

Building Integrated Social Health Protection Systems: Addressing Fragmentation and Ensuring Continuity of Coverage over the Life Cycle in the MENA Region

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Abstract :

Social health protection (SHP) is a key component of universal social protection systems and a critical instrument for advancing universal health coverage. In the Middle East and North Africa (MENA) region, however, social health protection is often characterised by high levels of fragmentation across legal frameworks, institutions, financing arrangements and public policies. This fragmentation contributes to persistent gaps in effective coverage, inequity, and frequent interruptions of health protection over the life cycle. The objective of this article is to examine the concept of integrated social health protection and to analyse how integration can ensure continuity of coverage, equity in financing and in accessing health care benefits, and enhance administrative efficiency in the MENA region. The methodology draws on international social security standards, comparative international experiences and analytical work. The article analyses integration across four interrelated dimensions: legal and regulatory frameworks, governance and administration, financing and risk pooling, and policy coherence across social protection branches and national development policies. The article highlights that fragmentation weakens the effectiveness of social protection responses to lifecycle risks overall. By contrast, integrated systems facilitate extension of coverage and maximise health outcomes. The article contributes a structured analytical framework to support policymakers and institutions in the MENA region in designing and implementing more coherent and life-cycle-oriented social health protection.

Keywords: integrated social health protection, universal social protection, MENA region, Universal Health Coverage, human right

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1. Introduction

Social health protection is a key component of universal social protection and a key instrument for advancing universal health coverage. In this article, SHP is understood as a “series of public measures (or publicly organized and mandated private measures) against social distress and economic loss caused by the cost of necessary treatment, reduction of productivity, or stoppage or reduction of earnings that can result from ill health” (ILO, 2008).

Around the world, SHP coverage has expanded, yet arrangements often remain fragmented across legal frameworks, institutions, financing, and policies (ILO 2021; ILO, 2024g). This fragmentation maintains inequities and gaps in effective coverage and can interrupt protection over the life cycle. Individuals may face discontinuity in access to protection, while institutions contend with duplication, weak coordination, and inefficiencies that undermine equity and performance.

Against this background, the article examines how integrated SHP can reduce fragmentation and ensure continuity of coverage over the life cycle in the MENA region, while strengthening equity and administrative efficiency in line with international social security standards. It asks how “integration” can be operationalized beyond institutional consolidation; which dimensions of fragmentation—legal, institutional, operational, financial, and linkages with other social protection branches and broader policy coherence—should be addressed; and how international standards on social protection can guide reform options.

Methodologically, the article adopts a normative and comparative analysis approach grounded in relevant international standards and a review of international and regional experience. The article clarifies the concept of integrated SHP and its normative foundations, examines key forms and consequences of fragmentation, and discusses integration pathways and mechanisms relevant to the MENA region to strengthen continuity of coverage, equity in financing and access, and administrative efficiency, before concluding with implications for policy design and implementation.

2. Conceptualising integrated social health protection

2.1 Integrated social health protection as a design concept

Integrated social health protection refer to arrangements in which the legal framework, policy instruments, financing mechanisms and governance structures governing health protection and operational arrangements are internally consistent, aligned and mutually reinforcing. Integration implies that these different elements function coherently as part of a unified

system rather than as disconnected or parallel components. From this perspective, integration is not primarily defined by an institutional model or by the existence of a single scheme, but by the degree of coordination and convergence within and across the building blocks of social health protection, enabling universal and equitable access to health care.

A second central feature of integrated social health protection is its embedding within a comprehensive social protection system. Health protection, or medical care as referred to in the ILO social security (minimum standards) convention, 1952 (C.102) constitutes one of the core life contingencies addressed by social security, alongside income security risks such as sickness, maternity, unemployment, employment injury, disability and old age benefits. Conceptually, this implies that social health protection cannot be designed or implemented in isolation. Instead, it must be understood as an integral component of a broader system that combines financial protection for access to health care with income replacement that compensate for the loss of income resulting from an incapacity to work. Integration therefore requires coordination across all social protection branches, institutions and policies that jointly shape individuals' exposure to risks and their ability to cope with them. Indeed, this system perspective stems from a life-cycle approach to social protection: individuals' health and social protection needs are unpredictable and evolve over time, shaped by social determinants of health – “the conditions in which people are born, grow, work, live and age” (WHO 2013)- and by transitions related to education, entry or not into the labour market, employment status, family structure, and by lifecycle risks such as maternity, sickness, disability, unemployment and old age. An integrated social health protection is one that is capable of accompanying individuals throughout these transitions, ensuring that access to health care is maintained irrespective of employment status, income level or eligibility for specific schemes. Continuity of coverage over the life cycle thus stands as a central objective of integration.

