination of different mechanisms, often differentiated for different population groups. As a first step, it is important to identify which mechanisms are present in a country and how effective they are, and to prepare an inventory.

1.1 Mechanisms for financing health care costs and their adaptation to extended coverage

Schematically, there are four main sources of financing for health care:

- i. General government revenues;
- ii. Income from social health insurance contributions;
- iii. Income from private health insurance premiums;
- iv. Direct payments from out-of-pocket households.

These sources of funding may be associated with a specific coverage mechanism. Typically, national health services, such as in the United Kingdom, are funded by taxes, while social health insurance schemes have part or all of their revenues coming from social contributions as deductions from salaries, e.g. by employers/employees or individuals paying directly into the scheme. In all health systems, different mechanisms for financing health-care costs are used in combination. In this section, the mechanisms are depicted in an exemplary, simplistic form to highlight their main characteristics and facilitate conceptual clarity.

Figure 2: Diversity of health financing sources and coverage mechanisms

In the context of humanitarian assistance, direct provision of health services for specific target groups by NGOs or other entities, such as the Red Cross/Red Crescent movement, which are funded by external aid, co-exist with the above financing mechanisms.

Public mechanisms

ILO standards on social health protection lay out two main options to finance the costs of health care: national social health insurance and national health or medical care services (social assistance),¹¹ which, in practice, are most often used in combination:

1. Social health insurance

Publicly led scheme (but possibly delivered by public or private agencies under government regulation) based on contributions (usually from employers and workers in the formal sector, government and other beneficiaries). In practice, governments often subsidize part or all of the contribution costs for vulnerable population groups who do not have the capacity to contribute or for whom it is too difficult to collect contributions. Social health insurance can be mandatory or voluntary, though evidence shows that voluntary schemes encounter difficulties to extend coverage and tend to be financially unsustainable. As voluntary schemes become more numerous, they tend to fragment health systems further. In general, the more they are integrated into a national system, the more effective they become in increasing health protection; however, mandatory social health insurance is more effective.¹²

¹¹ ILO Medical Care Recommendation No. 69, 1944.

¹² National social health insurance schemes are usually mandatory for certain categories of workers, such as those in the public and private sectors, but often they reach well beyond them. These schemes are based on the principle of social solidarity, with contributions community-rated (i.e. based on an average user health service cost). These are known as social health insurance, with contributions generally collected through payroll deductions for those in formal employment relationships. For own-account workers and those in the informal economy, many countries have put in place mechanisms to facilitate their participation through individually paid contributions, usually with some levels of subsidy from the government budget, sometimes covering the full contribution.

Fragmentation of different schemes for different population groups should also be reduced, to pool risks and to ensure equitable access to health care.

2. National medical care or health service (social assistance)

Facilities managed by the Ministry of Health offering free or reduced-cost services¹³ for all or some groups of the population (such as pregnant women and newborns). These schemes may or may not register their beneficiaries, meaning that people may or may not have a registration card. When health care is free at the point of service for all, there are usually fewer administrative barriers to access. Evidence shows that this type of programme works best when there are mechanisms of community control to ensure that gratuity is enforced at the facility level; otherwise, informal payments can take place. Another non-contributory option is when countries try to protect the poorest through a system of health user fee exemptions, voucher programmes or targeted subsidies as a form of social assistance. There may be difficulties, however, in identifying and reaching target populations, which include a lack of administrative capacity and high administrative costs of managing means-tested social assistance programmes.

Even if a national social health insurance scheme and/or a national health service is in place, there might be issues regarding the availability and quality of health services and goods, resulting in high out-of-pocket payments (OOPs) or poor health outcomes. In most countries where UNHCR operates, only parts of the population will typically be covered by a health insurance scheme, and UNHCR might have to cover contributions for refugees to enrol.



Photo: Lebanon. UNHCR supports refugees to access lifesaving hospital care.

©UNHCR/ Jordi Matas

¹³ With or without fee waivers for some groups.

Box 4. Co-payments

Even when people are enrolled in a social health insurance or in a national health service scheme, it does not mean that 100 per cent of their health care costs are automatically covered. Indeed, some countries choose to establish a co-payment by which a proportion of the cost of health interventions is left to the patient to pay out of their pocket.

The ILO standards highlight that health financing through collective mechanisms is a tool to meet international and national commitments towards the realization of the human rights to health and social security. At the same time, they provide guidance on acceptable levels of co-payment.¹⁴ In particular:

- Convention No. 102 lays out that: Co-payments are allowed, but only as regards morbid condition (in other words in the case of maternity medical care in case of pregnancy and its consequences, there should be no co-payment). Where there is co-payment, it should be designed in such a way to avoid hardship.
- Convention No. 130 adds that the rules concerning such co-payments should not prejudice the effectiveness of medical and social protection.
- Recommendation No. 134 further states that the beneficiary should not be required to share in the cost of the medical care (a) if his means do not exceed prescribed amounts; (b) in respect of diseases recognized as entailing prolonged care.

In addition to these public mechanisms, some countries leave coverage to **private pre-payment mechanisms**.

3. Private health insurance schemes can take two main forms:

- **Community-based health insurances (CBHI)** are non-profit mechanisms whereby communities pool resources in a mutual fund that can cover the cost of their medical care in case of need. They can be managed by large mutual funds called mutuals, non-governmental organisations (NGOs), community-based organisations (CBOs), charities or associations (non-profit) with professional management, or by local community health insurance schemes run by small organizations, often with volunteer staff and limited capacities.
- **Private commercial (for-profit) health insurance** whereby private insurance companies sell policies for a premium which is determined on the basis of the individual risk profile of the persons who subscribe to it. It is not a solidarity-based mechanism.

¹⁴ ILO. 2020. "Towards Universal Health Coverage: Social Health Protection Principles." Social Protection Spotlight. Geneva: ILO. <https://www.social-protection.org/gimi/RessourcePDF.action?id=56009>

In practice, private health insurance schemes play a small role in health financing globally¹⁵ and make marginal contributions to the extension of coverage, unless they are mandated by the government and fall under a government-led initiative (which can be the case of CBHIs). It is important to note that such mechanisms are *not an option* for the coverage of refugees in countries that have neither a national social health insurance programme mandating those organizations nor viable private or non-profit CBHIs with track records in providing workable schemes.

Absence of a collective mechanism

Some countries leave all or part of the population to rely on their own means in times of health care needs.

4. Direct OOPs

Direct OOPs by households of user fees to medical facilities. In this case no coverage or pre-payment mechanism is put in place as such; when they are sick, people pay themselves, at the point of service. OOPs are not considered a desirable health-financing mechanism as it is regressive and potentially impoverishing.¹⁶ It is important to note that even if a public social health protection system is in place, OOPs can still present a barrier for accessing health care. People might have to pay for services that are not included in the benefit package, or are unavailable at a public facility or take the form of co-payments (such as insurance covering only 80 per cent of costs). OOPs per se presents a regressive health financing system that widens existing inequities and pushes people into poverty, and is, therefore, not in line with international social security standards.

Direct provision by humanitarian partners

Special situation for refugees and other vulnerable groups

UNHCR advocates UHC for refugees, best obtained by enabling refugees to access an equitable national system in which the use of services is based on need, and the ability to pay determines financial contributions, with health risks pooled as much as possible. Levels of prepayment are increased to maximize the size of the risk pool, while user fees are reduced along with other out-of-pocket payments.¹⁷

Common scenarios observed in countries with large refugee populations are as follows:

- (a) That UNHCR or donors use humanitarian funding to cover health costs by supporting direct provision of health services to refugees. This is done by setting up health facilities by contracting NGOs or other entities, or by paying providers (public, private or NGOs) to supply services for refugees.
- (b) The other option is enrolment into national social health protection schemes that allow refugees to access health care on a par with nationals.

¹⁵ WHO. 2018. "Public Spending on Health: A Closer Look at Global Trends." <https://apps.who.int/iris/bitstream/handle/10665/276728/WHO-HIS-HGF-HF-WorkingPaper-18.3-eng.pdf?ua=1>

¹⁶ ILO. 2014. World social protection report 2014–2015.

¹⁷ McIntyre, D. et al. 2011. "Beyond fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic of Tanzania." Bulletin of the WHO.

In many countries, it is possible to transition from the first to the second scenario, once the national social health protection schemes are functional and the health facilities supported by UNHCR are handed over to the government.

In some countries, UNHCR has built partnerships with mutual health organizations to cover the costs of caring for refugees, especially in urban areas. However, this approach has limitations regarding weak technical management and poor-quality services, especially when they are not backed up by a national social protection system. In practice, it has been observed that UNHCR provides initial support to households for the payment of contributions in order to enrol them and then reduces its contribution over time, with the risk that refugees withdraw from the scheme as their contribution increases, if the services are not satisfactory.

1.2 Inventory of the different financing and coverage mechanisms available in the country

Once the different mechanisms that can exist in a country are understood, the next step is to compile an inventory of existing social health protection schemes and programmes. A practical tool to conduct this step is available in Annex 1.

For each scheme, identify:

- The benefit package (which services and extent of coverage) and level of financial protection;
- Who is covered and how?
- Who provides the health services?
- How sustainable/equitable is the mechanism (especially CBHI/private)?

Box 5. Examples from sub-Saharan Africa: A variety of country models and modalities

More and more countries in sub-Saharan Africa are implementing national health insurance or health coverage schemes with a wide range of modalities and achievements.

Population coverage.

- In Rwanda, Sudan and Djibouti, all segments of the population are covered under national health insurance systems, which are handled by the social security institutions.
- In Mauritania, a universal health insurance plan is handled by the National Health Insurance Fund (NHIF). Its expansion to the informal economy is recent and still limited.

- In Senegal, a UHC programme is implemented countrywide, with mutual community funds as implementing agents. However, its capacity to expand to the informal economy and agricultural sector is limited by financing and technical challenges.
- In other countries, systems are in the design stage (Cameroon and Burkina Faso) or under consideration (Congo DR and Guinea).

Approaches are also diverse; for example, in the above-mentioned countries the following can be found in terms of modalities under which population groups are covered:

- Mandatory and contributory for employees of the public and formal private sectors;
- Automatic enrolment (population enrolled by national programmes) and non-contributory (contributions entirely funded by the state) for the poorest or most vulnerable population;
- Voluntary or mandatory and contributory or semi-contributory (contributions subsidized by the state) for the informal and agricultural sectors.

This diversity of contexts and possible modalities prevents a standardized inclusion strategy for refugees in social health protection schemes and calls for a thorough analysis.

This inventory enables the identification of the available options in which refugees could potentially be included in the next two steps. Schemes should be analysed, bearing in mind the different living situations of refugees: whether they live in camps or urban areas, if they have an economic activity, and so forth. This diversity is also found in the host population, and national social protection systems are meant to organize adapted responses. The assessment of the refugees' situation is part of Step 2.

