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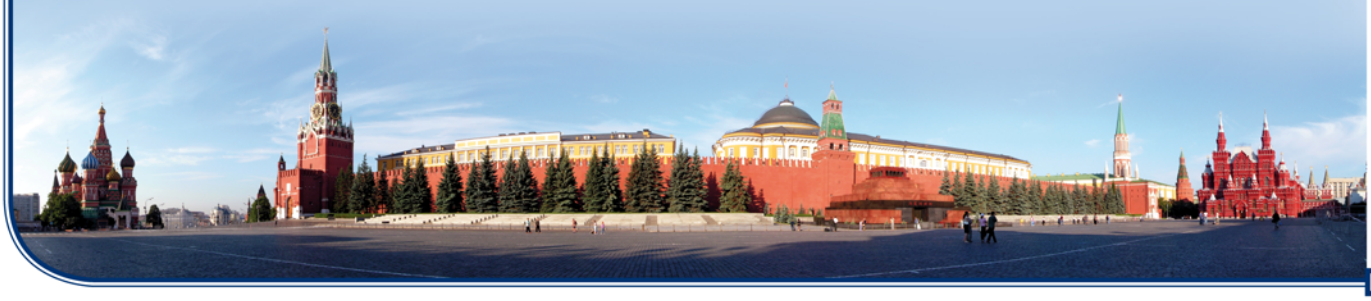
# Linkages between statutory social security schemes and community-based social protection mechanisms: A new approach


**Alain Coheur**
**Director of European and International Affairs**
**National Union of Socialist Mutual Benefit Societies, Belgium**

**Christian Jacquier**
**Coordinator of the ILO/STEP programme**
**International Labour Office**

**Valérie Schmitt-Diabaté**
**Social Protection Expert**
**International Labour Office**

**Jens Schremmer**
**Senior Programme Manager**
**International Social Security Association**

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

**Alain Coheur**
**Director of European and International Affairs,**
**National Union of Socialist Mutual Benefit Societies**
**Belgium**
**and Vice-Chairperson,**
**Technical Commission on Mutual Benefit Societies**

**Christian Jacquier**
**Coordinator of the ILO/STEP programme**
**International Labour Office**

**Valérie Schmitt-Diabaté**
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**Jens Schremmer**
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**International Social Security Association**

## 1. Extension of coverage: a matter of urgency

Access to adequate social security and health care protection are two fundamental human rights. However, these rights are far from being achieved worldwide. For example, up to 80 per cent of the population in sub-Saharian Africa and some parts of Asia live without such protection. This problem is exacerbated by uneven needs: the living and working conditions of informal economy workers and rural populations expose the most to health and accident risks, however, they are the groups most often excluded from social security.

Exclusion from social security has a devastating impact on the individual and his/her family. The World Health Organization (WHO) estimates that every year 100 million persons enter into a vicious circle of ill health and poverty due to health care costs. What is more, it also reduces opportunities for economic growth and social development and makes countries more vulnerable to the consequences of health shocks.

The extension of social health protection is therefore a matter of urgency to contribute to economic growth and to social development but above all to protect hundreds of millions of people around the world against poverty and unnecessary suffering.

# 2. Towards extending coverage - making the best of various mechanisms

Various financing and institutional methods are at the disposal of policymakers intending to work towards the extension of coverage. Social health insurance, tax-financed universal health care systems, private health insurance, community-based and micro-insurance schemes financed by contributions or taxes have each been implemented to protect people against the risk of ill-health in various countries.

It is up to each country to choose the coverage extension strategy and tools most adapted to its national circumstances. However, experience has shown that each of the methods above has its specific advantages and disadvantages. Each is specifically adapted to cover certain population groups but has weaknesses in covering others. Each has specific strengths and weaknesses to provide coverage in a long-term and sustainable manner. None of them alone has emerged as a panacea for the sustainable extension of health care coverage to the entire population in the short term.

This leads to two crucial conclusions:

- Urgent action to extend coverage should build on the respective advantages of various methods depending on the target groups for extension and the existing infrastructure.
- This should be done by exploiting the complementarities of different methods through an integrative approach that avoids opposition, duplication or competition between different schemes.

These conclusions at first sight increase the complexity of coverage extension strategies. But they open a new potential for extending coverage through more targeted actions that build on synergies and the respective advantages of different methods. The crucial condition for realizing this potential is the establishment of coherence between the different methods used. As a mechanism to achieve this coherence we propose the concept of linkages that are necessary both during the policy formulation and the implementation phase.

# 3. Linkages: a new tool to ensure sustainable extension of coverage

This paper intends to both underline the high potential of coverage extension strategies that build on linkages between various extension mechanisms and to respond to the existing gap of both empirical and conceptual considerations on linkages.

It focuses on statutory social security (SSS) schemes and community-based social protection (CBSP) mechanisms in order to develop a typology of potentially promising linkages between these types of mechanisms. Both SSS schemes and CBSP mechanisms have each their specific advantages and disadvantages in terms of their capacity to cover different types of population groups in developing countries. Linking the two in order to compensate for their respective weaknesses and to exploit their respective strengths therefore appears to have important potential.

And indeed, this paper provides first innovative empirical examples on some of these types of linkages based on a joint ILO/ISSA/AIM study covering a number of countries in three regions. For each country covered in the study, a report was prepared based on a standard set of guidelines.[1] These reports are accessible on the ISSA Extranet site and the ILO/GIMI platform.[2]

## 3.1 Statutory social security (SSS) schemes

SSS schemes are for the purpose of this paper defined as compulsory social health insurance schemes financed by contributions. In view of their financing and administrative processes, they require a certain degree of employment formality of their target population.