A third critical dimension is the close coordination between social health protection, health policy and the organization of medical care, so that benefits coverage, revenues pooling, strategic purchasing and service-delivery arrangements all contribute to the same objective: ensuring effective access to affordable, quality care across levels of care without financial hardship, while avoiding fragmented risk pools, duplicative administrative structures and misaligned incentives that undermine continuity of care, equity and overall efficiency. Beyond policy coherence, this requires strong institutional and operational coordination to ensure that the services included in the benefit package are actually available and of adequate quality at health facilities, and that social health protection institutions and providers apply coherent arrangements for provider payment, referral, eligibility verification, data sharing, reporting and claims administration. At the financing level, it also requires a national health financing

strategy that aligns revenue mobilization, pooling and purchasing across schemes and levels of care.

Finally, a further dimension of integration concerns strategic coherence between social health protection and broader sectoral policies that shape health status and exposure to life cycle risks. From an integration perspective, social health protection must be conceived as a core investment embedded within national development strategies. To start with, integrated policy frameworks are characterised by intentional alignment between social health protection with gender and family policies, disability policies, occupational safety and health frameworks and other sectoral policies addressing the social determinants of health. Such coordination strengthens the preventive and protective functions of social health protection by ensuring that health risks are addressed both *ex ante* through regulation, prevention and sufficient government budgetary allocation to the sector, and *ex post* through access to quality healthcare without financial hardship. This is particularly important because many social determinants of health (such as housing, education, nutrition, water and sanitation, care responsibilities, employment conditions) sit outside the health sector and shape both exposures to risks and people's ability to seek and adhere to care (WHO, 2010). Integration also requires a shared vision with employment and labour market policies, enabling inclusive coverage for all, including workers in diverse and new forms of employment, migrant workers, persons with disabilities so to ensure universality of coverage, regardless of the employment situation.

Hence, an integrated approach between social health protection, broader social protection and sectoral policies helps address upstream drivers through coordinated income support and services, while also reducing non-medical barriers (e.g. transport, caregiving time, and loss of earnings) and negative coping strategies that can otherwise undermine effective access and health outcomes, especially for those living in poverty or in precarious employment (ILO, 2022a). In this sense, policy coherence constitutes a central pillar of integrated social health protection arrangements, reinforcing their effectiveness, sustainability and capacity to prevent and alleviate poverty, vulnerability and social exclusion resulting from ill health.

Within this conceptual framework, integration operates across several interrelated dimensions. *At the policy level*, integration requires alignment between social health protection and broader public policies that influence health risks and life cycle risks and condition how people are covered through social health protection schemes. *At the legal and regulatory level*, integration implies the existence of clear and coherent statutory provisions that define rights and obligations in a consistent manner and establish linkages across social protection branches. *At the institutional level*, integration refers to governance and administrative arrangements that enable coordination between responsible entities and

schemes, whether through unified institutions or through structured mechanisms for collaboration and information sharing. *At the financing level*, integration is associated with arrangements that support solidarity in financing and risk pooling, allowing resources and risks to be redistributed across population groups and over time. Finally, at the *operational level*, integration concerns the administrative and service-delivery arrangements that connect social health protection schemes with health-care providers and with other social protection branches, for coordinated enrolment, eligibility control, referral pathways, provider payment, claims processing and interoperable information systems, so that entitlements in law result in effective access to quality care in practice, continuity of coverage across life-cycle, and an appropriate combination of health care and income protection where needed.

Conceptualising integrated social health protection also requires recognising diversity in national institutional arrangements and development paths. Integration does not prescribe a single model or institutional architecture. Countries may pursue integration through different combinations of measures including legal harmonisation, institutional consolidation, coordinated governance, depending on historical pathways, fiscal capacity and administrative structures. What matters is not uniformity, but the capacity of the system to function coherently and to ensure that individuals are protected without interruption as they move through different social, employment and economic situations.

Lastly, integration should not be understood as a purely technical or administrative objective. Embedded in the international labour standards, this reflects a vision of social protection as a system designed to ensure universal coverage all along the life cycle. Hence, integration serves as a mean to operationalise core principles such as universality, adequacy and continuity of protection, rather than as an end in itself.

