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LOCAL HEALTH SYSTEM SUSTAINABILITY PROJECT

ADDRESSING NON-FINANCIAL BARRIERS TO EXPANDING FINANCIAL PROTECTION TO UNDERSERVED AND SOCIALLY EXCLUDED POPULATIONS

A synthesis of findings from a global literature review and Senegal case study

COMPENDIUM REPORT

June 2022

Catastrophic health expenditures, resulting from out-of-pocket payments, remain a widespread concern globally. They are most prevalent in low- and middle-income countries, where inadequate investments, allocative inefficiencies, and poor targeting mechanisms within state-provided health systems result in high out-of-pocket expenditure (Xu et al. 2003). Evidence points to approximately 100 million people being pushed below the poverty line annually due to out-of-pocket health care costs (Kawabata et al. 2002). Developing an effective, tax-funded health system in low- and middle-income countries remains difficult for several reasons, including an insufficient tax base, limited priority for the health sector in budget allocation and spending, and inadequate mechanisms for collecting funds. Thus, many countries have shifted toward implementing different financial protection schemes—such as government schemes like social health insurance or voluntary insurance models like community-based health insurance (CBHI), or conditional cash transfers—as a mode for providing citizens with protection from catastrophic health care costs (Habib et al. 2016). Inequities remain within such models, where differences exist in health status or the distribution of health resources between different population groups, like the chronically underserved and socially excluded (WHO 2017). Orienting health systems to direct resources to the neediest not only will bring benefits to those who are worse off but can also offer important population health gains.

Who are underserved and socially excluded populations?

These groups include the poor, ethnic groups, migrants, or populations marginalized due to their beliefs, educational or legal status, financial constraints, lack of language proficiency, residence in resource-poor areas where services are largely scant, or other stigmatizing factors (Rao et al. 2019).

The most common underserved and socially excluded populations referenced in this review are:

- The poor (other terms include people living in poverty, people below the poverty line, and the indigent) (66 percent of papers)
- People living in rural, remote, or hard-to-reach areas (22 percent of papers)
- Children (including newborns and infants) and youth (16 percent of papers)
- Pregnant women (14 percent of papers)
- In many cases, the underserved and socially excluded population was the conjunction of two or more of the populations (e.g., 'poor women' or 'poor children living in rural areas').

Low- and middle-income countries often grapple with extending financial protection schemes to the entire population. Countries commonly focus on measures addressing the financial constraints to enrolling the poor and most vulnerable, but many other challenges exist related to population behaviors. Drivers of these

behavioral challenges include: distance of patients from health facilities; non-health financial costs like transportation, accommodation, and related costs; discriminatory attitudes and behaviors by health workers; lack of knowledge of the benefits of financial protection; bureaucratic enrollment requirements; and an overall lack of trust in the program. Countries need to understand how to address these challenges to optimize coverage of the poor and vulnerable.

(Photo: USAID 2013)

The USAID-funded Local Health System Sustainability Project conducted a review of the global literature (Johns et al. 2021) and a case study in Senegal (LHSS 2022) to focus on practical experiences and lessons learned when expanding financial protection to socially excluded and vulnerable groups. The literature review included 215 papers focused on interventions in low and middle-income countries to address financial or non-financial barriers that socially excluded and vulnerable populations face when accessing social health protection or health care services. This compendium report synthesizes the key findings and lessons from the literature review and case study.

Lessons from a review of the global literature

What barriers do underserved and socially excluded populations face when enrolling in social health protection schemes and accessing health care?

Financial barriers to accessing health care services or financial protection schemes were consistently documented in the literature (mentioned in roughly 80 percent of papers). In addition to the cost of health services themselves, financial barriers to accessing health care services also include paying for transportation to a health facility, cost of accommodations, meals, and so forth for the patient or for people accompanying the patient to the health facilities. In addition to financial barriers to accessing health facilities, people often also face financial barriers to accessing financial protection schemes, and health insurance in particular. Payment for health insurance premiums is the primary financial barrier to accessing health insurance. Health insurance itself may not fully alleviate financial (or non-financial) barriers to accessing health services, since the degree of financial protection depends on the benefit package/service coverage, amount of co-payments, ceilings, deductibles, and other design features of the insurance.