Further reading on coverage mechanisms for health care costs

C. Normand et al.: *Social health insurance. A guidebook for planning*, 1st and 2nd edition. ILO and WHO. 1994, 2009. Available at <https://www.who.int/health-financing/documents/shi-guidebook.pdf>

M. Cichon et al.: *Modelling in Health Care Finance: A Compendium of Quantitative Techniques for Health Care Financing*. ILO. 1999. Available at: https://www.ilo.org/global/publications/ilo-bookstore/order-online/books/WCMS_PUBL_9221108627_EN/lang--en/index.htm

ILO: "Social Health Protection: An ILO Strategy towards Universal Access to Health Care." *Social Security Policy Briefings*. Geneva, 2008. <http://www3.ilo.org/public/english/protection/secsoc/downloads/1695sp1.pdf>

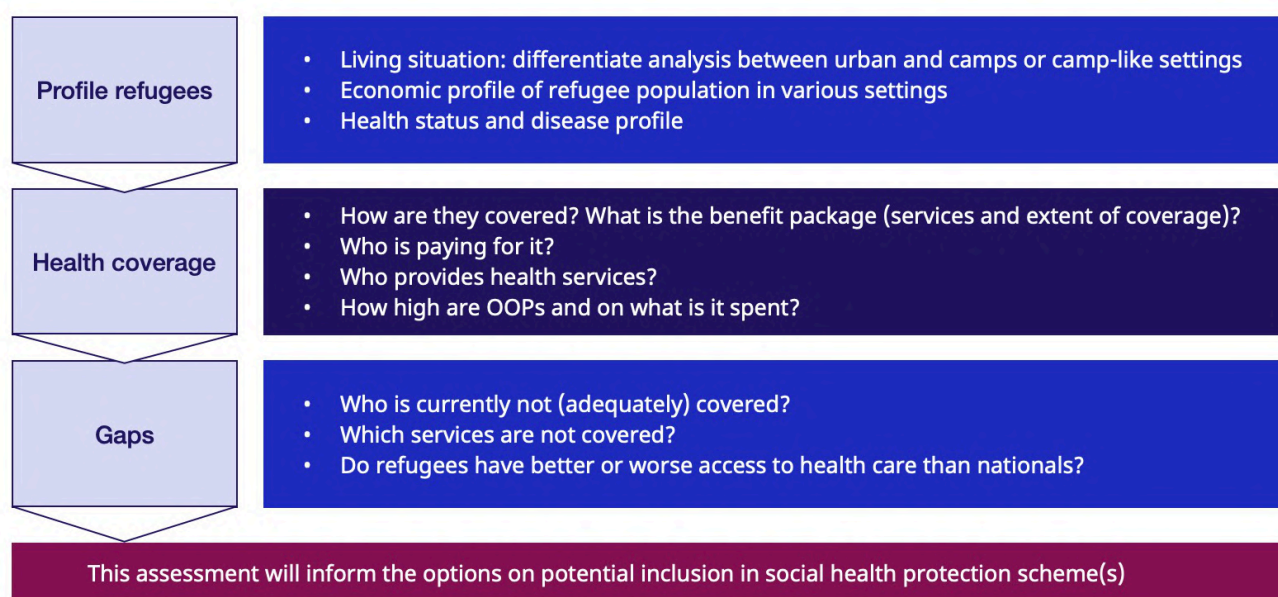
Step 2: Analyse current health coverage of refugees and identify gaps

Key messages

- Identify the way in which refugees already access and finance health care, as well as the gaps in coverage they experience. It is important to anticipate their perception of the advantages and challenges of transitioning to a national scheme on a par with nationals.
- Consider the professional and socio-economic situation of refugees, as it determines the type of coverage options that may be possible. A national social health protection system may include different schemes for different categories of income groups or groups with different employment status.

Once the different mechanisms existing on social health protection at the national level have been identified, it is important to clarify the following points in this second step.

- How do refugees currently access health care, who operates the facilities, how is their access financed, and what are the gaps in coverage they experience? How does this differ between refugees in different areas and under different living circumstances? The answers will allow the establishment of the perceived benefits (and potential resistance) of transitioning refugees from their current coverage mechanism towards a new one on a par with nationals.
- What is the professional and socio-economic situation of refugees? The responses available within a national social health protection system will not necessarily be the same for all households, depending on their employment or economic status, for example. Certain households, especially the poorest and most vulnerable, may fall under targeted social assistance mechanisms, while others may be integrated into the formal or informal economy, and may be oriented towards contributory or semi-contributory social health insurance schemes.

Figure 3: Analysis of health coverage gaps for refugees.

2.1 How to analyse the current coverage of refugees and identify coverage gaps

In this step, the existing mechanisms available to cover refugees' health needs should be described. The assessment should explain how refugees currently access health care (which facilities they access and who operates the facilities), how health expenditures are covered, which health services they can access, and what gaps they experience. UNHCR and its partners use several approaches depending on the context and living situation of refugees – most notably the difference between those living in camps or settlements and those living in urban areas.

Common mechanisms and scenarios

- Health care for refugees living in camps is generally supported partly or fully by UNHCR together with partners (usually NGOs but possibly government and other entities) who manage the provision of primary health care. Facilities are usually also open to host communities who similarly benefit from free health care. In addition, UNHCR supports the referral of refugees to the secondary and tertiary levels, usually government facilities (transport, food, accommodation, and often the treatment costs).
- In some areas, refugees use public health services, for example in Cameroon where an agreement has been signed between the Ministry of Public Health and UNHCR for health care in public health facilities and cost sharing between the state (reduction in the prices of health facilities by 30 per cent, with the exception of drugs and delivery care) and UNHCR, for refugees from the camps of Adamawa, the East, the Far North and North.

- In urban areas, UNHCR aims to support refugees' access to health care either: a) through inclusion in social health insurance schemes wherever possible – usually by covering their contributions partly or completely, or b) through agreements with NGO partners and/or health facilities. The intention is to reduce financial barriers so that refugees may access health care at the same level as nationals, and subsidies may be accorded for care provided.
- Refugees can be included in national health systems in various ways, not all of which involve social health insurance mechanisms. One example is that of Zambia, where refugees from the Democratic Republic of Congo living in the west of Zambia are fully included in the national health system. Refugees access Ministry of Health facilities at the same level as nationals. The same is true for Uganda, where public health facilities are free for nationals and refugees alike. This demonstrates that inclusion does not necessarily involve a social insurance mechanism.
- In some countries, access to social health protection schemes is linked to employment status.
 - Refugees in formal employment can or are obliged to enrol in social health insurance programmes. UNHCR should verify that authorized refugee workers are registered in social security schemes and benefit effectively from relevant social protection programmes, especially social health insurance. In some countries, even when employers collect contributions paid to social health insurance, there may be barriers of access when seeking the benefits.
 - For refugees working in the informal and agricultural economy, a suitable strategy needs to be identified for each context. If voluntary enrolment mechanisms are in place for the informal sector, it should be determined if a combination of UN organization, the government and refugees (depending on their means) can cover contributions and enable the refugees to enrol in the social health protection scheme.

Assessment of gaps in access to health care

- From the assessment of refugees' access to health care, it is important to identify gaps in access to health care and financial protection, and to differentiate between various situations as they influence coverage and access to health services (i.e. camp and camp-like settings versus urban areas).
- It is also important to determine which services are currently included, as this can provide useful information on the acceptability of a potential inclusion in a national social health protection scheme in which the benefit package might be less comprehensive. In some cases, UNHCR or other donors might cover complementary services.
- The situation of refugees always needs to be compared with nationals – is the access to health better for refugees than for nationals when living in camp-like settings? Is the service package better or worse for refugees? What are the obstacles faced by refugees?

The assessment should also consider the existing health-care infrastructure in camps or settlements and the prospects of these being included in the national system if UNHCR and partner support were to be discontinued.

Box 6. Mandatory provisions for health care and practical barriers of access

In some countries, though refugees may occupy a formal job and contribute to social health insurance (SHI), they could still face practical barriers to accessing their entitlements under the scheme. For example, in the Middle East region, some refugees in formal employment indicated that social health insurance contributions were regularly paid by their employers, but the refugees were not provided with social health insurance cards and could not benefit in practice. The principle of equality of treatment is enshrined in ILO social security standards,¹⁸ and attention should be paid to the administrative bottlenecks that may impede its application.

2.2 Employment status and contributory capacities of refugees

A review of existing data should be carried out on the professional and socio-economic status of refugees. Data may be from UNHCR, and can include results of surveys that may have been conducted by the host government and humanitarian or development partners (World Food Programme (WFP), UNICEF, World Bank, etc.). This review needs to be the basis for providing an overview of the refugees' employment situation and their socio-economic status.

1. Status in employment and informality

Whether refugees have access to employment, either in wage employment or self-employment (as options for health coverage may be directly linked to employment status in some countries), and whether it is formal or informal.

In many countries, and for several reasons, integration into formal employment is difficult for refugees. They may not be granted labour market access with work permits; their status may be uncertain; formal employment may be unavailable in the country or region of destination; practices may be discriminatory, and so on. Overall, a significant number of refugees work in the informal economy and consequently are not covered by the labour and social protection associated with formal employment.

The issue of informality in employment is crucial in many low-income countries. It affects the social protection system, including health, in two ways:

- It makes the implementation of contributory social health insurance more difficult;
- It reduces the tax base, thus limiting the space available for financing public health measures, free medical care and social protection programmes.

¹⁸ Equality of Treatment (Social Security) Convention, 1962 (No. 118). Available at: https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C118

The question of informal employment is present in debates on the extension of social protection in many countries. It is crucial to identify precisely the employment status of refugees in order to position them within this framework and to support their transition from the informal to the formal economy. In some countries (e.g. Turkey), refugees have been supported to transition at least partially from the informal to the formal economy and are hence better protected. The inclusion of refugees in contributory schemes, if applicable, can help avoid labour market distortions. If employers can take on refugees without paying social security contributions (and often lower wages), inefficiencies might be created in the labour market, as well as tensions between refugees and the host populations.

2. Refugees' socio-economic or poverty status

Whether refugees have a contributory capacity, or whether they have socio-economic characteristics that would fall under the existing national categorization of vulnerable groups.

Where possible, the methodology used to determine and classify the socio-economic status of refugees should be aligned with those used by the government in its various social registries or national methodologies for means-tested social protection programmes to ensure equity between host population and refugees. This would facilitate the comparison of the socio-economic status of refugees with that of nationals, and would, for example, support their integration into non-contributory or subsidized programmes. An assessment of vulnerability is most useful if this is linked to benefits or an organization or government covering contributions for the enrolment of refugees.



Photo: Iran. Refugees receiving haemodialysis. Approximately 100,000 Afghan refugees in Iran are adherents to the National Social Health Insurance Scheme, *Salamat* (contributions paid annually by UNHCR).

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Step 3: Assess available options for inclusion of refugees

Key messages

- National social health insurance and national health or medical care services, where available, provide the best long-term financing and coverage option for refugees, in terms of minimizing impoverishment linked to health expenditure and providing effective access to health services on a par with nationals. In some countries, enrolment is mandatory.
- Private health insurance, if voluntary and not mandated by the government, is usually not cost-effective for refugees. Private insurers may not be able to influence the quality of care and costs of treatment in public facilities and tend to exclude those with the greatest health risks (McIntyre et al., 2011).
- Before deciding to integrate refugees into a scheme, *expert assessments* are needed, which consider a variety of factors and determine the feasibility, quality and effectiveness of available schemes, including the cost-effectiveness of integrating refugees when compared to direct assistance. An assessment further needs to consider the availability and accessibility of providers under the national scheme and quality of services. This expertise should be sought through ILO staff working on social protection, as they are providing this type of service to social protection institutions on a regular basis.
- If direct assistance remains the best option for the time being, it is still worthwhile to develop a long-term strategy for social health protection for refugees, given the decline in humanitarian budgets. This may entail going directly to Step 4 and conducting advocacy towards change in the national social health protection system.