2.2 International normative guidance for integrated social health protection

International social security standards provide a strong normative foundation for the development of integrated social health protection. The ILO's normative framework promotes a systems-based and life-cycle approach of social protection, in which social health protection is embedded within a coherent and coordinated social protection system. In particular, the Social Security (Minimum Standards) Convention, 1952 (No. 102), and the Recommendations on Social Protection Floors, 2002 (No.202) provide guiding principles that support integration across legal frameworks, institutions, financing arrangements and policies, while allowing gradual implementation according to national circumstances.

Consistent with the principles set out in the Medical Care Recommendation, 1944 (No. 69), the Convention 102 establishes medical care as one of the nine core contingencies of social

security and sets health protection alongside income security benefits such as sickness, maternity, unemployment, employment injury, disability, survivorship and old age. By defining these contingencies within a single international instrument, Convention No. 102 implicitly promotes an integrated approach to social protection, recognising the interdependence between access to health care and income security over the life cycle. Maternity Protection Convention, 2000 (No. 183) and Medical Care and Sickness Benefits Convention, 1969 (No. 130) further strengthen these necessary complementarities of medical care with maternity and sickness income protection. Furthermore, Employment Promotion and Protection against Unemployment Convention, 1988 (No. 168) as well as Invalidity, Old-Age and Survivors' Benefits Convention, 1967 (No. 128) requires that level of benefits be sufficient to ensure healthy and reasonable living conditions (art 16, C168) or shall be sufficient to maintain the family of the beneficiary in health and decency (art 27, C128). This integrated framing underscores the importance of coordination across branches, particularly during periods when health needs and income loss are complementary, such as maternity, sickness or employment injury. Building on this foundation, the Social Protection Floors Recommendation, 2012 (No. 202), explicitly calls on countries to establish nationally defined social protection floors that comprise access to essential health care *and* basic income security for all. Recommendation No. 202 emphasises universality, adequacy and continuity of protection, while stressing the need for coherence, coordination and complementarity across schemes and institutions. It promotes an integrated approach in which contributory and non-contributory mechanisms are complementary, supported by solidarity-based financing and State responsibility. Finally, it supports policy coherence beyond the boundaries of social protection systems by stressing the importance of coherence with social, economic and employment policies. In doing so, it provides normative guidance for addressing coverage gaps and ensuring continuity of social health protection across different population groups and employment statuses. Finally, ILO Medical Care Recommendation, 1944 (No. 69) provides a framework for coordination between social health protection and healthcare services, and particularly envisage social insurance medical care as closely coordinated with general health services, including regarding financing and access to services, choice of primary provider and continuum of care.

Importantly, as mentioned above, the ILO normative framework does not prescribe a single institutional model for integrated social health protection. Instead, it provides a set of principles, such as legal entitlements, predictability of benefits, solidarity in financing, State responsibility, coordination across institutions and continuity of protection, that can inform countries along diverse reform paths. In this sense, international standards, whether ratified or not, serve as an enabling framework for national dialogue and policy design, supporting gradual and context-specific approaches to integration.

Overall, the ILO international normative framework provides essential guidance for countries seeking to reduce fragmentation, strengthen continuity of coverage and advance universal social protection in line with national priorities.

Across the MENA region, conceptualisation of integration in social health protection matters because many countries experience fragmentation in their social health protection systems, although its forms and intensity vary considerably. This reflects the fact that many national arrangements have developed through institutionally segmented schemes, often with separate rules, financing arrangements and administrative systems for different population groups, leading to uneven entitlements and persistent gaps in effective coverage (Axelson, Tessier, 2022; Bergthaller, Tessier, 2025; ILO, 2020b). At the same time, the MENA region continues to face high employment informality and low labour force participation (ILO, 2024a; ILO 2024f) and, as the world of work diversifies, including the expansion of new forms of employment, social health protection schemes must be strengthened and adapted to ensure continuity and portability of coverage over the life cycle, in line with the ILO's rights-based approach and the objective of progressively extending social protection to all, including access to essential health care under national social protection floors.

This conceptualisation sets the stage for a more detailed examination of fragmentation and its implications, as well as for an analysis of integration pathways and policy responses in subsequent sections.

3. Fragmentation in social health protection: dimensions and consequences

Despite their central role in advancing universal health coverage, social health protection in many countries remains characterised by high levels of fragmentation. Fragmentation refers to situations in which the legal, institutional, operational, financial and policy components of social health protection operate in parallel or in isolation, with limited coordination or coherence. Rather than functioning as parts of an integrated system, these components evolve separately, often in response to short-term policy objectives or sector-specific priorities.