Non-financial barriers to accessing health care services are widely reflected in the broader public health literature, and include poor quality of health care services, long waiting times at facilities, poorly perceived provider behavior (including cultural or gender-based poor behavior), lack of knowledge among the population on the need for health care services, cultural or language barriers, and distance or access to health services, among others. The non-financial barriers to accessing health facilities may also hinder enrollment in financial protection. For example, people may be less willing to enroll in health insurance if they believe that the health care provided under the insurance is of low quality, health facilities are far from their places of residence, or they do not believe they need health services. Additionally, these factors may represent non-financial barriers to enrollment in financial protection schemes. For instance, people may not enroll in insurance if the insurance itself is perceived to be of poor quality: late payments, frequent refusals of claims, limited benefit package, small network of providers associated with the scheme, rude insurance staff, or insurance staff who are difficult to reach or communicate with. Long enrollment times, excessive or confusing

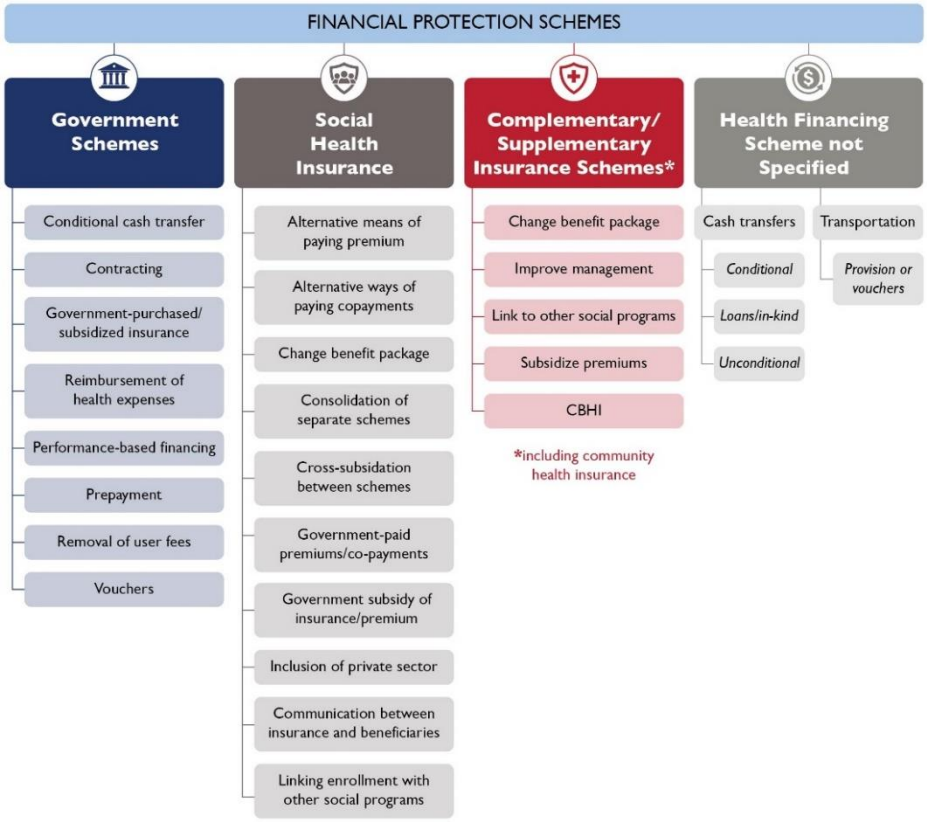
administrative procedures for enrollment or claiming of benefits, lack of knowledge of insurance or the need for health insurance among the target populations, and cultural and linguistic barriers can also affect financial protection schemes.