This step builds upon findings from the previous two steps by considering the socio-economic categories of the refugees and the available social health protection schemes and aims to assess the feasibility of enrolling refugees in these systems. It requires significant knowledge of social protection mechanisms and may therefore require the mobilization of expertise external to the country team. Tools to guide this step are available in Annex 1. Before conducting a detailed cost and coverage assessment, a good understanding of the options is necessary.

3.1 Typical country contexts

Countries fall broadly into three groups according to the degree of development of their social health protection system and how it may be made available to refugees.

1. The country has almost reached UHC for its population

Most of the population has good access to primary and essential health services and incur less household expense on health because: i) much of the primary and secondary health care package is free; ii) they are registered in a mandatory national health insurance scheme; iii) they benefit from a combination of both (usually countries that have reached UHC have a combination of both). The government has the political will and a fiscal commitment to providing social health protection. There is a legal framework in place and regulatory enforcement by the government. Examples include Rwanda, Costa Rica, Thailand, Indonesia and Iran.

In these countries, the government may or may not encourage or mandate refugees to enrol in the national scheme(s). Vulnerable refugees may or may not be able to enrol in social protection programmes, including social health insurance schemes. UNHCR's role in these instances would be to advocate for the inclusion of refugees in national schemes with the same rights and obligations as nationals. The ILO can help to provide the necessary evidence when it comes to the feasibility of their integration and its alignment with ILO social security standards.

2. The country is developing social health protection and improving health services

The population has access to some free primary health care (PHC) services. Civil servants and other formal workers in the public and private sector are enrolled in national social health insurance. Extending coverage to those in the informal economy opens opportunities for participation, including migrant workers and refugees in some cases. There is limited private health insurance but many voluntary insurance schemes (including traditional community-based schemes) of variable quality, some of which could be considered as a transitional option for refugees if the national social health insurance cannot integrate them. There is a legal framework in place and regulatory enforcement by the government.

Countries where refugees currently access community health insurance schemes include Burkina Faso, Ghana, Mali, Senegal and Togo, with differences in terms of effectiveness, coverage and sustainability. In some countries such as Ghana or Rwanda, the CBHI is universal and functions like a national health insurance scheme. In many of those countries, the government has a conscious strategy and coordinates the sector while building its national health financing and social protection strategies for extension. UNHCR's role in these instances would be to monitor refugees' access to health care services as well as their ability to contribute. The ILO can support mainstreaming the issue of coverage of refugees and migrants, within national dialogues on social protection and the formulation of social protection and health financing strategies and plans at the national level.

3. The country has limited access to free PHC, no national social health insurance and few voluntary health insurance providers

These do not often meet the quality criteria of essential health care needed by UNHCR to consider refugee enrolment. There is a high level of household expenditure on health, and many people are driven into poverty from catastrophic health expenditure. Private health insurance is not usually cost-effective (and has too many enrolment exclusions). There is no legal framework in place, or the existing legal framework is not adequately enforced.

Countries where no health insurance option has been viable for refugees include Cameroon, Chad, Guinea and Niger. UNHCR's role in these instances would be to support and monitor access to health care for refugees through the national system wherever possible, and through partners. UNHCR will work on health system strengthening and encourage coordinated action by development actors. The ILO typically has ongoing advocacy efforts for the extension of social protection coverage in such countries. It can keep close contacts with UNHCR teams at the country level to ensure that linkages are made with humanitarian-type support as the national policy framework on social protection develops.

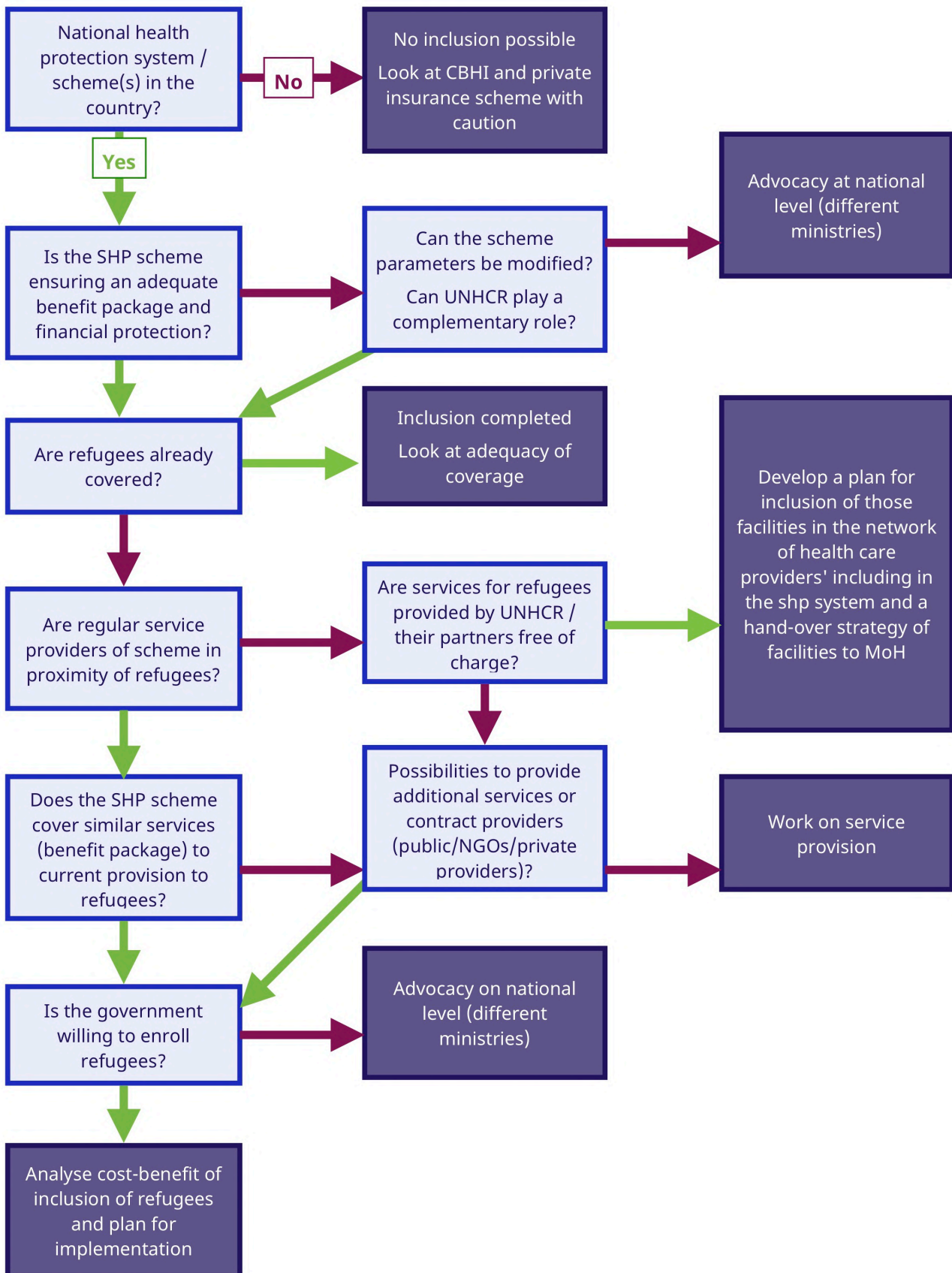
Depending on the context, options to cover the health expenditure of refugees through their inclusion in a national social health protection system may be limited because of two main factors:

- i. The country may be far from reaching UHC and may not have sufficiently strong institutions and programmes to ensure the protection of their population against high health care costs;
- ii. Among other reasons, non-nationals may be excluded from the system by law or are excluded in practice; refugees mostly work in the informal economy, which may not be covered, for example.

Options for inclusion should favour national social health insurance and national health service schemes when they exist. Otherwise, chosen providers should offer a high quality of coverage with transparent benefits and claims procedures, cost-effective management, affordable contribution rates, a track record of improving access to health care for beneficiaries, and without exclusion for pre-existing conditions. These requirements are not often met by private providers.

In situations 1 and 2 described above, it is recommended to begin by discussing with the government the potential inclusion of refugees in the national social health protection scheme. If there is no major opposition by the government, the next step is to develop a detailed assessment of the options for the coverage of refugees, including related costs. In situation 3 described above, UNHCR and ILO staff should engage within the broader development of the health financing and national social protection strategy to support the country in building a system that would eventually include refugees.

Figure 4: Decision tree to analyse the country context, and the next steps



3.2 Detailed cost and coverage analysis

The assessment calculates the potential costs of including refugees in a scheme and compares it with the existing costs of direct health service provision by UNHCR. It provides a detailed costing of the social health protection schemes with a multi-year costed plan, enabling discussions with partners and long-term strategic planning. In most cases, the plan would include an “exit strategy”: decreasing UNHCR contributions as the livelihoods of the refugees improve. If the benefit package offered does not include certain categories of persons or conditions (such as non-communicable diseases, including mental health, gender-based violence services, rehabilitation), the assessment may suggest that a complementary package be set up, ideally supplied by the same provider as the core package. The assessment (including cost analysis) provides UNHCR with recommendations of the choices that could be made. The ILO is well placed to provide its social health protection expertise when this kind of exercise is conducted. Relevant tools are available in Annex 1. The cost analysis would include details on the following points:

- **Enrolment**

Social and professional characteristics of members; numbers enrolled; those paying regular contributions and those effectively covered; growth rate; proportion receiving services via the scheme. Analysis of inclusion and exclusion criteria and identification of any discriminatory practices.

- **Payment of contributions**

Calculation of average annual payment by beneficiary; mechanism and percentage co-payment for services.

- **Package of services**

Numbers of service providers included in scheme; analysis of package offered (including out-patient consultation, transport, in-patient care, emergency care, investigations, deliveries, essential surgery, chronic disease, HIV, medicines prescribed, health prevention and promotion services); other services offered (such as life or accident insurance, employment insurance, pensions); potential for adding a complementary package.

- **Claims and provider payment procedures**

Evaluation of policies and procedures for payments to service providers or reimbursements to the insured; dispute resolution, etc.

- **Costing of integration in the schemes**

Cost benefit estimation that looks at membership costs and contributions; growth rate in membership; number of beneficiaries and average per capita pay-out by scheme; amounts received from contributions.

- **Hidden costs**

Effect of inflation on scheme financing. Is the scheme value-added-tax (VAT) rateable? What are the other “hidden” costs? Percentage Medical Loss Ratio (minimum 85 per cent, meaning that 85 per cent of the premiums are spent on health services for those enrolled in the scheme and a maximum of 15 per cent on management costs).

Box 7. The example of Rwanda

The national social health protection system in Rwanda comprises several schemes addressing different professional and socio-economic groups. In 2017, the Rwandan government pledged to integrate refugees gradually into the national social health protection system, namely the community-based health insurance (CBHI), which is a public social security scheme administered by the Rwandan Social Security Board (RSSB). A technical feasibility study was conducted by the ILO and UNHCR the following year. The enrolment of urban refugees began in September 2019, along with the issuance of identity cards by the Rwandan government. The feasibility study effectively revealed close links between legal protection measures for refugees, such as access to identification documents in the host country, and administrative barriers to accessing social protection and care.