3.1 Legal fragmentation

One key dimension of fragmentation relates to the legal and regulatory framework governing social health protection. Fragmentation at this level occurs when multiple laws, decrees and regulations govern access to health protection and related benefits without sufficient coordination or harmonisation. Different population groups may be covered under separate

regimes and schemes, with distinct eligibility rules, contribution requirements and benefit entitlements. Such arrangements can result in inequities and gaps in legal coverage, overlapping provisions or unclear responsibilities, weakening the clarity and enforceability of rights and obligations. Legal fragmentation also constrains the portability of entitlements across schemes and over the life cycle, making it difficult for individuals to maintain health coverage when their employment or income level change.

3.2. Institutional fragmentation

Institutional fragmentation constitutes a second major dimension. This arises when multiple institutions are responsible for providing or administering social health protection to specific population groups and/or geographic areas, with limited coordination among them. Separate institutions may manage schemes for public sector workers, private sector employees, self-employed workers or low-income populations, each operating under its own benefits structure, administrative procedures and information systems. Separate schemes may provide coverage based on geographic areas. Institutional fragmentation increases the risk of individuals losing coverage when they no longer meet the eligibility criteria of a particular scheme, such as during periods of unemployment, transition between formal and informal employment, or change their geographic location. It also contributes to inequalities in access and benefit levels, as different institutions may apply different rules and standards. From an administrative perspective, institutional fragmentation often leads to duplication of functions, higher operational costs and reduces efficiency. Finally, over time, these inefficiencies undermine public confidence in social health protection schemes and constrain progress towards universal health coverage.

3.3. Fragmentation in financing

Fragmentation is closely intertwined with the way social health protection is financed. Fragmented financing arrangements typically involve the existence of multiple, separate financing pools or funds linked to distinct schemes or population groups. This results in fragmented risk pooling, weakening financial solidarity by limiting the redistribution of risks and resources across individuals with different income levels, health risks and employment statuses. Ultimately, fragmentation in financing increases inequities in access to social health protection. Fragmented financing also complicates transitions between schemes, as contribution histories and entitlements may not be easily transferable. As a result, individuals

may experience interruptions in coverage or face administrative barriers when moving between schemes.

3.4 Fragmentation with the health sector

Another important dimension of fragmentation concerns the relationship between social health protection and the health sector. Even where individuals are formally covered, social health protection cannot effectively protect them from catastrophic health expenditures if the services to which they are entitled are not actually available, accessible, acceptable and of adequate quality, which often result from underinvestment in health services. Fragmentation in this area arises when there is insufficient coherence across policies, financing and operational processes which are affecting both social health protection and the health sector. At the policy level, this may concern the definition of the benefit package and entitlement rules, creating gaps between services that are covered and those that are effectively provided. At the financing level, weak coordination between government budget allocations to health facilities, social health protection payments to providers and out-of-pocket payments can generate inefficiencies and undermine financial protection. At the operational level, interruption of coverage may result from weak alignment in provider contracting and payment mechanisms, poorly coordinated provider networks and referral pathways, limited quality assurance, and the absence or weak interoperability of information systems for beneficiary identification, eligibility verification and claims processing. Such fragmentation reduces efficiency, weakens continuity of care and ultimately limits progress towards universal health coverage.

3.5. Fragmentation within the overall social protection system

A further dimension of fragmentation concerns weak or missing linkages between social health protection and other branches of the social protection system. In many contexts, health protection operates separately from income-replacement benefits such as maternity, sickness, unemployment or employment injury benefits. When institutional and financial coordination across branches is limited, individuals may not automatically retain health coverage during periods when they receive income support. This lack of coordination undermines the effectiveness of social protection as a whole, as income security is not combined with access to necessary health care. For instance, gaps in social health protection during maternity or sickness undermine the effectiveness of cash benefits, as income support is not combined with access to necessary healthcare.

3.6. Fragmentation within national and sectoral development policies

Policy fragmentation represents another critical and often overlooked dimension. It refers to the absence of strategic alignment between social health protection policies and broader national policy frameworks that should lead to inclusive and sustainable economic growth and decent work. In fragmented policy environments, national development plans do not consistently recognise social health protection as a core investment in human and economic development.

From a systems perspective, social health protection's performance and sustainability are closely influenced by policies in areas such as gender and family protection, occupational safety and health, disability and care, and public health, employment and labour market regulation. Cross-sectoral integration is therefore essential to ensure that social health protection functions as part of a preventive policy framework, rather than as a residual mechanism responding to avoidable risks.