Interventions used to overcome financial and non-financial barriers

This literature review identified 27 different interventions used to extend financial protection to underserved and socially excluded populations (Figure 1). Many of these interventions are designed explicitly to overcome financial barriers to accessing health services or for enrolling certain groups of the population in some type of health insurance scheme, but some can also address non-financial barriers (including contracting, performance-based financing, changing the benefit package, consolidation of separate schemes, cross-subsidization between schemes, inclusion of the private sector, liaisons/communication systems between insurance and beneficiaries, and linking enrollment with other poverty reduction programs).

Furthermore, many of the interventions addressing financial barriers also include activities addressing non-financial barriers as part of the intervention's focus. For example, in the Philippines, the government-paid premium subsidy for social health insurance is accompanied by the provision of information about insurance to enrollees, such as follow-up reminders and household visits (Capuno et al. 2014). Many of the interventions assessed in these papers include an informational component. Additionally, many of the interventions designed to increase demand for health services or health insurance (including, for example, conditional cash transfers, prepayment for defined services, removal of user fees, vouchers, and linking health insurance to other social programs) also include a component to improve the quality of health services available to the targeted populations. Given the simultaneous implementation, it is difficult to disentangle the effects of a single component of an intervention from the effects of the combined package of activities.

Figure 1: Classification of interventions used to extend financial protection to underserved and socially excluded populations



Taken together, the co-mingling of activities with interventions, the simultaneous implementation of multiple interventions, and the mixed results from many of the interventions at different times or in different settings suggest that no single effort is sufficient to fully provide adequate financial protection to underserved and socially excluded populations. In many cases, for example, while the financial protection measured increased, catastrophic or impoverishing health payments did not disappear altogether in the targeted population. While assessing the effectiveness of single interventions remains crucial for determining whether it is working in a particular context, the results also indicate that finding the right mix of interventions, and activities within interventions, is crucial for alleviating barriers to financial protection and accessing health services. The activities implemented in many of the interventions found for this review further suggest that activities to address both supply-side (e.g., availability, accessibility, and quality of health care services) and demand-side (underserved and socially excluded populations' knowledge, attitudes, ability, and capacity to enroll in financial protection schemes and access health services) barriers may have better chances to succeed.

However, with these caveats in mind, some of the interventions found stand out both because of the number of papers reviewed that assess them and because of the consequent strength of evidence that support them.

- In settings where there is sufficient number and competition between private health insurance schemes and sufficient health services, having the government buy or subsidize private insurance does seem to help provide financial protection to underserved and socially excluded populations, although the effect of private insurance on people's utilization of health services and health outcomes is less certain.
- Removing user fees along with ensuring sufficient quality of health services can be an effective means of providing financial protection, increasing the use of health services, and improving health.
- Changing the benefit package of health insurance by itself has fairly mixed results; likely, ensuring that the changes are relevant to the targeted population, communicating the changes in the benefit package and what the changes mean for beneficiaries, and ensuring the quality of services related to the changes are also necessary.
- Having the government pay the premiums and/or copayments for certain targeted populations, especially when done in a way that allows automatic or very easy enrollment for that population, has typically increased enrollment in health insurance, increased use of health services, and provided financial protection. In a few settings, it has been associated with improved health.
- While CBHI can accrue enrollment and the subsequent benefits of insurance, it also typically does not achieve universal enrollment, may miss the most vulnerable portions of a population, and may have trouble maintaining financial sustainability if not subsidized.