Costing table used for the integration of refugees in the national social health insurance system in Rwanda:

	Households income category 1	Households income category 2	Household income categories 3 and 4	Total
Distribution of households by category	XX%	XX%	XX%	100%
Number of households				
(A) Number of Individuals				
(B) Annual total cost of SSHI contribution per individual				
(AxB) Total annual SSHI contributions				
Year 1				
Refugees' household contribution (per person and year)				
UNHCR contribution (per person and year)				
State subsidy (per person per year)				
Total amount contributions by the refugees' households				
Total amount UNHCR contributions				
Total amount State subsidy				
Total yearly cost per refugee for UNHCR				
Total yearly cost per refugee for the Government				
Year 2				
Household contribution (per person and year)				
UNHCR contribution (per person and year)				
State subsidy (per person per year)				
Total amount contributions by the refugees themselves				
Total amount UNHCR contributions				
Total amount State subsidy				
Total yearly cost per refugee for UNHCR				
Total yearly cost per refugee for the Government				

Just over 6,200 refugee adults and children were covered by CBHI by the end of 2018. The short-term goal is to enrol the 12,000 refugees living in urban areas into the CBHI, with this coverage to be extended to those living in camps at a later stage if feasible. Any adaptations are discussed in the context of a memorandum of understanding between the ministry responsible for refugees, CBHI and UNHCR, with the aim of ensuring that refugees can access conditions similar to those enjoyed by host communities. In particular, this will require a contribution categorization system, registration and a membership renewal process for refugees, similar to those available to Rwandan households operating in the informal economy. It is envisaged that the cost of this health coverage will be shared progressively between refugees and UNHCR, depending on the refugees' capacity to contribute.

Box 8. Lessons learned: the importance of detailed analysis and considering multiple criteria; the Democratic Republic of Congo and private health insurance

Because no national social health protection options were accessible to refugees, those living in urban areas of the Democratic Republic of Congo (DRC) were enrolled in different health insurance schemes by UNHCR to allow an informed comparison when UNHCR decided to select only one for scale-up.

The private commercial insurance company Lisungi had the lowest membership fees, while offering a coverage equivalent to the others.

System	Membership fees asked		Amount (USD) reported by		Costs covered	Health structures covered
	Amount (USD)	Periodicity	Month and person	Month and household (3 persons)		
BDOM (1)	39	Per month and per "group" of seven persons	5.6	16.8	100 %	BDOM
MS SOLIDAR-CO	36	Per month and per household (average size of six persons)	6	18	100 %	BDOM
LISUNGI (2)	16	Per month and per "group" of six persons	2.7	8	100 %	Private hospitals
MS LISANGA	80	Per person and per year	6.7	20	100 %	BDOM and private
CGAT network mutuals	54	Per person and per year	4.5	13.5	Co-payments	BDOM and private

(1) Actual convention between UNHCR partner NGO and the Diocesan Office of Medical Works – Bureau Diocésain des Œuvres Médicales (BDOM) at Kinshasa.

(2) Product "Alliance" proposed to Lubumbashi refugees.

Membership fees of Lisungi were lower, owing to better cost-control capacities. Lisungi was operating in a context where, despite the adoption of a law relating to insurance in 2015, a functional regulation of the insurance market did not exist yet. It had a lot of flexibility, but the insured persons did not have any guarantee that their rights would be protected. Furthermore, the scheme contracted a reduced number of health care providers, often located far from the refugees. Finally, this private insurance scheme had put in place a drug provision system for the insured persons (in response to stock running out in contracted health facilities) which did not function well. All these factors led to a negative perception of the quality of this insurance by beneficiaries and discouraged new adherents.

Moreover, this private health insurance was not included in the extension of social protection planned under the National Social Protection Policy and therefore would not have been useful in terms of integrating refugees into future national schemes of UHC.

This example shows the importance of considering multiple criteria for selecting a mechanism of health coverage, especially if a national scheme is not yet available.

3.3. Ensuring equity and fostering participation

Taking into consideration the findings of the socio-economic situational assessment (Step 2), the expert assessment and cost analysis should also include sustainable ways of financing contributions for vulnerable refugees (for example from targeted livelihood programmes or related social protection income support). Clear and objective criteria should be in place to identify them. Where possible, UNHCR should adopt similar or compatible criteria for vulnerability assessments with the national social protection system, in order to facilitate the future inclusion of refugees. Participation is important in the design and implementation to ensure a shared understanding of the said criteria.



Photo: Rwanda. Urban refugees in Kigali are enrolled in the national social health insurance scheme (contributions paid by UNHCR) which covers primary and secondary healthcare as per nationals.
©UNHCR/ Tobin Jones

Step 4: Engage in advocacy with national authorities

Key messages

- In practice, different conditions sometimes apply for nationals and non-nationals when it comes to accessing the social health protection system. In some countries, refugees face legal barriers to accessing the labour market as well as social protection in general, including social health protection. Often, fiscal space limitations are a main concern as governments are already struggling to cover nationals with adequate benefits.
- In those cases, the inclusion of refugees in social health protection systems can be blocked by the legal and regulatory framework, even if it proves to be technically feasible. Advocacy efforts are required from all actors, including UNHCR, ILO and their partners, for the legal access of refugees to services that meet their health needs and the transition from direct assistance. Government ownership and collaboration is key to overcoming these challenges and expanding social protection to refugee populations, in line with international commitments.
- Granting refugees access to social protection benefits is especially relevant in long-term displacement. It can: i) reduce social tensions between host communities and refugees and avoid parallel systems; ii) increase social security contributions when there is a contributory system (improved risk-pooling); and iii) strengthen the system itself, leading to more investments in institutional capacity, health service provision and delivery mechanisms.

Once the assessment of coverage options is made and one or more options are retained, the next step is to engage in advocacy with the relevant partners and the national authorities in particular.

In some countries, social protection systems are open to all residents, including refugees. Nevertheless, sometimes different conditions apply for nationals, who may benefit from state subsidies reducing their contributions to the scheme, and non-nationals, who tend not to benefit from these subsidies whatever their economic situation. This is the case for people with no contributory capacity, as well as for the self-employed (see section 4.2). Such practices are not in line with ILO social security standards. In addition, formal social security schemes are usually open to refugees when they are employed, provided that their rights are respected and their work is declared. However, it is important to note that this situation is not to be taken for granted, and in some countries refugees face legal barriers to access the labour market as well as social protection in general, including social health protection (refer to boxes 5 and 6). In Annex 2, a number of case studies are presented to illustrate the diversity of existing situations.

In those cases, the inclusion of refugees in social health protection systems, even if it proves to be technically feasible, can be blocked by the legal and regulatory framework. Sometimes governments will be unwilling to include refugees or cover part of their contributions, owing

to fiscal space limitations. Advocacy efforts are required from all actors, including UNHCR, the ILO and their partners for legal access of refugees to services that meet their public health needs. It is a question of reminding states of their international commitments and advocating to:

- Guarantee social protection for refugees, such as social health protection, at a cost (if any) similar to that contributed by nationals, taking into account individual needs and socio-economic status;
- Guarantee the right to work and respect for labour rights for refugees, particularly in terms of registration and contribution to existing social security schemes;
- Take into account the issue of refugees in social protection policies and strategies and their inclusion in both social insurance and social assistance programmes. The question of financing the integration of refugees into national social protection systems must be examined. In order to provide social protection for refugees similar to that of host communities, the government can expand its total or partial grants to refugees or mobilize external sources of funding with UNHCR.

The ILO advocates for the inclusion of migrant workers and refugees in social protection programmes and for broader access to decent work. In particular, the following suggestions are often put forward:

- Ratify the ILO conventions on migration and social protection;
- Bring national legislation in line with international standards and ILO principles, including reducing residence requirements or introducing exemptions;
- Adapt social security systems and integrate refugees into national health and other social security schemes (avoiding parallel systems, improving cost efficiency), thus strengthening systems that benefit both refugees and host communities;
- Extend social security schemes to workers in the informal economy, which can have positive effects on the inclusion of migrant workers and refugees;¹⁹
- Strengthen institutional capacity in the host country, as well as building and strengthening social protection systems in the countries of origin, to facilitate return when conditions are favourable;
- Reduce delays and lengthy processes to obtain refugee status (this is relevant in terms of social protection in host countries where refugees have access to the labour market and social protection but asylum seekers do not);
- Remove practical obstacles through information campaigns, cultural mediators, interpreters, anti-discrimination campaigns.

It is important to consider that granting refugees access to social protection benefits both host communities and refugees, which is especially relevant in long-term and protracted crises. This can:

¹⁹ <http://informaleconomy.social-protection.org>

- Reduce social tensions between host communities and refugees and avoid parallel systems and labour market distortions.
- Increase resources from social security contributions (improved risk-pooling).
- Strengthen the system itself, leading to more investments in institutional capacity and delivery mechanisms.

Within this framework, the ILO works closely with social protection institutions to support the coordination of social protection systems and the effective implementation of existing bilateral and multilateral instruments or agreements. Likewise, the ILO supports constituents in promoting social protection floors and access for all, including refugees, to basic guarantees, including UHC schemes and programmes.

Refugees are particularly represented in low-paid jobs in the informal economy, in which working conditions tend to be more hazardous and where their rights at work are not always fully respected. In this context, it is important to strengthen the capacities of governments as well as workers and employers organizations for taking refugees into account in national policies and programmes in order to guarantee fair treatment and access to decent work, including social protection.

When governments are unwilling to include refugees in social health protection schemes, a viable option can be to work towards the expansion of health protection to the informal economy. This can benefit refugees who largely work in that sector if they can enrol with their refugee ID cards.

Step 5: Prepare for implementation

Key messages

- The transition from direct humanitarian assistance to a social health protection scheme needs to be carefully prepared and planned for. A strategy needs to be devised based on up-to-date data, effectively articulated with employment and livelihood interventions, social protection and poverty alleviation policies, as well as health system strengthening efforts.
- In many countries it will be crucial to plan for institutional reinforcement and capacity- building activities for national social protection institutions. Indeed, to ensure effective social protection systems for both refugees and host communities, reinforcing institutional capacities may be required. The ILO has a key role to play in this respect.
- Practical planning needs to include a communication plan for refugees and partner NGOs, as well as the identification of synergies with UNHCR and partners' cash-based interventions. The transition will have an impact on UNHCR multi-year budget planning, which must be anticipated.

5.1 Planning for inclusion

When the decision is made to implement the selected option, a coherent multi-year plan needs to be put together in order to organize a gradual and sustainable inclusion of refugees within the scheme. This plan has different components.

5.1.1 Strategic planning

Collect and maintain up-to-date data

Any transition to social health protection schemes should be implemented using updated registration data on the target refugee population, including, if necessary, through the conduct of verification exercises.