A key analytical distinction in this regard lies between *ex ante* and *ex post* approaches to health risk management. *Ex ante* policies aim to reduce the likelihood and severity of health risks before they materialise, through regulation, prevention, protection and social investment. *Ex post* interventions, by contrast, address the consequences of risks once they have occurred. In integrated policy environments, these two dimensions are necessary and mutually reinforcing. Social health protection complements preventive and protective policies by ensuring financial protection to avoid impoverishment resulting from health care costs, while *ex ante* policies reduce avoidable health risks and contain long-term costs. Where policy coherence is weak, however, social health protection is increasingly expected to compensate for risks and vulnerabilities that could have been reduced through coordinated preventive policies. This shifts the burden toward more costly curative care, placing additional pressure on health financing and service delivery systems, and is associated with poorer health outcomes, with ripple effects on productivity and the economy as a whole.

This dynamic is particularly evident when social health protection is weakly aligned with *employment and labour market policies*. In contexts where labour market regulation does not adequately address informality, non-standard employment or transitions between employment statuses, large segments of the workforce remain outside contributory arrangements, may remain unprotected in the absence of non-contributory arrangements, or put fiscal pressure on Government to extend subsidies to populations whose exclusion is driven by broader labour market structures rather than individual circumstances. Hence, in the absence of coordinated employment and social protection policies, social health protection

bears the downstream consequences of labour market fragmentation, placing additional pressure on financing and administrative capacity.

Similar dynamics arise in the absence of effective coordination with *gender and family policies*, particularly regarding maternity protection. When maternity leave, income replacement during maternity and employment protection are weak or poorly enforced, women may face incentives to return to work prematurely or to forgo necessary antenatal and postnatal care (ILO, 2009). The resulting health risks are then absorbed by social health protection schemes in the form of increased demand for medical care and higher costs. In such contexts, social health protection functions as an ex post compensatory mechanism for gaps in maternity protection, rather than as part of a coherent package combining income security, employment protection and health coverage.

Occupational safety and health policies provide another illustration of the importance of cross-sectoral integration (ILO, 2024b). Where preventive measures, regulation and labour inspection are insufficient, preventable work-related injuries and diseases increase, particularly in high-risk sectors and informal employment. Social health protection schemes are then required to finance treatment and rehabilitation for risks that could have been mitigated through stronger ex ante interventions. Without effective coordination between occupational safety and health systems and social health protection, the burden of avoidable occupational risks is shifted downstream, undermining both prevention gains and financial sustainability.

The absence of income protection during periods of *sickness or unemployment* further reinforces this ex post dynamic. When income-replacement mechanisms are weak or fragmented, individuals may delay or avoid seeking care due to income insecurity, leading to the deterioration of health conditions and higher treatment costs when care is eventually accessed (ILO, 2020a). In such cases, social health protection schemes face increased financial pressure due to delayed utilisation and more complex health needs.

Cross-sectoral incoherence also emerges in relation to *disability and long-term care policies* (ILO, 2024d; ILO 2024d; ILO 2024e, ILO&UNICEF, 2023). When early intervention, rehabilitation, assistive services or long-term care arrangements are underdeveloped, social health protection schemes are often expected to finance repeated medical interventions for conditions that require social care, workplace adaptation or community-based support. This confusion of responsibilities weakens the effectiveness of both health and social policies and illustrates how insufficient ex ante coordination increases reliance on ex post medical responses.

Taken together, these dynamics highlight that policy coherence is not an optional complement to integrated social health protection, but a core condition for its effectiveness and sustainability. When social health protection is embedded within a coherent policy framework that prioritises prevention, regulation and social investment, it can fulfil its intended role as a pillar of universal and continuous social protection. Strengthening cross-sectoral integration is therefore essential to rebalance social health protection towards a more preventive, efficient and sustainable model of protection.

4. Integration as a policy response: pathways and mechanisms in the MENA region

4.1. Status of social health protection in the MENA region

Most social health protection systems in the MENA region rely on mixed financing arrangements, combining social insurance contributions with tax-financed public subsidies or direct public provision to varying degrees, although some display stronger Bismarckian features, such as Morocco and Tunisia, while others are closer to Beveridgean or tax-financed models, particularly Algeria and Oman..

Social health protection coverage has increased over the years across the region, although important differences remain between subregions. As of 2023, 72.3 percent of the population in the MENA region is protected by social health protection, much above the global average of 60.1 percent. This represents a significant increase from 66.7 percent in 2020. It is also higher than the proportion of the population covered by at least one social protection benefits (SDG indicator 1.3.1; excluding health), which stood at 44.7 per cent in the MENA region. However, achievements remain highly uneven across subregions. Northern Africa records high social health protection coverage (73.3 per cent) and the fastest improvement since 2020 (up from 63.5 per cent). In the Arab States, coverage is lower (52.1 per cent) despite notable gains since 2020 (40.4 per cent). Inequalities within the Arab States are particularly pronounced: GCC countries maintain comparatively high coverage (80.4 per cent), while non-GCC countries remain far behind at 27.7 per cent, with virtually no change since 2020. Overall, these contrasts underline that progress in coverage is advancing at different speeds across the region, leaving substantial population groups without access to social health protection (ILO 2024g).

