The extension of coverage through linked schemes: a typology and several examples

Valérie Schmitt-Diabaté, ILO/STEP

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The extension of coverage through linked schemes: a typology and several examples

① **Access to social protection is far from being a reality**

② **Microinsurance: an instrument to significantly extend social protection coverage?**

③ **A promising approach: the concept of linkages**
- **Potential, definition, typology**
- **Examples of major linked schemes**

④ **Sharing information and knowledge on these experiences is key to develop microinsurance for the poor**

STEP

Access to basic social protection (notably health care coverage) is far from being a reality

Reality

In most public health care providers: lack of consumables and equipments, drugs shortage, poor staff's motivation, poor availability of services, corruption, concentration in urban areas with a focus on secondary health care

Why?

Underfunding of health care supply (public and private)

e.g., 13 up to 24 US $ / person and year << 40 US $ recommended

Public spending of health is low in % of public expenditure

Allocation of public funds on health is not efficient, with a focus on:

Curative care	***instead of***	Prevention and education
Secondary/Tertiary		Primary health care
Urban areas		Rural areas
Staff's salaries		Overhead costs
Vertical approach/disease		Minimum funding/service

Result

Patients go to the private sector (where high out of pocket payments and are forced to use ex post strategies that lead to lasting poverty)

The poor do not have access to basic health care services

Each year 100 million people fall into poverty due to sickness-related costs (WHO)

Microinsurance: an instrument to significantly extend social protection coverage?

A global phenomenon: 78 million people covered in 2006 in 100 countries with a 100% increase by 2012

ILO / STEP's and regional networks' permanent inventories

In western and central Africa : more then 1.9 millions people covered in 2007

In 5 Asian countries : 25,7 millions covered in 2004

In India: 11 millions people covered under health schemes in 2007

www.concertation.org www.amin-net.org www.acym.net

Mechanism	Use among others the mechanism of insurance
Target	Cover excluded (from SSS and private insurance schemes)
Affiliation	Voluntary or automatic affiliation (not compulsory)
Contribution	Con[illegible] supplemented by other sources of funding
Benefit package	Limited benefit package but responding to the priority needs and availability of HC services
Administra-tion	Administrative procedures (enrolment, premium collection) adapted to the context

Common features??

Microinsurance: an instrument to significantly extend social protection coverage?

++	- -
Coverage	
Ability to reach the excluded Ability to identify the poorest	Voluntary basis and marketing complexity → small population covered (3% max)
Protection and solidarity	
Real financial protection (prepayment and risk pooling) Protection adapted to the needs and local characteristics (organization, ability to pay, HC services available) Solidarity at the local level	Limited risk pooling (exceptions) Low ability to pay => limited benefit packages Ceilings and flat rate contributions → reduced solidarity between healthy and sick; rich and poor The poorest are excluded
Participation	
Empowerment of excluded people, increased dignity	

Microinsurance: an instrument to significantly extend social protection coverage?

++	Access and impact on health care supply	- -
Increased access and utilization Prevention, education, promotion Improved quality and availability Transparency of management (fee setting, billing, procedures)		Limited by the weak capacity to negotiate with health care providers on a large scale (lack of bargaining power)

++	Efficiency	- -
Cost effective benefit package (primary and maternal care) Contained transaction costs, short reimbursement delays, little incidence of frauds (social control)		Non professional technical and financial management Non efficient monitoring process nor information systems

++	Environment	- -
		Poorly adapted legal framework, lack of State's involvement, inadequacy of health care supply

STEP

To overcome MI's limitations, a promising approach: linkages

Potential

	Statutory SS schemes &	CBHI schemes
Ability to cover IE workers?	**NO.** Civil servants, workers in employment relationship of a certain level of formality	**YES.** IE workers clustering around certain characteristics (occupational, regional)
Affordability?	**NO.** Relatively high and shared by employers and employees	**YES.** Low levels, corresponding to ability to pay
Well suited benefits?	☺ Comprehensive *But* standardized benefit packages	☹ Limited scope and levels *But* well suited to priority needs
Redistribution?	**YES.** Linked with income	**NO.** Flat rate contributions
Risk pool, financial consolidation?	**YES.** Big and geographical diversified risk pools Steady contribution income flows	**NO.** Small and varying size of risk pool Income difficult to predict
Management & administrative procedures?	☺ Computerized MIS, trained staff *But* high standardization, difficult to adapt to non standard groups	☹ Low level of sophistication and training *But* adapted to characteristics of target, low transaction costs, prevention of fraud
Contracting power?	**YES.** Contracting power and agree-ments at a national / regional scope	**LOCAL.** Contracting power and agreements at the local level
Policy planning	Top down policy approach	Bottom up with / without policy support