Senegal's experience expanding financial protection by addressing non-financial barriers

In Senegal, LHSS conducted a case study examining three social protection mechanisms targeting the most vulnerable, underserved, and socially excluded populations (LHSS 2022). The objective of the Senegal case study was to identify promising approaches and strategies to ensure more equitable financial protection, especially for underserved and socially excluded populations. In general, non-financial barriers to people using social protection schemes to access health care services are closely related to social determinants of health; therefore, some of the initiatives in this case study aim to describe how Senegal is trying to address these social determinants of health related to their impact on demand for health. The social protection mechanisms covered, include:

- CBHI, which provides general financial protection through the Mutuelles scheme and includes free health care programs (free caesarean section in the public sector for any pregnant woman whose health requires it, free care for children under 5 years old in the public sector, free dialysis in public facilities for patients with chronic renal failure, and free care through the public sector for those 60+).
- Family Security Grant (La bourse de sécurité familiale (PNBSF)), which provides conditional cash transfers to targeted families below the poverty line and facilitates the enrolment of these vulnerable populations in CBHIs. The PNBSF is national in scope, and as of 2016 reached almost 200,000 vulnerable families (with a goal to expand to 300,000 families). The main recipient of the cash transfer must be the mother. The mother receives 25,000 FCFA every three months for five consecutive years (the allowance is fixed regardless of household size). The beneficiaries of PNBSF are also enrolled in CBHI and government pays the total contribution for these beneficiaries.
- Equal Opportunity Card (La carte d'égalité des chances (CEC)), which aims to reduce inequalities faced by people with disabilities by providing them subsidized access to seven basic social services (services related to employment, finance, health, education, training, transportation, and functional rehabilitation) and facilitating their enrollment in CBHI schemes. To date, only three of the seven services are implemented: finance, health, and transportation services. Only the person with disabilities (and not the household) is enrolled in CBHI. By the end of 2021, the CEC program had reached 69,768 people with disabilities, representing a coverage rate of approximately 6 percent.

Across the social protection schemes, a consistent set of non-financial barriers were identified. Table 1 summarizes the non-financial barriers that vulnerable populations face, and the strategies and methods Senegal has implemented to try and address these barriers.

TABLE 1: NON-FINANCIAL BARRIERS FACED BY VULNERABLE POPULATIONS IN SENEGAL AND METHODS TO ADDRESS THEM (LHSS 2022)

NON-FINANCIAL BARRIER	WHAT WAS DONE TO ADDRESS THE NON-FINANCIAL BARRIER?
Lack of information about social health protection. Populations are not always well informed about the existence of the health protection mechanisms available in their communities and the services offered by these mechanisms. For example, there is a misunderstanding among the population of what is covered by the free services. The free-of-charge services only cover the medical intervention and some drugs (in some cases). The other direct and indirect costs are paid by the patient; they include medical control analyses, certain drugs and consumables outside the kit, food, and transportation expenses for accompanying persons.	Community involvement has been critical for awareness-raising about CBHI and in enrolling the population. Some CBHI schemes have tried to implement innovative and ambitious communication strategies with appropriate, targeted, and convincing messages to strengthen the schemes' membership. They have worked to involve local and regional authorities in the dissemination of messages to raise awareness of CBHI. But more progress is needed in this area.
Socio-cultural and religious barriers. For many, traditional medicine remains the first recourse to care. Additionally, there is lack of an insurance culture with sentiments like "why contribute when you are healthy?" or , "contributing for a healthy person to take care of him in the event of illness attracts bad luck".	There is strong involvement of the community in the mobilization and sensitization of the population on PNBSF, particularly through communication campaigns.