On average, the level of catastrophic health expenditures is moderate in the MENA (WHO definition) with 14.1 percent of households spending more than 10 percent of their household budget on health (WHO, 2025). However, the average hides wide disparities across countries.

The indicators show a clear contrast across subregions. Gulf countries generally combine relatively low out-of-pocket expenditure with comparatively stronger public financing capacity: OOP ranges from around 6.3 per cent in Oman to 14.1 per cent in Saudi Arabia, although Bahrain is higher at 28.6 per cent; domestic general government health expenditure ranges from about 2.1 per cent of GDP in Qatar to 4.4 per cent in Saudi Arabia. By contrast, North African countries still record substantial household out-of-pocket payments, even where effective coverage is relatively broad: OOP ranges from 19.2 per cent in Libya to about 57 per cent in Egypt, with Algeria, Morocco and Tunisia standing at around 37–45 per cent. Domestic general government health expenditure in North Africa also varies widely, with most countries falling between roughly 1.6 and 4.3 per cent of GDP with a maximum of 6.3 per cent of GDP in Libya. The situation is most acute in fragile and low-income contexts such as Yemen, Sudan and Syria, where very high OOP expenditure – 69.1 per cent in Yemen, 57.4 per cent in Sudan and 72.4 per cent in Syria – combined with low public health expenditure – 0.8, 0.6 and 0.4 per cent of GDP respectively – points to severe effective coverage gaps and major fiscal constraints (World Bank, 2026).

Along with population coverage and financial protection, the availability of essential healthcare services is a fundamental component of universal health coverage. In Middle East and Northern Africa (World Bank definition), progress on availability of services, measured by the Service Coverage Index (SCI, SDG target 3.8.1), have stalled between 2019 and 2021, from 68 to 69. Analysis shows that progress and deficits in service coverage are unevenly distributed across countries, with major achievements observed in UAE and Israel (SCI at 80+) while access to essential services remains a challenge in Iraq, Sudan and Yemen (SCI < 60) (WHO, 2025)

A further structural challenge concerns the interaction between health needs, health financing and effective access to care. Earlier regional evidence shows that the MENA region faces a high burden of non-communicable diseases and injuries, together with risk factors such as obesity, raised blood glucose, raised blood pressure and smoking that exceed global averages in many countries. At the same time, public health expenditure has often not kept pace with economic growth, while out-of-pocket payments remain high in many non-GCC and lower-income countries. This suggests that progress in social health protection coverage must be accompanied by stronger public financing, expanded prepayment and pooling arrangements, and closer integration with preventive public health policies and service-delivery reforms, so that coverage translates into effective access to quality care without financial hardship (Asbu, 2017).

4.2. Regional approaches to integrated policy solutions in MENA

Rather than addressing shortcomings in isolation, integration focuses on improving how the different components of social health protection function together as part of a coherent system. From this perspective, integration seeks to align schemes design and implementation across multiple dimensions so that legal frameworks, governance arrangements, operational measures, financing mechanisms and policy instruments are mutually reinforcing and support shared objectives.

A first pathway for integration concerns the legal and regulatory framework governing social health protection. Integration at this level involves establishing clear and consistent statutory provisions that harmonise rights and obligations across schemes and population groups, facilitate inclusive eligibility rules and enable portability of entitlements across employment statuses and life-cycle transitions. Egypt's Universal Health Insurance Law (Law No. 2 of 2018) provides an example of integration through the legal and regulatory framework. The law establishes a single statutory basis for a comprehensive health insurance with mandatory enrolment for all citizens, with mix financing mechanisms, grounded in social solidarity. The enactment of this law addresses the legacy of previous fragmentation where various laws covered specific groups under parallel legal arrangements, leaving large segments outside effective health protection (ILO, 2022).

A second key mechanism relates to governance and administrative arrangements. Morocco illustrates integrated governance through institutional consolidation: the Code of Basic Medical Coverage (Law No. 65-00) designates the Caisse Nationale de Securite Sociale (CNSS) as the managing body for mandatory health insurance (AMO) for persons insured under the social security regime, thereby anchoring AMO administration within a single social security institution. This consolidation has been reinforced by Law No. 54-23 (Official Bulletin No. 7478, 29 January 2026), which provides for the transfer of the public-sector AMO management-related assets and records from CNOPS to CNSS, an illustration of the institutional consolidation pathway underpinning integrated governance.