To overcome MI's limitations, a promising approach: linkages

Actors involved

- State; MofHealth, MoFinance, MoLabour, MoAgriculture
- Social security institutions, mutuals, CBHIs, private and public insurance companies, reinsurance companies
- NGOs, civil society org°, MFIs, cooperatives
- TPAs (Third Party Administrators), information system and software providers
- Bi- and multilateral agencies, global funds, foundations
- Private corporate sector
- Public and private HCare structures
- Pharmaceutical industry and distribution networks
- Regulation agencies
- Local and regional administration
- Schools, social workers

Various instruments

- Social insurance
- Microinsurance
- Social assistance
- Cash transfers
- Universal benefits

Complementary roles

- Design and costing of the benefit package
- Funding
- Distribution, marketing, communication
- Selection of health care providers
- Assisting insured in the use of HC services
- Management of the portfolio
- Technical and financial management
- Governance and control

→ Concept of linkages: build strategies of extension that use respective advantages of these methods & actors, and develop synergies

To overcome MI's limitations, a promising approach: linkages

Examples

Roles	Shared responsibilities (examples)
Definition of the benefit package	**Colombian subsidized regime:** Regular updates of the subsidized benefit package (POSS) thanks to discussions between the insurers (ARS) and the government
Costing	**Yeshasvini:** Negotiation with health care providers to reduce up front costs of health care services
Financing	**Rwandan national health insurance scheme**: various sources of financing, e.g. premiums, global fund, international NGOs, State **Colombian subsidized regime:** Taxes; solidarity cross contribution from the contributory regime **RSBY scheme in India:** Shared between Central and regional states
Distribution	**Philippine's Kasapi model:** Distribution through cooperatives, with incentives to enrol large numbers
Insurance function	**Indian** Partner-agent model
Technical management	**Outsourcing management** of membership, premium collection, claims and relationship with health care providers: Indian TPAs, Healing fields model

To overcome MI's limitations, a promising approach: linkages

1st example: Yeshasvini

Where?	Karnataka, India
Why?	Dr Shetty, cardiac surgeon. It is possible to extend access to the most sophisticated health care services to the poor
Benefits?	1600 surgeries, OPD, normal deliveries, pediatric care during the first 5 days after birth, stabilization of defined medical emergencies requiring indoor treatment
Nb insured	2.2 million people insured in 2007
Premium	120 Rs / person and year. Discount 15% family of 5.
Decision makers?	Board of 6 trustees (prominent state and private individuals); the chairman is the Principal secretary of the cooperative department
Stake-holders	Government of Karnataka (subsidies: +1/3 of income) Cooperative department (communication) Cooperative societies (enrolment) Cooperative banks (assist in premium collection) FHPL (claims settlement + network of hospital) 320 hospitals (health care provision) *Low admin costs* (Cooperative department, Cooperative societies, Cooperative banks)

To overcome MI's limitations, a promising approach: linkages

1st example: Yeshasvini

Figure 2.1 Organisational Structure of Yeshasvini Cooperative Farmers Health Scheme

Linkages

- Governance
- With health care sector
- Administration
- Financial

To overcome MI's limitations, a promising approach: linkages

2nd example: RSBY (Rashtriya Swasthya Bima Yojana)

Where?	India, 17 States
What?	A subsidized national health insurance scheme for the BPL in India that will rely on health insurance projects in all the districts of the States of India. A new bill was introduced in parliament.
Why?	Majority of the unorganized sector workers (93% of total workforce) are still without any social security coverage
Benefits?	Total sum insured Rs. 30,000/- per family per year Cashless attendance - All pre-existing diseases to be covered Hospitalization expenses, taking care of most common illnesses with as few exclusions as possible Transportation costs (limit of Rs. 100 per visit, overall limit of Rs.1000)
Nb insured	Target : 300 million BPL
Funding pattern	Estimated annual premium: 750 Rs per family per year Government of India: 75% of premium + cost of smart card State Governments: 25% of the annual premium Each beneficiary pays: Rs. 30 / year as registration/renewal fee.
Stake-holders	Central government and States governments Health insurance projects including NGOs, TPAs, Insurance companies

To overcome MI's limitations, a promising approach: linkages

2nd example: RSBY (Rashtriya Swasthya Bima Yojana)

Linkages

- Governance / design / decisions
- With health care sector
- Administration
- Financial

To overcome MI's limitations, a promising approach: linkages

3rd example : philHealth-KaSAPI in the Philippines

Where?	Philippines, 70% population covered by health insurance ie 62 million
What?	The Individual Paying programme (15% of all PhilHealth insured) targeting IE workers & the POGI / KaSAPI initiatives (2003 & 2005)
Idea behind KaSAPI	Rather than targeting individual households directly, would target groups (*admin efficiency gains, limit adverse selection*).
Funding pattern	The program offers a discounted premium when a group of a minimum level is enrolled under a contract with PhilHealth. An organized group qualifies for the group premium rate if at least 70% of the group size is enrolled in Philhealth and an even more preferential rate applies if at least 85% become members.
Stake-holders	Cooperatives, microfinance groups, NGOs, etc market the Philhealth scheme, register workers and collect contributions on behalf of Philhealth Philhealth is the insurance company