NON-FINANCIAL BARRIER	WHAT WAS DONE TO ADDRESS THE NON-FINANCIAL BARRIER?
Need to address other factors that influence social determinants of health. Health issues are only one of many challenges facing these groups. In parallel with social health protection, other financial and non-financial support measures need to be considered to help address other factors—including education, literacy, and employment—that ultimately influence good health outcomes.	To address other factors that influence social determinants of health, trainings focused on micro-investment have been conducted to help some beneficiaries create income-generating activities using their PNBSF and thereby create more wealth in their families. Beyond financial protection, the PNBSF and CEC programs address certain non-financial aspects that have an impact on the demand for care, such as lack of access to affordable transportation, and jobs that pay poverty-level wages, which precludes them from taking time off to seek care and use the free health care services made available to them.
Provider discrimination against vulnerable and socially excluded populations. Vulnerable and socially excluded beneficiaries of the UHC policy often face differentiated treatment and sometimes even poor reception by providers. This results from the cash flow difficulties experienced by those health facilities because of the delay in the repayment of debts for benefits billed to the Universal Health Coverage Agency.	PNBSF accountability mechanisms have been established: a hotline, listening group at the beneficiary level, etc. Since 2015, a complaint system has been in place to facilitate reporting of information and handle complaints. Complaint forms are filled out by the correspondents at the village level and are then forwarded to the territorial administration. The General Delegation for Social Protection and National Solidarity gathers the complaints and handles them on a case-by-case basis.
Geographic accessibility of services. Geographical access to CBHI services is still limited. This is especially true for rural populations for whom transportation to services is often unpredictable, such as road inaccessibility, particularly during the winter. The physical distance between rural populations and the nearest health facilities, particularly hospitals, is another problem.	To address constraints around geographic accessibility, the PNBSF program has developed "close payment sites" to manage the issue of remoteness. The “close payment sites” bring financial services closer to beneficiaries and ensure that beneficiaries incur no costs for either transportation or payment collection.
Perception of low quality of care (including frequent stock outs). The perception of poor quality of care discourages utilization of services. Additionally, there are frequent stock-outs of important products for the management of free services, such as dialysis. There are difficulties in supplying kits and drugs (anti-rejection drugs) for transplant patients.	Beneficiary associations collect data to monitor health care in various health facilities to help address the barriers around long waiting times, low perception of quality of care, and frequent stock-outs of important medical goods.
Administrative bottlenecks (including delays in payments and reimbursements). The waiting time and the cumbersome administrative procedure to obtain letters of guarantee discourage the use of free services. Delays in payment of the state grant contributions to schemes and the reimbursement of the exempted (free) services affects the entire health care purchasing chain and causes tensions between the beneficiaries, CBHI schemes, and providers.	Beneficiary associations contribute to the resolution of problems and administrative bottlenecks in collaboration with the ministries involved and the universal health coverage agency.

NON-FINANCIAL BARRIER	WHAT WAS DONE TO ADDRESS THE NON-FINANCIAL BARRIER?
Limited availability of services. The UHC health care package is not attractive, particularly in view of the increased incidence of non-communicable and chronic diseases, which UHC does not explicitly cover. The lack of CBHI coverage for treatments such as physical and functional rehabilitation, and for medical equipment, is a major health challenge for people with disabilities. Most people with disabilities need prostheses, devices to improve their living conditions and mobility (crutches, braces, carts, other technical aids ordered, etc.), but UHC program benefits do not include such care and are limited mostly to medicines, first aid, and hospitalization.	For the CEC program, a working group has been established to develop commitment for a regulatory and legal framework for the correct implementation of the CEC program and to ensure that services listed in the program are actually available.
Challenges in accurately targeting beneficiaries. Challenges in targeting the beneficiaries of financial risk protection mechanisms, with inclusion errors in the non-eligible segments of the population, can lead to poor performance in the financial viability of programs.	There is significant community participation in PNBSF in the targeting and periodic monitoring phases of the program. In addition to geographic targeting and category-specific targeting, there is also community targeting, which involves the Village Targeting and Monitoring Committees and the Neighborhood Targeting and Monitoring Committees. These committees draw up lists of the poorest households in the community. The committees have a minimum of 5 members, including the village chief (or the neighborhood delegate), representatives of community-based organizations (youth representatives, women's representatives), the imam or the priest, the community health correspondent/Badianou Gokh, and parent representatives. The Communal Targeting Committee, under the authority of the territorial administration, ensures the distribution of quotas by neighborhood or by village and the control of household lists. Once validated, the lists are aggregated at the communal level and submitted to the prefect or sub-prefect of the district.
Accessibility challenges by the disabled. Accessibility to CEC registration sites is a problem for people who are blind or have mobility problems. In the absence of local access to the CEC, people with "severe" disabilities are more likely to have difficulty reaching the registration sites.	To mitigate underperformance related to the registration of people with disabilities in the program, the ministry implements the Equal Opportunity Card Acceleration Program. In this program, the ministry often involves representatives of disability organizations in the regions in the implementation of advanced strategies. Beneficiaries' organizations contribute to targeting, information flow, awareness campaigns, etc.