However, integrated governance does not necessarily imply institutional consolidation, but rather effective coordination between entities responsible for social health protection. This may include shared administrative structures, coordinated enrolment processes or clearer allocation of institutional mandates. Reforms undertaken in Egypt illustrate strengthening of institutional coordination, including the centralisation of contribution collection, the clarification of purchasing and provision roles, and the reduction of administrative overlap. Indeed, the Universal Health Insurance Law (Law No. 2 of 2018) establishes the core institutional architecture of the reformed arrangements, with the Universal Health Insurance Authority ensuring purchasing function alongside separate provider (Egypt Health Care Authority) and accreditation/regulatory bodies (General Authority for Healthcare

Accreditation and Regulation), creating clearer legal foundations for coherent governance, thereby improving efficiency and coherence in the management of social health protection.

Financing and risk pooling constitute a third central pathway for integration. Across the MENA region, financing arrangements remain fragmented to varying degrees (WHO, 2019), but reforms are underway to expand pooling and strengthen solidarity. In Algeria, despite multi-actor institutional architecture, free access to care in the public health system (financed predominantly through the State budget) enables broad risk pooling through public financing, complemented by pre-determined annual amount paid from the social security funds (CNAS/CASNOS) to public health facilities^{1,2} (Boukhedimi, 2025; ISSA, 2024). In Morocco, the integration of different population groups under the compulsory AMO framework has been accompanied by differentiated contribution arrangements reflecting contributory capacity, combined with state-financed coverage for vulnerable groups^{3,4,5,6} (IMF, 2024). This approach is a step towards enhanced risk pooling while supporting the progressive universalisation of coverage. In Tunisia, the 2004 reform established the National Health Insurance Fund (CNAM) to unify the management of compulsory health insurance for public- and private-sector workers within a single national fund. Contributions support broader pooling within the contributory scheme, strengthening solidarity and redistribution through a single purchaser. However, non-contributory coverage for poor and vulnerable households (AMG1/AMG2 cards) remains outside the CNAM, maintaining parallel financing and unclear pooling levels. (Safa, 2022)

Integration also operates through mechanisms that explicitly support continuity of coverage over the life cycle. Experiences such as the integration of subsidised coverage for poor and displaced populations within Sudan's national health insurance arrangements prior to the conflict illustrate how explicit linkages between social assistance and health insurance can help maintain coverage for vulnerable groups across changing circumstances. (ILO, 2025). In

¹ *Loi n° 18-11 du 2 juillet 2018 relative à la santé*, Journal officiel de la République algérienne, n°46, 29 juillet 2018

² *Loi n° 23-22 du 24 décembre 2023 portant loi de finances pour 2024*, Journal officiel de la République algérienne, n°86, 31 décembre 2023

³ Royaume du Maroc, Secrétariat Général du Gouvernement (2002), *Dahir n° 1-02-296 du 25 rejev 1423 (3 octobre 2002) portant promulgation de la loi n° 65-00 portant code de la couverture médicale de base* (Bulletin officiel n° 5058, 16 ramadan 1423 / 21 novembre 2002), detailed website: https://www.sgg.gov.ma/Portals/0/lois/couv_med_fr.pdf (consulted on 01/03/2026)

⁴ Royaume du Maroc, Secrétariat Général du Gouvernement (2022), *Bulletin officiel, Dahir chérif n° 1.22.65 du 30 rabii II 1444 (25 novembre 2022) portant promulgation de la loi n° 27.22 modifiant et complétant la loi n° 65.00 portant code de la couverture médicale de base* (Bulletin officiel n° 7147 bis, 5 jourmada I 1444 / 30 novembre 2022)

⁵ Royaume du Maroc, Secrétariat Général du Gouvernement (2021), *Bulletin officiel, Dahir n° 1-21-30 du 9 chaabane 1442 (23 mars 2021) portant promulgation de la loi-cadre n° 09-21 relative à la protection sociale* (Bulletin officiel n° 6975, 22 chaabane 1442 / 5 avril 2021)

⁶ Royaume du Maroc, Agence Nationale des Registres / Autorité Nationale du Soutien Social (ANSS) (2022), *Loi-cadre n° 09-21 relative à la protection sociale (traduction officielle en langue française)*, detailed website: https://www.anss.gov.ma/sites/default/files/decrets/loi-cadre_09-21_FR.pdf (consulted on 01/03/2026).