To overcome MI's limitations, a promising approach: linkages

3rd example : philHealth-KaSAPI in the Philippines

Claims processing

PhilHealth

NETWORK HC PROVIDERS

ORGANIZED GROUP

ID GENERATION
CLAIMS PROCESSING AND PAYMENT OF BENEFITS
GROUP PREMIUM RATE (discount // Nb of members)

EDUCATION/ IEC
ENROLMENT
PREMIUM COLLECTION OF CONTRIBUTIONS
SUBMISSION OF REPORTS

Hospitalization
OPC

Members of Organized Groups

Linkages
- With health care sector (green)
- Administration (yellow)
- Financial (blue)

To overcome MI’s limitations, a promising approach: linkages

4rth example: Colombian subsidized regime

Where?	Colombia
What?	In 1993, Bill No100, reform including: •Equity in access to health services •Mandatory health insurance to everyone •Comprehensive coverage (the POS of the mandatory health plan ; the POSS subsidized basket including 50% of the POS) •Free choice of insurer and health care provider Shift from supply side subsidies to demand side subsidies + increase public hospitals efficiency
Population covered	19.5 million through the subsidized scheme 15 millions through the contributive regime Total 80% population in 2007 (28% en 1992)
Funding pattern	•Solidarity contributions (24%) from members of the contributive regime •Transfers from the Nation (69%) •10% was financed through regional sources for health care
Stake-holders	ARS: ESS, Caisse de conpensation, EPS publiques, EPS privées FOSYGA, SISBEN Regional Entities, the State Networks of HC providers

STEP

To overcome MI's limitations, a promising approach: linkages

4rth example: Colombian subsidized regime

FOSYGA
Equalization fund

STATE

REGIONAL ENTITIES

Transfer of contribution – UPC*

"solidarity point"

24%

69%

7%

EPS (insurer)

POS

NETWORK HC PROVIDERS

REGIONAL ENTITY

Subsidy

ARS (insurer)

SISBEN

Keeps 1 UPC / insured

12% income (2/3 employer, 1/3 employee)

POSS

Level 1 or 2

Assessment of level of poverty (1 to 6)

CONTRI-BUTIVE REGIME 15 million insured

SUBSIDIZED REGIME 19.5 million insured

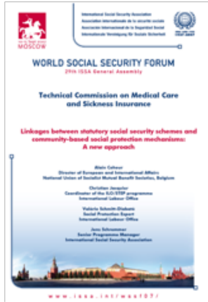
Linkages

- Red: Governance / design / decisions
- Green: With health care sector
- Yellow: Administration
- Blue: Financial

*UPC: value of the premium stipulated by legislation

Building a knowledge base on these experiences

1st STEP



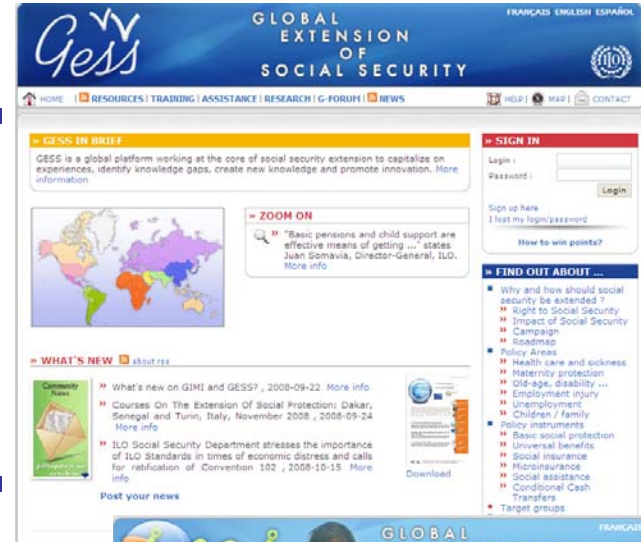
WORLD SOCIAL SECURITY FORUM

Technical Commission on Medical Care and Sickness Insurance

Linkages between statutory social security schemes and community-based social protection mechanisms: A new approach

Describe the phenomenon, draft a 1st typology

We identified 10 good examples of linked schemes, we documented them and produced a typology of these schemes, available in this article.



2nd STEP

Document each type of linkage (e.g., financial linkage, contracting process)
Produce updated information of existing linked schemes
Disseminate this information

3rd STEP

Participate in the development of these schemes through identification of issues and provision of appropriate support (technical, political)
Involve various actors (researchers, experts, managers of other schemes …) and enhance **collaboration** between them through networks and collaborative work