Common themes and recommendations for the way forward in Senegal

Senegal's social protection policy is innovative, committed, and ambitious, but also remains fragile in terms of achieving its results. There were some common themes and recommendations that arose across the schemes:

- **Community involvement is at the heart of CBHI decision-making, functioning, and evaluation.** The involvement of communities and community leaders is an asset to Senegal's social protection schemes. The community sees it as a privilege to mobilize oneself to make contributions to the development of one's village and commune (see box). The level of contribution, leadership, and community participation is important but needs to be capitalized on and strengthened. Moreover, to enable community actors to participate more effectively in social protection mechanisms, there is a need to strengthen the leadership capacities of community actors and give communities a central role in the social protection system, through technical and financial support for citizen accountability bodies such as the community-based organizations and professional associations.

"If I am in a village with so much poverty and my contribution could bring change and fight against it and if I don't do it, it would be a pity for my own existence."

— CBHI Association Leader

- **There is need to integrate other non-financial aspects into the social protection package.** This will require coordination across the various social protection mechanisms. An example of these actions is the transition of CBHI to social insurance. In coordination with the West African Economic and Monetary Union, other interventions could include maternity leave for rural women, support in the event of social events (expenses related to the arrival of a new child, death, accidents, etc.), or eliminating all forms of exclusion. These interventions require more reflection among actors, such as the social security fund and the federation of CBHI schemes, to raise awareness on the merits of the mechanisms.
- **There is need to improve the quality of services and expand the benefits package.** To address the challenges around benefits package coverage, the universal health coverage program must conduct a prioritization of the process for updating the content of the social protection package based on the financial, technical, and human resources available. This process should also be in accordance with the priority needs of the populations, and the cultural and social aspects of the country. There will be a tension between meeting all the priority needs and working within the resources available.
- **Strengthening the effectiveness of the Single National Registry (Registre National Unique) to improve targeting of beneficiaries.** The registry has a cross-cutting objective of harmonizing the targeting of beneficiaries across all social protection mechanisms. This will improve the efficiency of the social protection system, especially in monitoring beneficiaries through the system's operational management bodies. It will also improve the integration and interconnection of the different mechanisms, including the management of the beneficiaries of the free health care initiatives within the Ministry of Health, and the evaluation of the impact of the programs on the vulnerability of PNBSF and CEC beneficiaries for their eventual exit from the system.
- **Increase domestic resource mobilization.** There is a need to identify ways to expand fiscal space for health and innovative resource mobilization strategies to facilitate the expansion of protection mechanisms and the inclusion of more beneficiaries. Sustained actions must be taken by all the actors, including the communities, to mobilize domestic resources to achieve appropriate financing to cover the estimated needs of social protection in Senegal, which is estimated at 7 percent of gross domestic product.

- **Social protection mechanisms are spread across several ministries with fragmented functions and missions.** It is necessary to provide Senegal with a global approach to social protection with sub-mechanisms that will enable harmonization of efforts with a clear definition of vision and directions within a single institutional, legal, and steering framework. There is a deficit in the institutionalization of social protection policies, particularly in high-level implementation, coordination, and alignment of interventions to optimize results.

Recommendations for designing interventions and targeting the poor and vulnerable

When designing a social health protection intervention, countries face multiple and often competing barriers, as well as the concerns of limiting the cost of the intervention or ensuring financial viability. Design decisions often represent trade-offs; for example, greater benefits for the target population to entice enrollment, increase use of health services, and improve overall health must be balanced against the cost of the program, financial health of the program, and ability of health service providers to deliver the benefits. As such, there are often no 'correct answers' to the design decisions, but the decisions must be made in the context of a particular health and socioeconomic system. Even where there seems to be some consensus in the literature found for this review, such as household enrollment, it is not clear that this consensus is applicable in all cases.