Create an integrated strategy on employment or livelihoods and social protection

The transition towards social health protection schemes should not be considered as an isolated action but rather should be integrated into a more comprehensive strategy, consistent with other social protection mechanisms and alongside employment and livelihood interventions. On the one hand, these employment and livelihood activities should enable households to generate income and ultimately assume a larger share of social health insurance contributions, for example, if such an option is retained. On the other, the social health protection scheme coverage serves to protect the revenues generated from these

activities in the face of financial shocks related to health expenditure. This mutually reinforcing relationship between employment and livelihood activities and the continued adherence of refugees to social health protection schemes should be prioritized in all planning activities, including in UNHCR multi-year multi-sector plans. The ILO can feed this strategy by providing expert information on the coordination of national employment and social protection policies and can help to relay the need for an integrated strategy within the respective coordination bodies at the national level.

Use social health protection as a gateway to the social protection systems

The integration of refugees within social health protection schemes is a learning opportunity for the social protection sector within a country. The ILO, alongside a number of sister agencies, supports the development and strengthening of comprehensive universal social protection systems at country level. Hence, ILO staff can foster cross-fertilization and knowledge-sharing to ensure that the legal framework and institutional practices allowing for the integration of refugees within social health protection schemes are documented and shared with a view to:

- Possibly integrate refugees into other social protection schemes;
- Use similar institutional practices to cover additional vulnerable groups that may face similar challenges for access.

Link with health system strengthening and infrastructure development interventions

Bridging humanitarian and development efforts is key to finding longer-term, more sustainable solutions for both refugees and host communities. Displacement may occur in places within limited reach of national health services. Development activities aimed at upgrading health systems may or may not be underway. Efforts should be made to plan humanitarian response activities in a way that links them to existing or planned development programmes. For instance, where refugee health facilities ultimately need to be integrated into the national health system as part of multi-year strategies, planned investments into these services, including infrastructure, human resources for health and supply chain, should be shared jointly among humanitarian and development agencies, as well as with national partners. Health system strengthening, such as quality improvement measures and investments in health workers and infrastructure, will also be key to improving health service provision. Only if the health system is functional will refugees adhere and contribute to the scheme, OOPs be reduced and health outcomes be improved.

5.1.2 Practical planning

Effective communication

UNHCR, together with the concerned social health protection institution, the implementation partners as well as the broader social protection coordination groups (the UN social protection working group if there is one, for example), should plan effective communication

strategies for implementing social health protection schemes, in order to fully inform refugees about the existence of the scheme, its advantages and disadvantages, the documentation process when applying, and how to seek treatment and reimbursement when applicable. The ILO is usually present in the social protection coordination groups and can facilitate information dissemination at that level. Refugees will also need to be made aware of their rights within the scheme and their obligations (for example, the amount of co-payment they would be making and how quickly they have to inform the scheme of their admission to hospital). Such information can be developed jointly with the social health protection institution, and the ILO should seek to determine how this type of material could be useful for other vulnerable groups included within the scheme.

Furthermore, if a contributory option was chosen, refugees should be made aware of their impending, increasing responsibility for making contribution payments for their own health coverage over time, in line with the multi-year strategy. Awareness-raising efforts should also ensure that refugees understand how the social health protection scheme functions, and its advantages, in a culturally appropriate way.

Managing relationships with UNHCR implementing partners

Efforts should be made to evaluate and improve the capacities of NGO partners participating in the implementation of refugees' inclusion in social health protection schemes. For this, they should be involved in the assessment exercise and should be sensitized to social protection principles and management. Because of their close contact with refugee populations, partner NGOs should be enabled to communicate clearly with refugees about the rules laid out under the social health protection scheme arrangement, and enforce them consistently.

During and after the transition, alternative options such as provision of health services by implementing partners should be phased out. Refugees should not be offered reimbursement for other health expenditure that could have been covered under the social health protection scheme. Partial transitions need to be particularly well planned and communicated, meaning that at first only vulnerable groups are enrolled in the scheme.

Unless it is a mandatory national scheme, refugees will have the choice to leave a scheme, in which case they would be responsible for their own health care costs. It is, therefore, important that clear rules be established, communicated and adhered to by the NGO partner and by UNHCR staff.

As a result, the transition from direct assistance towards a social health protection scheme may have negative implications on UNHCR partner NGO roles, including budget allocations. Communication will need to be managed accordingly.

Synergies with cash-based humanitarian interventions

Cash-based interventions led by UNHCR or other humanitarian partners can be an important modality to facilitate access to contributory social health protection schemes and increase the involvement of beneficiaries in their own health care. Cash-based interventions may be appropriate in this context as the cost of premiums is known in advance and will likely vary only by household size, and existing vulnerability criteria can be used. Cash assistance for

this purpose can be provided as a top-up to cover all or part of the cost of contributions to vulnerable refugees who are already receiving multi-purpose cash or cash for basic needs. The amount and timing of the grant is important and should be considered early in the planning phase, as the cash should be provided at the time of the contribution payments. Any targeting in this context should be considered with respect of UHC principles of universality and equity. If cash is to be provided to fund part of social health insurance contributions, for example, a communications strategy is critical, so that the targeted population is aware of the payment schedule, time frame and expectations. Indicators can be included in the post-distribution monitoring template for cash assistance to complement regular monitoring of the social health protection scheme outcomes. As for all cash interventions under UNHCR, it is recommended to implement cash to cover contributions of social health protection schemes directly, i.e. use the existing UNHCR cash transfer assistance available rather than having a partner provide the cash. Partner engagement should be maximized in the quality aspects of public health, including assessment, referral, targeting, capacity-building and monitoring.

5.1.3 Budget implications of a transition to a social health protection scheme

Transition of all or some of the refugees under UNHCR protection from direct provision of health services (humanitarian assistance) to a public social health protection system will have implications on the planning and budget of UNHCR operations in the country. This should always be part of a wider multi-sectorial planning strategy within UNHCR.

This exercise needs to be based on the costing of the options developed during Step 3. It is important to anticipate the budget impact of integrating refugees into a social health protection scheme for UNHCR. Indeed, a budget for a multi-year integration plan needs to be prepared, outlining how the current expenditure on direct implementation of health services would gradually be reduced as refugees are able to enrol in social health protection schemes.

The following table outlines the items that need to be budgeted. The time frame could be considerably longer, depending on the country context.

Table 1: Budget exercise of integrating refugees into a social health protection scheme for UNHCR.

Item	Current year actual budget (US \$)	Integration Year 1 to 2 (US \$)	Integration Year 3 to 4 (US \$)	Integration Year 5 to 6 (US \$)
Medicines, consumables				
Implementing partner management costs				
Implementing partner staff costs				
Health facility infrastructure (buildings and equipment) and staff (health workers and administrative support staff)				
Referrals to specialist care – transport costs				
Referrals to specialist care – treatment costs				
Social insurance scheme enrolment costs				
Social insurance annual contribution				
TOTAL				

The budgeting exercise is important as it can form a basis for discussion with government counterparts about the planning and cost-sharing arrangements for integrating refugees into the identified national coverage solution. Indeed, refugees with reliable livelihoods and sufficient economic means may be able to pay contributions to social health insurance initially or progressively if this option is chosen, on a par with nationals. For refugees with no contributory capacity, their enrolment in subsidized schemes (e.g. whereby the host government pays the contributions partly or totally out of its general budget for vulnerable population or the self-employed) may require UNHCR to continue covering the costs of contributions, as the host government may not be in a position to do so. UNHCR may wish to develop livelihood interventions which gradually generate greater economic independence and the ability to contribute to social protection in the long run.

If the selected scheme covers all the specialist care that is available to nationals, then UNHCR's support for referrals can be tapered off once the refugees benefit from referral under the scheme. If, however, treatment that is available to nationals for certain chronic conditions is not offered under the scheme, UNHCR may need to maintain a budget and an exceptional care committee, under its referral care programme, for transparent and fair decisions on what further specialist care can be provided.

In the initial years of integration, the costs may increase as UNHCR might invest in the physical infrastructure of national systems and other health systems support with partners to ensure that future health services are of high quality and geographically accessible to refugees and their host communities. Health facilities set up by NGOs may be handed over to national structures but need to meet national infrastructure standards as well as accreditation standards, in terms of human resources, quality services, medicines and medical supplies. In this perspective, it is important to take into account the national health systems strengthening plans and regulation, including the support of sister agencies (i.e. WHO, UNICEF, ILO) and the World Bank.

Box 9. Considerations on financing

- If social health insurance is selected as a programmatic choice, enrolment needs to be accompanied by consistent messaging and effective communication so that refugees, national institutions, service providers and partners are fully informed of the changes.
- If UNHCR is initially supporting enrolment fees and contributions, then alternative options such as provision of health services by NGOs may need to be curtailed, and refugees may not be offered reimbursement for other health expenditure that could have been covered under the scheme. UNHCR may decide to enrol refugees automatically and pay initial enrolment and contributions. Unless it is a mandatory national scheme, refugees would have the choice to leave a scheme, in which case they would be responsible for their own health care costs.
- UNHCR should progressively transfer to refugees the responsibility of paying contributions once they are assessed to have incomes that can support this. Where possible, refugees could contribute from the outset. UNHCR may need to maintain payment or partial payment of contributions for those in vulnerable categories or to ensure that these refugees have sufficient support through cash assistance or livelihoods support to meet insurance costs.
- Greater early investments of finance and expertise may be needed in assessing options, in enrolling refugees in social health protection schemes and in monitoring outcomes. But these should result in less direct assistance for health as refugees become more self-reliant and able to contribute to social health insurance, for example.

5.1.4 Monitoring implications

Monitoring should be an integrated component of the contracted service provided by a social health protection scheme. If it is not a national social health insurance scheme and UNHCR has to resort to voluntary options, UNHCR will only accept schemes that have a robust monitoring and evaluation (M&E) framework built into the proposal of the provider, and that this is stipulated in the request for proposal.

- The scheme should provide as a minimum the following data: the numbers enrolled; the numbers paying regular contributions; the amount paid in enrolment and in contributions; the amounts paid by refugees and by UNHCR; the amount paid out by the scheme, either directly for health services provided to enrolled persons or as reimbursement for services that are covered under the scheme; the average service cost and average payout per enrolled member; the share of administrative expenses; and the medical loss ratio.
- The scheme should ideally be supported by a specialist agency working at national level that recommends a standardized health financing matrix using benchmarks to compare the performance between schemes operating in the country.
- Where possible, data is disaggregated for refugees by the scheme manager.
- Adequate feedback on satisfaction with the scheme and the quality of care from services, as well as a complaints mechanism, need to be incorporated into the M&E, and there should be some degree of refugee participatory assessment of the scheme.
- If UNHCR is not directly involved in the overview of a scheme in an area where refugees have sufficient livelihoods or multi-purpose cash assistance to be independently enrolled in a scheme, then alternative monitoring of access to health services may be needed via a household access and utilization survey (HAUS).
- UNHCR Regional Bureau public health staff and the Public Health Section can support country offices in interpreting results from different schemes to enable effective fine-tuning of the costs and package of services, and they can continue to analyse the best health financing options for refugees. At times, UNHCR may commission studies on total costs paid by refugees for health, including insurance and out-of-pocket expenditure on user fees and transport, to assess the impact of insurance on the financial burden of scheme beneficiaries.

Once refugees have been integrated into the national scheme, UNHCR and ILO staff can plan for regular evaluation of the impact of such integration on the effective access to health care services without impoverishment. This could be done periodically and can involve a capacity-building component for the national institution in charge of their coverage. The evidence gathered can help anticipate any drawback and make an assessment of the benefits of such integration, which can be further used for advocacy purposes and to disseminate the information.