Morocco, the AMO is organised with several “entry points”, defined mainly by employment status and contributory capacity. Private-sector employees fall under the AMO managed by the CNSS, while public-sector employees are covered by the CNOPS⁷. Self-employed workers access AMO through contributory arrangements defined by professional categories. Finally, specific pathways cover people previously outside contributory insurance, notably AMO-Tadamon (state-financed solidarity coverage) and AMO-Chamil (contributory affiliation for certain people without employment) (CESE, 2024). Overall, this multi-entry design helps ensure continuity of coverage across life-course and labour-market transitions, as individuals’ employment situations change. In Egypt, the National Organisation for Social Insurance is responsible to make health social insurance contribution for the unemployed entitled to unemployment compensation, ensuring continuity of coverage through periods of unemployment⁸, hence reducing health-related barriers to job search, maintaining work capacity and supporting return to employment.

An important pathway is coordination between social health protection and health policy and service delivery systems to ensure that insured persons can effectively access quality health-care services, and countries in MENA are progressively moving towards this direction. At the policy level, Jordan Ministry of Health’s Strategic Plan 2018–2022, aligned with Jordan Vision 2025 and the Executive Plan to Reform the Health Sector, links the provision of preventive and curative health services to the objective of achieving universal health coverage, while also prioritizing stronger primary health care and improved service quality (Ministry of Health, 2018). At the governance level, the Egyptian institutional set up mentioned above also provides a clearer institutional separation between purchasing, service provision and accreditation/regulation thereby clarifying responsibilities across government agencies and strengthening coordination between social health protection and the health sector. At the operational level, Saudi Arabia provides a strong example of integrated health and insurance information systems through NPHIES, a centralized platform that enables standardized data exchange hereby facilitating eligibility verification and electronic claims processing between providers and payers⁹.

Finally, integration extends beyond social health protection itself and encompasses coherence with other sectoral policies that shape health risks and protection needs. Strategic alignment with public health, gender, disability, occupational safety and health and environmental policies strengthens the preventive and protective functions of social health protection. Saudi

⁷ CNOPS continues to administer the public-sector compulsory health insurance scheme (AMO) on a transitional basis. Law No. 54-23, which provides for the transfer of CNOPS to CNSS, has been adopted and establishes a one-year transition period to allow for the adjustments required for the transfer of the scheme. The transfer is scheduled to take effect in March 2027.

⁸ Arab Republic of Egypt (2019), *Social Insurance and Pensions Law promulgated by Law No. 148 of 2019*, First edition, Egypt.

⁹ <https://portal.nphies.sa/ig/toc.html>, accessed on 18 March 14h26

Arabia's Vision 2030 provides an example of such cross-sectoral alignment, in which health, social protection and broader social and economic policies are treated as interdependent pillars, reinforcing the role of social health protection within a wider human development and resilience agenda (Kingdom of Saudi Arabia, 2016).

Taken together, these countries examples illustrate that integration is a multidimensional and incremental process rather than a single reform measure. It involves deliberate choices about scheme design, implementation, coordination and financing, guided by the objective of ensuring universal, continuous and equitable access to health care.

6. Conclusion

Integrated social health protection is increasingly central to the capacity of social protection systems to deliver universal, continuous and equitable access to health care. In contexts characterised by demographic change, double burden of diseases, labour market mobility and evolving social risks, fragmented arrangements are ill-suited to ensure continuity of protection or efficient use of resources. A systems perspective that prioritises coherence, coordination and complementarity across policy instruments is therefore essential.

Experience across the MENA region shows that, despite diverse starting points and institutional configurations, countries have been able to progressively improve integration through incremental reforms that strengthen legal coherence, institutional coordination and financing arrangements over time.

Looking ahead, advancing integrated social health protection calls for moving integration from a conceptual objective to an operational priority. This requires sustained attention to system design choices, institutional coordination and financing arrangements, as well as to the interfaces between social health protection, health care and other public policies that shape health risks and protection needs. Integration should be understood as an incremental and context-specific process, supported by continuous social dialogue, institutional learning and adaptive reforms rather than one-off structural changes.

Future efforts should focus on strengthening administrative interoperability, improving data and information systems to support portability of entitlements, and enhancing coordination across social protection branches and sectors. Greater investment in ex ante risk prevention—through occupational safety and health, gender-responsive measures and disability inclusion—will be critical to reduce pressure on social health protection schemes and improve their long-term sustainability. In this perspective, integrated social health protection can act

not only as a mechanism for financial protection, but also as a stabilising force supporting resilience, inclusive development and social cohesion.

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