With the above caveats, we highlight some of the intervention design decisions common across many of the interventions.

1. *To what extent and how to engage the community:* In Senegal, community involvement has been critical for awareness-raising about CBHI and in enrolling the population. The community plays an important role in identifying eligible populations and this has strengthened the implementation of the country's social protection schemes. Across the literature, the community has been critical for awareness-raising, supporting enrollment through community-based enrollment locations, running community-based clinics and providing community-based services. As an overall lesson, to enable community actors to participate more effectively in social protection mechanisms, the leadership capacities of community actors often benefit from professionalization and strengthening.
2. *How to raise awareness:* Gaps in understanding and lack of awareness of a social health protection scheme or the services being provided through that scheme are barriers to enrollment and use of health services. Specific strategies countries have used to raise awareness include: mass media campaigns around program benefits, developing radio ads, distribution of informational pamphlets, conducting door-to-door enrollment efforts, using community workers to raise population awareness of available service, providing information to beneficiaries at the time of enrollment, and more.
3. *Whether to include the cost of transportation*: Provision of transport to access health services attempts to overcome the lack of availability of transportation, cost of transport, and/or distance barriers to accessing health care services. Many of the interventions had some examples including a specification for addressing the financial (and in some cases, non-financial) barriers associated with the transportation of people to health facilities, including conditional cash transfers, contracting, removal of user fees, vouchers, social health insurance, and CBHI (the latter two of which can include transportation to health facilities or for referral as a claimable expense). While carrying with it a cost, provision of or payment for transport can also encourage enrollment in financial protection and/or access to health services. The extent to which transport is a barrier for the population targeted by the intervention should also be considered.
4. *Timing and sufficiency of payments*: This decision point involves two aspects: First, collecting payments from people (e.g.,

insurance premiums) is typically more affordable if spread out over time, but administratively more complicated and burdensome if, for example, membership is monthly instead of annually. To some extent, electronic payments have simplified this process, but there still needs to be a decision about what to do in the case of non-payment or similar situations. Related, payments to health service providers can be monthly, annually, or on some other schedule, which may influence providers' behaviors. Second, the amount of payments from (e.g., for premiums or prepayment schemes) or to people (for cash transfer programs) or health service providers (for insurance, user fee exemptions, subsidies of insurance, etc.) are often made in situations with little information about either the adequacies of the payment to influence behaviors or ensure quality health services are provided to people. Monitoring and updating decisions about the amount of payments, as well as development of robust information systems (Hanvoravongchai 2013), are likely needed in many cases. These observations are also reflected in Digital Finance Services for Health: A Global Evidence Review (Mangone et al. 2021). Although digital financial services facilitate financial protection when electronic payment systems are shared across a large group of people and can contribute to improving health systems performance, there is still a need to fund additional studies to examine how models can be used to develop robust information systems and sustainably advance universal health coverage (Mangone et al. 2021).

5. *Who will implement the intervention*: Often decisions have to be made about who will be responsible for different aspects of an intervention. These decisions can include the degree of decentralization (which level of government(s) is funding the intervention, which is implementing the intervention), which parts of the government are responsible (e.g., social health insurance agency, Ministry of Health, Ministry of Finance) for different aspects of the intervention, and to what extent other stakeholders (NGOs, international development partners, local organizations, etc.) will be involved in the design, implementation, and monitoring of the intervention.

6. *Whether to include the private health service delivery sector*: Contracting, subsidizing insurance, reimbursing medical expenses, performance-based financing, prepayment of services, removal of user fees, service vouchers, social health insurance, and CBHI all potentially could involve private sector health service delivery providers. In many cases, private sector health service providers are perceived by the target population as providing better quality health services and may be more accessible to the population. The extent to which the private health sector can further the goals of the intervention needs to be balanced against the costs and ability of the intervention to engage with the private sector.