5.1.5 Implications for monitoring the coverage at the national level

It is important that at national level the coordination body in charge of social protection should monitor the expansion of social protection coverage in general, including the progression of the inclusion of refugees. In this respect, the ILO has a toolbox in place to help countries to monitor social protection coverage.

Box 10. The ILO toolbox on social protection statistics

Since 1940, the ILO has been collecting and analysing quantitative information on social protection schemes around the world. The ILO Social Security Inquiry (SSI) is the main source of global data on social protection, used daily by policy-makers, officials of international organizations and researchers. A number of tools are available and can guide the monitoring of coverage in line with the SDGs:

- Database
- Social Security Inquiry Questionnaire in five languages
- Social Security Inquiry Questionnaire in five languages (including a module on migrants)
- Getting Started Guide and Technical Guide in four languages

Resources accessible at: www.social-protection.org in Tools/Social Security Inquiry

Annex 1: Practical tools and templates

Inventory of national social health protection policies and strategies

The objective of this review of national policies and strategies, within the framework of Step 1, is to examine whether refugees are taken into account and, if not, to prepare the elements of advocacy for their inclusion. It is also a question of looking at the extent to which UNHCR assistance fits into the options provided for in these framework documents and, if necessary, determining which adjustments should be made to this assistance in order to ensure consistency with national options and a smoother approach towards the humanitarian-development nexus.

The information to be collected can be gathered in a table, in an Excel file, such as the following model:

Document	Specific social health protection objectives	Planned interventions	Inclusion of refugees
1	2	3	4

1. **Document:** What national development frameworks and policy documents address the issue of social protection, including social protection in health? Each line of the table corresponds to a framework document (national framework for economic and social development, national policy on social protection, health financing policy, strategies and action plans, etc.) whose title is mentioned in this first column.
2. **Specific objectives in terms of social health protection:** For each document, the main objectives in terms of health coverage and the populations concerned will be summarized here.
3. **Planned interventions:** Which interventions, measures, programmes and projects are planned to achieve the objectives in terms of social health protection? This column summarizes the measures envisaged in order to achieve the objectives set and to reach the target populations. We limit ourselves here to a summary of the main measures planned, in order to have a vision of the major orientations. However, it may be useful to complete this table with comments and/or a brief presentation of large-scale programmes that may be envisaged in the context of these interventions (e.g. a universal health insurance project or a national registry for the entire social protection system). It may also be useful to indicate here which are the main national actors and external partners associated with the different interventions.
4. **Inclusion of refugees:** Is the issue of refugees mentioned? If not, how could it be integrated here? This column makes it possible to note to what extent refugees are considered in national policies and strategies and to mention the elements of advocacy to be carried out for this consideration. It also makes it possible to check whether current UNHCR assistance is consistent with national strategies, plans and guidelines.

For more tools on assessing social protection programmes:

- ILO. 2017. Social Protection Assessment-Based National Dialogue: A Global Guide. Available at https://www.ilo.org/wcmsp5/groups/public/---dgreports/---integration/documents/publication/wcms_568693.pdf
- Inter-Agency Social Protection Assessments: <https://ispatools.org/>

Mapping and assessing social health protection schemes

The review of social protection systems takes place in Step 1 and is then completed in Step 3. The same matrix can be used for these two steps; the template proposed here aims to show a synthetic mapping of existing schemes and their main characteristics.

	Name of the scheme	Management body	Oversight	Existing provisions							Planned provisions	Are refugees eligible?	
				Type of scheme	Benefit package	Target population	Number of protected persons	Financing	Strengths	Weaknesses			Evaluation
Government-led schemes													
Social Health Insurance													
National health or medical care service													
Gratuity programmes													
Private mechanisms													
Community-based health insurance (CBHI) or health mutuals													
Private commercial schemes and employer schemes													
Others													
		1	2	3	4	5	6	7	8	9	10	11	12

1. **Management body or institution:** Which body ensures the administrative, technical and financial management of the schemes? They can be administered directly by a Ministry (i.e. schemes for civil servants are sometimes managed directly by the Ministry of Finance), social security institutions, employers (internal company health insurance plans), mutual health insurance associations, insurance companies or even trade unions. It can also be national or international organizations in the case of social assistance programmes, for example.
2. **Supervision:** Which public entity ensures the control and supervision of the schemes? Social insurance and social assistance systems operate under the administrative and/or financial supervision of the state, and many private schemes are under the supervision or regulation of the state. The institutions in charge of this supervision should be associated with a strategy for the integration of refugees.
3. **Type of scheme:** What is the nature of the scheme which provides the benefits? This column makes it possible to identify the different schemes depending on whether they are, for example, a universal, categorical, contributory or non-contributory scheme, of mandatory or voluntary nature (definition available in the Glossary).
4. **Benefit package:** What services are offered? This column aims to describe the benefits covered by the scheme: health interventions covered, levels of the health pyramid covered (primary, secondary, tertiary care), percentage of expenses covered, support mechanism (third-party payment or reimbursement). If the information is available, it is important to indicate also how the health service providers are being paid (through a fixed amount per capita, through a set price for each service provider, or through a set amount per case or diagnosis), as those provider payment mechanisms have an important impact on service availability and quality.
5. **Target population:** Which population groups are intended to be covered by the scheme? This indicates the population groups to which the scheme applies, for example: workers in the formal sector (public and/or private), the entire population, the poorest households, etc. Secondly, depending on the data available, the size (number of people) of this target group will be indicated.
6. **Number of protected persons** (and contributors, if applicable): How many persons are effectively covered by the scheme? Belonging to a target group does not necessarily mean that the individuals or households that should be affiliated to a scheme are affiliated in practice. This is particularly the case for voluntary schemes where individuals can choose to join or not, as it is also the case for compulsory schemes where employers do not always comply with the law and sometimes do not register or affiliate all of their employees. There may thus be a difference between the number of people who should be covered (column 5) and that of the actual number affiliated to the scheme (column 6). If it is a contributory scheme and the data are available, this column should include the number of contributors as well as the total number of protected persons (contributors plus their dependents).
7. **Financing:** How is the scheme financed? This column lists the sources of funding and, to the extent available, the scheme's budget (resources). These sources of funding can come from contributions from employers and workers (for which the

distribution will be indicated), members (voluntary schemes), the state budget, funding from external partners or a combination of these sources.

8. **Strengths:** What are the strengths of the scheme? They can be of different kinds, such as a strong membership base, dynamic management, transparent governance, or the use of an information system. They reflect the elements of dynamism in this regime, most often linked to those of the managing body, and constitute an important diagnostic element.
9. **Weaknesses:** What are the weaknesses of the scheme? Weak points may include, for example, the absence of data on the beneficiaries, or they may reflect the bottlenecks and weak institutional capacities, which can be organizational, technical or financial. They are also important diagnostic elements.
10. **Evaluation:** Have the scheme and/or the health service providers been subject to a recent evaluation? Indicate here whether one or more recent assessments (including actuarial studies, studies on quality of care, etc.) have been carried out and, if applicable, the documents available.
11. **Planned provisions:** Is the scheme the subject of a particular strategy or specific objectives in terms of development or reinforcement in the near future? These objectives or strategies can arise from a national social protection policy or form part of an internal policy of the managing body, or of a technical and financial partner. This level will indicate whether the planned reforms include refugees.
12. **Eligible refugees:** What categories of refugees can join this scheme? This last column makes it possible to check whether certain households could be covered by the mechanisms identified, such as refugees with a job in the formal sector, refugees working in the informal economy, refugees without resources, etc. To the extent of the data available, the number of households and individuals concerned is indicated.

For more tools on assessing social health protection programmes:

C. Normand et al.: *Social health insurance. A guidebook for planning*, 1st and 2nd edition. ILO and WHO. 1994, 2009. Available at https://www.who.int/health_financing/documents/shi-guidebook.pdf

Annex 2: Country examples

Burkina Faso

In Western and Central Africa, CBHI, called health mutuals, are often the only options available. They are implemented by national or external actors and are usually set up for specific population groups. The enrolment of refugees can generate an imbalance that may not be predictable and can be difficult to identify and manage by these schemes if their technical management capacity is insufficient.

This is particularly the case in Burkina Faso, where the refugees living in Ouagadougou and Bobo Dioulasso were enrolled from 2016 in two functional health insurance mutuals offering a good service package. In order to encourage refugees to renew their membership, UNHCR gradually reduced household contributions from 100 per cent in the first year to 0 per cent after five years.

A study carried out in 2018 made several observations.

- Refugees in Ouagadougou consumed eight to twelve times more services than national members in the mutual health organization. This situation is partly explained by the fact that UNHCR assumed the costs of care that were not covered by the mutual insurance company, thus ensuring additional coverage that encouraged a high level of use of health services.
- Another part of the explanation lies in the fact that as UNHCR subsidy gradually decreased, households decreased the number of people for whom they contributed, thus insuring only individuals who were at high risk of disease (adverse selection phenomenon).
- As a result, the refugees, although a minority in the mutual health insurance, increased the average level of consumption of care. As the technical management of the mutual is weak, it had not been able to measure this phenomenon, which could have generated a serious financial imbalance.

The lessons learned from this experience are twofold.

- i. When membership is voluntary, refugees, as well as host populations, have little understanding and acceptance of the principle of rationing within health systems and the underlying principle of risk-pooling. Intense community engagement and communication is required to explain the scheme and assess the willingness of refugees to contribute to the schemes before they are implemented.
- ii. Community mutuals have weak management capacities, yet insurance is complex to manage. In this case, the inclusion of refugees created an imbalance in the scheme, which the mutual was unable to manage. An agreement with a mutual health insurance company must be considered carefully, with an assessment of its technical management capacities and the need for strengthening these capacities. If a national social health protection scheme is under construction, it may be better to support that process and help the early inclusion of refugees.

Burkina Faso had planned to set up a national universal health insurance scheme from 2020, which would gradually cover the entire population, but this has yet to be launched. The government has said that the system will be open to refugees.

Cameroon

UNHCR in Cameroon has initiated a strategy of progressive disengagement from direct assistance, but currently there are no alternative solutions in the form of health insurance schemes for refugees who live essentially in the informal urban and rural economy. The mutualist movement is very weak and does not offer a solution. Nevertheless, Cameroon has started working towards the development of UHC aiming at promoting access for the whole population to quality for health care through contributive and non-contributive schemes. There is, however, much technical preparation to be done, as well as full political commitment for this project. Therefore, the UHC will not be available in the short term but offers an interesting possibility for which UNHCR is preparing, through an integrated strategy as part of UNHCR's multi-year multi-partner strategy and the Strategic plan for the integration of refugees' health care in the national health system of Cameroon 2017–2021.

Democratic Republic of Congo

The self-reliance strategy developed by UNHCR in the DRC in 2016 shifted medical assistance towards the enrolment of urban refugees in health mutuals, with the long-term plan that refugees would eventually pay their own contributions. This strategy was started for refugees in urban areas of Lubumbashi, Goma and Bukavu, where partnerships are tied with different systems of micro health insurance. Currently, there is no national system of social protection in health that would enable standardized coverage for refugees. In this context, UNHCR could engage in implementing the national policies in social protection, by supporting the development of an innovative approach in terms of health coverage for the refugee population in urban and rural settings. This would involve implementing a programme of technical support to existing insurance systems and in parallel would reinforce refugee self-reliance by improving access to economic empowerment activities.

Mauritania

In Mauritania, the feasibility of urban refugees' enrolment in the basic health insurance scheme managed by the Caisse Nationale d'Assurance Maladie (CNAM), was examined, but was found to be unsuitable, based on the performance of the scheme and its cost. A new Regional Mutual Health Fund (RMHF), supported by the EU and operated by MoH, will improve social health protection for the informal sector. The roll-out is planned for late 2020 in Nouakchott West and South and Brakna, with the goal of being extended to the entire territory. UNHCR is assessing the new scheme to see if it is suitable for the inclusion of refugees. For camp-based refugees in Mbera, the Inaya project funded by the World Bank will see the progressive transition (from 2020) from UNHCR-supported services to their inclusion in the national health system, where refugees will have access to services on a par with host nationals.

Rwanda

The national social health protection system in Rwanda comprises several schemes that address different professional and socio-economic groups. Many students are registered with the national university mutual fund, and workers are covered by the Rwandaise d'Assurance Maladie (RAMA). CBHI is a public social security scheme administered by the Rwanda Social Security Board (RSSB). In 2017, the Rwandan government pledged to integrate refugees gradually into the national social health protection system. A technical feasibility study was conducted the following year by the ILO and UNHCR. The enrolment of urban refugees began in September 2019, along with the issuance of identity cards by the Rwandan government. The feasibility study effectively revealed close links between legal protection measures for refugees, such as access to identification documents in the host country, and administrative barriers to accessing social protection and care.

Just over 6,200 adults and children are now covered by CBHI. The short-term goal is to enrol the 12,000 refugees living in urban areas into the system, with this coverage to be extended to those living in camps at a later stage. Any adaptations are discussed in the context of a memorandum of understanding between the ministry responsible for refugees, CBHI and UNHCR, with the aim of ensuring that refugees can access conditions similar to those enjoyed by host communities. In particular, this will require the application to refugees of a contribution categorization system and registration and membership renewal procedures that are similar to those available to Rwandan households operating in the informal economy. Depending on their capacity to pay, refugees will increase their contributions, while UNHCR will progressively reduce theirs but will continue to cover contributions for children, people in vulnerable circumstances and those with specific needs.

Senegal

Since 2014 Senegal has a national programme on UHC which is largely subsidized by the state, with the objective of health coverage being extended to all households, including the poorest. Yet this generous policy is facing technical and financial issues, as well as difficulties in guaranteeing the continuity and quality of its services. The UHC, as well as policies on free health care for some population groups (children, pregnant women and the elderly), currently do not cover refugees. In late 2018, two opportunities arose: on the one hand, the preparation of a policy on universal health insurance, which will give the right to health coverage for every person living in Senegal, and on the other, a pluriennial strategy between Senegal and UNHCR that will enable resources to be mobilized in order to fund the same mechanisms of contribution subsidy as for Senegalese citizens. Thus, the UHC should be open to urban and rural refugees. In urban settings, this would take over from the current coverage of Dakar refugees by a health mutual insurance which is particularly expensive and leads to significant drop-out of refugees as UNHCR financial contribution decreases.

Sudan

The NHIF in Sudan covers approximately half the population and offers extended care, with services provided in mostly public health facilities and an approved list of drugs. This coverage is extended to poor and vulnerable populations whose adherence is supported by different grant programmes. UNHCR launched a pilot programme in 2016, enabling some urban refugees in Khartoum to benefit from NHIF coverage, contributions being paid on behalf of refugees for the first year. It appears, nevertheless, that most of the refugees were considered as poor, and their income potential is limited by the lack of economic opportunities. Continuing the coverage for refugees beyond the pilot project needs to be linked to activities aiming at promoting their livelihoods and their capacity to contribute to the insurance.

Glossary²⁰

Contributory scheme

Scheme in which contributions made by protected persons directly determine entitlement to benefits (acquired rights). The most common form of contributory schemes are social insurance schemes.

Contributory schemes can be wholly financed through contributions but are often partly financed from taxation or other sources. This may be done through a subsidy to cover the deficit, or through a general subsidy supplanting contributions altogether, or by subsidizing only specific groups of contributors or beneficiaries (e.g. those not contributing because they are caring for children, studying, in military service or unemployed, or have too low a level of income to fully contribute, or receive benefits below a certain threshold because of low contributions in the past).

Equality of treatment

No society is free from discrimination. Indeed, discrimination in employment and occupation is a universal and permanently evolving phenomenon. Millions of women and men around the world are denied access to jobs and training, receive low wages or are restricted to certain occupations simply on the basis of their sex, skin colour, migration status, ethnicity or beliefs, without regard to their capabilities and skills. Freedom from discrimination is a fundamental human right, and it is essential for workers to be able to choose their employment freely, develop their potential to the full and reap economic rewards on the basis of merit. Bringing equality to the workplace also has significant economic benefits. Employers who practice equality have access to a larger, more diverse and higher quality workforce. Workers who enjoy equality have greater access to training and often receive higher wages. ILO standards on equality provide tools to eliminate discrimination in all aspects of work and in society as a whole.

Relevant labour standards are accessible at: https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12030:0::NO:::Equality_of_opportunity_and_treatment

When it comes to social security in particular, see the Equality of Treatment (Social Security) Convention, 1962 (No. 118): https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312263:NO

Equality of treatment between refugees and nationals is also an important principle of the 1951 Refugee Convention, Article 24 on Labour Legislation and Social Security stipulates that: “The Contracting States shall accord to refugees lawfully staying in their territory the same treatment as is accorded to nationals”.

The Convention is accessible at: file:///I:/Health/9_Country%20operations/Refugees/GLO1911HCR/Handbook%20structure/1951_convention.pdf

²⁰ For more references: “World social protection report 2017–19: Universal social protection to achieve the sustainable development goals”. Geneva: ILO. <http://www.social-protection.org/gimi/gess/ShowWiki.action?id=594>.

Human right to health

The right to health is “an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information...” (Committee on Economic, Social and Cultural Rights).

Access the OHCHR toolkit on the Right to Health at: <https://www.ohchr.org/EN/Issues/ESCR/Pages/Health.aspx>

Informal economy

The term “informal economy” refers to all economic activities by workers and economic units that are – in law or in practice – not covered or insufficiently covered by formal arrangements, regulated or protected by the state. More than six out of ten workers and four out of five enterprises in the world operate in the informal economy.

ILO Recommendation No. 204, of universal relevance, acknowledges the broad diversity of situations of informality, including specific national contexts and priorities for the transition to the formal economy and provides practical guidance to address these priorities. It clearly defines a broad and detailed scope of application to all workers and economic units – including enterprises, entrepreneurs and households – in the informal economy. Such informal work may be found in all economic sectors and in public and private spheres.

Recommendation No 204 provides guidance to members to pursue a threefold objective:

- (a) Facilitate the transition of workers and economic units from the informal to the formal economy, while respecting workers’ fundamental rights and ensuring opportunities for income security, livelihoods and entrepreneurship,
- (b) To promote the creation, preservation and sustainability of enterprises and decent jobs in the formal economy and the coherence of macro-economic, employment, social protection and other social policies;
- (c) Prevent the informalization of formal economy jobs.

Means-tested scheme

A scheme that provides benefits upon proof of need and targets certain categories of persons or households whose means fall below a certain threshold, often referred to as social assistance schemes. A means test is used to assess whether the resources (income and/or assets) of the individual or household are below a defined threshold to determine their eligibility for a benefit, and at what level a benefit will be provided. In some countries, proxy means tests are used; that is, eligibility is determined without assessing the income or assets, on the basis of other household characteristics (proxies) that are deemed more easily observable. Means-tested schemes may also include entitlement conditions and obligations, such as work requirements, participation in health check-ups or (for children) school attendance. Some means-tested schemes also include other interventions that are delivered on top of the actual income transfer itself.

Non-contributory scheme

Non-contributory schemes, including non-means-tested and means-tested schemes, normally require no direct contribution from beneficiaries or their employers as a condition of entitlement to receive relevant benefits. The term covers a broad range of schemes, including universal schemes for all residents (such as national health services), categorical schemes for certain broad groups of the population (e.g. for children below a certain age or older persons above a certain age), and means-tested schemes (such as social assistance schemes). Non-contributory schemes are usually financed through taxes or other state revenues, or, in certain cases, through external grants or loans.

Out-of-pocket expenditure

Out-of-pocket payments (OOPs) are defined as direct payments made by individuals to health-care providers at the time of service use. This excludes any prepayment for health services, for example in the form of taxes or specific insurance premiums or contributions as well as reimbursements to the individual who made the payments.

For more information on the statistical definition of OOP: https://www.who.int/health_financing/topics/financial-protection/out-of-pocket-payments/en/

Primary health care

Primary health care (PHC) addresses most of a person's health needs throughout their lifetime. This includes physical, mental and social well-being and is people-centred rather than disease-centred. PHC is a whole-of-society approach that includes health promotion, disease prevention, treatment, rehabilitation and palliative care.

A primary health care approach includes three components:

- Meeting people's health needs throughout their lives;
- Addressing the broader determinants of health through multisectoral policy and action;
- Empowering individuals, families and communities to take charge of their own health.

By providing care *in* the community as well as *through* the community, PHC addresses not only individual and family health needs, but also the broader issue of public health and the needs of defined populations.

The principles of PHC were first outlined in the [Declaration of Alma-Ata](#) in 1978, a seminal milestone in global health. Forty years later, global leaders ratified the [Declaration of Astana](#) at the [Global Conference on Primary Health Care](#) which took place in Astana, Kazakhstan in October 2018.

For more information: https://www.who.int/health-topics/primary-health-care#tab=tab_1

Social insurance scheme

A contributory social protection scheme that guarantees protection through an insurance mechanism, based on:

- The prior payment of contributions, i.e. before the occurrence of the insured contingency;
- Risk-sharing or “pooling”;
- The notion of a guarantee. The contributions paid by (or for) insured persons are pooled together and the resulting fund is used to cover the expenses incurred exclusively by those persons affected by the occurrence of the relevant (clearly defined) contingency or contingencies.

Contrary to commercial insurance, risk-pooling in social insurance is based on the principle of solidarity as opposed to individually calculated risk premiums.

Many contributory social security schemes are presented and described as “insurance” schemes (usually “social insurance schemes”), despite being, in actual fact, of mixed character, with some non-contributory elements in entitlements to benefits. This allows for a more equitable distribution of benefits, particularly for those with low incomes and short or broken work careers, among others. These non-contributory elements take various forms, being financed either by other contributors (redistribution within the scheme) or by the state.

Social protection and the human right to social security

Social protection is the protection granted by society in case of life contingencies, which can occur within the life cycle. It is defined as the set of policies and programmes designed to reduce and prevent poverty, vulnerability and social exclusion throughout the life cycle. It is enshrined in the human right to social security. The right to social security is the right to access and maintain benefits, whether in cash or in kind, without discrimination in order to secure protection from (a) lack of work-related income caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member; (b) unaffordable access to health care; (c) insufficient family support, particularly for children and adult dependents (Committee on the Economic, Social and Cultural Rights, General Comment 19). The fundamental right to social security is set out in the Universal Declaration on Human Rights (1948) and other international legal instruments.