7. *How to accurately target vulnerable and socially excluded populations*: Individual, household, village, and district-level targeting are all possible. Across the literature, we found a few areas of consensus around the unit of targeting. Household enrollment in interventions emerged as the preferred method of targeting because it does ensure enrollment of the underserved and socially excluded within households; even some targeting based on use of health services use household enrollment (e.g., enrolling the entire household of a pregnant woman, and not just the pregnant woman). Findings from Senegal show indirect targeting (e.g., pregnant women, children, and the elderly) is associated with positive results. Many studies in this review suggest that medical staff at health facilities are not the best placed to implement mechanisms to identify underserved and socially excluded populations, although interventions that target populations using certain types of health services are an exception to this finding. The weakness of health facilities staff in identifying patients is especially acute when identifying members of the target population is in direct conflict with the interests of the health facility—health facility staff in certain settings may not be eager to identify people who do

not need to pay user fees if this means that the health facility will lose revenue. Finally, some degree of monitoring how well an intervention is reaching and being used by a target population is likely necessary, and adjustments to the intervention to ensure higher enrollment of the target population and/or less 'leakage' of program benefits to those outside the target population are likely necessary over time.

Conclusion

As countries continue on the path toward universal health coverage, addressing health inequities and expanding financial protection schemes to include the underserved and socially excluded groups is a critical, albeit complicated, step. The lessons around targeting and intervention design from countries that have already tried to expand coverage and reduce financial and non-financial barriers are critical resources to leverage and use in the quest for protecting individuals from catastrophic financial risk.

References

Capuno, J.J., et al. "Effects of Interventions to Raise Voluntary Enrollment in a Social Health Insurance Scheme: A Cluster Randomized Trial." In *Policy Research Working Paper no. 6893*. 2014, World Bank: Washington DC.

Habib, S.S., S. Perveen, and H.M. Khuwaja, 2016. "The role of micro health insurance in providing financial risk protection in developing countries--a systematic review." *BMC Public Health* 16: 281.

Hanvoravongchai, P., *Health Financing Reform in Thailand: Toward Universal Coverage under Fiscal Constraints*, in *UNICO Studies Series, no. 20*. 2013, World Bank: Washington DC.

Johns, Benjamin, Heather Cogswell, Neha Acharya-Harless, Rachel Rosen-DeLong, Sarah Gonzalez. The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ. September 2021. *Expanding Financial Protection to Underserved and Socially Excluded Populations: A Global Evidence Review*. Rockville, MD: Abt Associates.

Kawabata, K., K. Xu, and G. Carrin. 2002. "Preventing impoverishment through protection against catastrophic health expenditure." *Bull World Health Organ* 80, no. 8: 612.

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ. June 2022. *Expanding Financial Protection by Addressing Non-Financial Barriers: Senegal Case Study*. Rockville, MD: Abt Associates.

Mangone, E., P. Riley, and K. Datari, *Digital Financial Services for Health: A Global Evidence Review*. 2021, USAID Local Health System Sustainability Project, Abt Associates Inc.: Rockville, MD.

Rao, K., et al., 2019. "Vulnerable Populations and Universal Health Coverage.", in Leave No One Behind: Time for Specifics on the Sustainable Development Goals, edited by H. Kharas, J. McArthur, and I. Ohno, Editors. 2019: p. 129-148, Brookings Institution Press: Washington DC.

USAID. 2015. "Hapsatou spends time with her daughter." Senegal. Flickr photo. Accessed June 27, 2022 from https://www.flickr.com/photos/usaid_images/18088330034/in/album-72157654418122445/

USAID. 2013. "Team of young Ugandan boys." Senegal. Flickr photo. Accessed June 27, 2022 from https://www.flickr.com/photos/usaid_images/9790874463/

Xu, K., et al., 2003. "Household catastrophic health expenditure: a multicountry analysis." *Lancet*, 2003. 362, no. (9378): p. 111-7.

(Photo: USAID 2015)

The Local Health System Sustainability Project (LHSS) under the United States Agency for International Development (USAID) Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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