Social protection includes nine main areas: child and family benefits; maternity protection; unemployment support; employment injury benefits; sickness benefits; social health protection (medical care); old age benefits; invalidity/disability benefits; and survivors’ benefits. Social protection systems address all these policy areas by a mix of contributory schemes (social insurance) and non-contributory tax-financed benefits (including social assistance).

“Social protection” is a current term to refer to “social security”, and generally both terms are used interchangeably. It must be noted that sometimes the term “social protection” is used with a wider variety of meanings than “social security”, including protection provided between members of the family or members of a local community; on other occasions it is

also used with a narrower meaning, understood as comprising only measures addressed to the poorest, most vulnerable or excluded members of society. In most contexts, however, the two terms are largely interchangeable, and the ILO and, in general, UN institutions use both in discourse with their constituents and in the provision of relevant advice to them.

Relevant social protection standards are accessible through the following resources:

- Building social protection systems: International standards and human rights instruments: <https://www.social-protection.org/gimi/ShowResource.action?id=54434>
- ILO social security standards: A global reference for social security systems: <https://www.social-protection.org/gimi/ShowResource.action?id=55563>
- Joint UN website on social protection and human rights: www.socialprotection-humanrights.org
- Reports from the High Commissioner for Human Rights are accessible at: <https://www.ohchr.org/EN/Issues/RightSocialSecurity/Pages/SocialSecurity.aspx>

Social protection floor

Social protection floors are nationally defined sets of basic social security guarantees which secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion.

Social protection floors should comprise at least the following basic social security guarantees:

- (a) Access to a nationally defined set of goods and services, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality;
- (b) Basic income security for children, at least at a nationally defined minimum level, providing access to nutrition, education, care and any other necessary goods and services;
- (c) Basic income security, at least at a nationally defined minimum level, for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability; and
- (d) Basic income security, at least at a nationally defined minimum level, for older persons.

(ILO Recommendation No. 202, Paragraph 5)

Social protection floors are components of comprehensive social protection systems progressively ensuring higher levels of social protection. SDG 1.3 calls for the implementation of nationally appropriate social protection systems and measures for all, including floors, and for the achievement of substantial coverage of the poor and the vulnerable by 2030.

Universal social protection

According to the international framework, universal social protection encompasses three key aspects:

- Universal coverage in terms of persons protected;
- Comprehensive protection in terms of risks covered;
- Adequacy of protection.

Consult the following issue brief for an overview of the concept:

ILO. 2019. "Universal social protection. Key concepts and international framework", Social protection for all issue brief. April 2019. Available at: <https://www.social-protection.org/gimi/RessourcePDF.action?id=55517>

Guidance from ILO standards

1. Key principles on medical care

Principle of universality of coverage

The principle of universality of coverage was set out as early as 1944 within the Medical Care Recommendation (No. 69) in its Paragraph 8, “medical care services should cover all members of the community, whether or not they are gainfully occupied” (R69, Para. 8). The “universality of protection, based on social solidarity” was further reaffirmed by the Social Protection Floors Recommendation, 2012 (R202, Para. 3 a) ensuring that at a minimum, “over the life cycle, all in need have access to essential health care and to basic income security” (R202, Para. 4).

Principle of solidarity in financing

The costs of access to affordable health care should be borne collectively through broad risk-pooling mechanisms and should be financed “by regular periodical payments which may take the form of social insurance contributions or of taxes, or of both” (R69, Para. 4).

Principle of adequacy of the benefits

Relevant instruments address the various dimensions of adequacy, including services to be covered, the criteria of quality they should meet and the level of financial protection that should be provided against their cost.

- *Service coverage* – “Complete preventive and curative care should be available at any time and place to all members of the community (...) on the same conditions, without any hindrance or barrier of an administrative, financial or political nature, or otherwise unrelated to their health.” (Recommendation 69, Para. 20). The relevant Convention further set out that “any morbid condition, whatever its cause” shall be covered (C102, Art. 8 and C130, Art. 8) with a view to “maintaining, restoring or improving the health of the person protected” (C102, Art. 10.3 and C130, Art. 9).
- *Adequacy of services and working conditions of health personnel* – The system should aim at attaining “the highest possible standard of care” (R69, Para. 46), and health care services should “meet the criteria of availability, accessibility, acceptability and quality” (R202, Para. 5 a). In this respect, particular attention is paid to the working conditions and skills of medical personnel (R69, Para. 57–65 and C149).
- *Financial protection* – While the existence of co-payments is authorized for the purpose of precluding abuse, they should be “designed as to avoid hardship” (C102, Art. 10.2) and should not be required for beneficiaries who cannot afford it or in case of “diseases recognized as entailing prolonged care” (R134, Para. 7). In such conditions, the time limit that may be put on the benefit provision should be extended (C102, Art. 12 and C130, Art. 16.3). It is also advised that “the right to the medical care (...) should not be made subject to a qualifying period” (R134, Para. 4).

Main standards

- [Medical Care Recommendation \(No. 69\)](#)
- [Social Security \(Minimum Standards\) Convention, 1952 \(No. 102\)](#)
- [Medical Care and Sickness Benefits Convention, 1969 \(No. 130\)](#)
- [Medical Care and Sickness Benefits Recommendation, 1969 \(No. 134\)](#)
- [Nursing Personnel Convention, 1977 \(No. 149\)](#)
- [Social Protection Floors Recommendation, 2012 \(No. 202\)](#)

2. Main requirements: ILO social security standards on health care

	Convention No. 102 Minimum standards	Convention No. 130 ^a and Recommendation No. 134 ^b Higher standards	Recommendation No. 202 Basic protection
What should be covered?	Any ill health condition, whatever its cause; pregnancy, childbirth and their consequences.	The need for medical care of curative and preventive nature.	Any condition requiring health care, including maternity.
Who should be covered?	At least: <ul style="list-style-type: none"> - 50 per cent of all employees, and wives and children; <i>or</i> - categories of the economically active population (forming not less than 20 per cent of all residents, and wives and children); <i>or</i> - 50 per cent of all residents. 	<p>C.130: All employees, including:</p> <ul style="list-style-type: none"> - apprentices, and their wives and children; <i>or</i> - categories of the active population forming not less than 75 per cent of whole active population, and their wives and children; <i>or</i> - prescribed class of residents forming not less than 75 per cent of all residents (persons already receiving certain social security benefits shall also continue to be protected under prescribed conditions). <p>R.134: In addition: persons in casual employment and their families, members of employers' families living in their house and working for them, all economically active persons and their families, all residents.</p>	At least all residents and children, subject to the country's existing international obligations.

<p>What should the benefit be?</p>	<p><i>In case of ill health:</i> general practitioner care, specialist care at hospitals, essential medications and supplies, hospitalization if necessary.</p> <p><i>In case of pregnancy, childbirth and their consequences:</i> prenatal, childbirth and postnatal care by medical practitioners and qualified midwives, hospitalization if necessary.</p>	<p>C.130: The medical care required by the person’s condition, with a view to maintaining, restoring or improving health and ability to work and attend to personal needs, including at least: general practitioner care, specialist care at hospitals, allied care and benefits, essential medical supplies, hospitalization if necessary, dental care and medical rehabilitation.</p> <p>R.134: Also the supply of medical aids (e.g. eyeglasses) and services for convalescence.</p>	<p>Goods and services constituting at least essential health care, including maternity care, meeting accessibility, availability, acceptability and quality criteria; free prenatal and post-natal medical care for the most vulnerable; higher levels of protection should be provided to as many people as possible, as soon as possible.</p>
<p>What should the benefit duration be?</p>	<p>As long as ill health, or pregnancy and childbirth and their consequences, persist. May be limited to 26 weeks in each case of sickness. Benefit should not be suspended while beneficiary receives sickness benefits or is treated for a disease recognized as requiring prolonged care.</p>	<p>C.130: Throughout the contingency. May be limited to 26 weeks where a beneficiary ceases to belong to the categories of persons protected, unless he/she is already receiving medical care for a disease requiring prolonged care, or as long as he/she is paid a cash sickness benefit.</p> <p>R.134: Throughout the contingency.</p>	<p>As long as required by the health status</p>

<p>What conditions can be prescribed for entitlement to a benefit?</p>	<p>Qualifying period may be prescribed as necessary to preclude abuse.</p>	<p>C.130: Qualifying period shall be such as not to deprive of the right to benefits persons who normally belong to the category.</p> <p>R.134: Right to benefit should not be subject to qualifying period.</p>	<p>Persons in need of health care should not face hardship and an increased risk of poverty owing to financial consequences of accessing essential health care.</p> <p>Should be defined at national level and prescribed by law, applying principles of non-discrimination, responsiveness to special needs and social inclusion, and ensuring the rights and dignity of people.</p>
<p>Medical Care and Sickness Benefits Convention, 1969. ^bMedical Care and Sickness Benefits Recommendation, 1959.</p>			

Additional resources

C. Normand et al. 1994 and 2009. *Social health insurance. A guidebook for planning*. ILO and WHO. Available at: https://www.ilo.org/wcmsp5/groups/public/---dgreports/---integration/documents/instructionalmaterial/wcms_568927.pdf

ILO. 2020. *Towards universal health coverage: Social health protection principles*, Social protection spotlight brief. Available at: <https://www.social-protection.org/gimi/RessourcePDF.action?id=56009>

ILO. 2019. Building social protection systems: International standards and human rights instruments. Accessible at: <https://www.social-protection.org/gimi/ShowRessource.action?id=54434>

ILO. 2019. Policy resource package on extending social security to workers in the informal economy. Accessible at: <http://informaleconomy.social-protection.org>

ILO. 2017. *Social protection assessment-based national dialogue: A global guide*. Available at: https://www.ilo.org/wcmsp5/groups/public/---dgreports/---integration/documents/publication/wcms_568693.pdf

ILO world social protection database. <https://www.social-protection.org/gimi/WSPDB.action?id=32>

ILO global knowledge platform on social protection. www.social-protection.org

ILO Normlex information system on international labour standards. <https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:1:0::NO::>

Inter-agency social protection assessments. <https://ispatools.org/>

OHCHR toolkit on the right to health. <https://www.ohchr.org/EN/Issues/ESCR/Pages/Health.aspx>

WHO global health expenditure database. <https://apps.who.int/nha/database/Select/Indicators/en>

UNHCR public health guidance. <https://www.unhcr.org/search?comid=4b4c91c49&cid=49aea9390&scid=49aea93ad&tags=public-health-guidelines>

UNHCR public health strategies and policies. <https://www.unhcr.org/search?lcode=EN&comid=4b4c8da19&tags=pubhealth-strategies&policies>

UNHCR public health assessment, monitoring, evaluation. <https://www.unhcr.org/search?lcode=EN&comid=4b4df14f9&tags=evaluation-health>

UNHCR's principles and guidance for referral care for refugees and other persons of concern. <https://www.unhcr.org/protection/health/4b4c4fca9/unhcrs-principles-guidance-referral-health-care-refugees-other-persons.html>

UNHCR ensuring access to health care operational guidance in urban areas. <https://www.unhcr.org/protection/health/4e26c9c69/ensuring-access-health-care-operational-guidance-refugee-protection-solutions.html>



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