They have therefore in developing countries often been successful in covering civil servants and formal sector workers. However, they have apparent limits in covering informal economy workers. These are mainly related to the nature of informal employment without documented employment contracts, irregular and varying income and high transactions costs to collect contributions. The relatively high contribution rates of SSS schemes that finance generally rather comprehensive benefit packages are also more in line with the contributory capacities of formal economy workers, in particular because these workers benefit from a sharing of the total contribution with their employer. Due to relatively high levels of standardization, SSS schemes also have weaknesses in adapting their administrative processes and benefit packages to varying needs and capacities of different population groups.

Once established, statutory social security schemes often achieve relatively high levels of administrative sophistication and financial sustainability. Computerization and performance-based management procedures allowing for efficiency, a usually large risk pool and a steady contribution flow also contribute to this stability while at the same time ensuring a relatively high contracting power with health service providers.

The success of social health insurance schemes very much depends on the political backing of the compulsory nature of the scheme. This dependence on political commitment to ensure enforcement and compliance exposes social health insurance schemes to a political risk that can influence its sustainability. With political commitment, large scale coverage extension through social health insurance can be achieved, but it takes considerable time. In many countries, the short-term extension of coverage to the informal economy constitutes the main challenge.

## 3.2 Community-based social protection (CBSP) mechanisms

This paper works with a wide definition of CBSP mechanisms that encompasses not only micro-insurance or community-based schemes that directly manage an insurance mechanism but also institutions established by civil society (e.g. cooperatives, NGOs, associations or micro-finance institutions) that among other objectives facilitate the access of their members to insurance mechanisms.

[1] The countries included in the study were: Argentina, Burundi, China, Colombia, Ghana, India, Laos, Philippines, Rwanda and Uruguay. The ILO, the ISSA and the AIM would like thank the authors of the respective national reports: J.M Garriga and I. Olego (Argentina); J.M. Niyokindi (Burundi); A. Hu (China); A. C. Mercado Arias (Colombia); A. Grüb (Ghana); M. Chakraborty (India); A. Ron (Laos); A. Asanza (Philippines); A. Fischer (Rwanda); J. Martinez (Uruguay).

[2] *www-issa.issanet.int* and *www.ilo.org/gimi*

CBSP insurance mechanisms are usually small-scale and decentralized and often include a close participation of insured persons in their management. Flexibility in administrative processes and the targeted definition of benefits and contribution rates according to the capacities and needs of specific population groups such as rural workers, certain occupational groups or community members, allow them to effectively cover groups that are due to their specific characteristics difficult to cover by, and often excluded from, statutory schemes. Where existing civil society institutions (e.g. a cooperative or trade union) to which informal economy workers have already adhered participate in extending social protection but not directly manage a scheme, administrative process can be facilitated and transaction costs in registering members and in collecting contributions can be significantly reduced.

Relatively low contribution rates affordable for informal economy workers require CBSP insurance mechanisms to provide a limited benefit package. Furthermore, they face a number of administrative and sustainability challenges once established. The level of administrative and IT sophistication is often low and contribution flows are difficult to predict as the voluntary nature of membership can lead to high drop-out rates. The often small risk pool engenders an important sustainability risk where health shocks affect a large part of the insured population. While CBSP mechanisms contract with health care providers and have an important role in the development of quality health services at the local level, their contracting capacity and power can be quite limited.

The decentralized and flexible nature of CBSP mechanisms provides them with a great potential to extend coverage at the community level and they are quite independent from national politics in a country. However, it is difficult to achieve the extension of coverage at a large scale with these mechanisms and the extension of existing schemes beyond their current borders constitutes an important challenge.

**Table 1.** *Strengths and weaknesses of SSS schemes and CBSP mechanisms*

| | **Statutory social security** | **Community-based social protection** |
|---|---|---|
| **>> POTENTIAL FOR POPULATION COVERAGE** | | |
| Ability to cover | Strongest potential for civil servants and workers in employment relationships of a certain level of formality. | Strongest potential for informal economy workers clustering around certain commmon characteristics (either regional or occupational, e.g. agricultural workers). |
| **>> FINANCIAL ASPECTS AND SCOPE OF BENEFITS** | | |
| Levels of contribution | Relatively high and shared between employers and employees – often not affordable for informal economy and self-employed workers. | Low levels usually affordable to all members of the scheme. |
| Scope of benefits | Comprehensive and relatively standardized benefit packages. | Limited scope and levels of benefits but well-adapted to needs of target population. |
| Redistribution | Contributions according to ability to pay. | Flat rate contributions (no redistribution). |
| Risk pool and financial consolidation | Big and geographically diversified risk pools. Steady contribution income flow. | Small and varying (voluntary membership) size of risk pool. Income difficult to predict. |
| **>> OPERATIONS / ADMINISTRATION** | | |
| Management | Sophisticated computerization and management processes. Trained staff. | Low level of management training and low levels of computerization and management system sophistication. |
| Administrative procedures | High standardization and statutory contribution payments. Difficulties to adapt to non-standard groups. | Flexible according to needs and capacities of target group. Low transaction costs and strong capacity to reduce fraud and moral hazard. |
| **>> GOVERNANCE** | | |
| Participatory nature | Representation of workers and employers in centralized decision-making. | Direct participation of members in decentralized decision-making. |
| **>> HEALTH SERVICE PROVISION** | | |
| Contracting | High market power and contracting capacity - agreements at a national / regional scope. | Contracting power and agreements at the local level. |
| **>> POLICY PLANNING** | | |
| Advocacy | Top-down policy approach. | Bottom-up with/without policy support. |

## 3.3 Possible synergies

Recent experience and the short summaries of their main characteristics show that neither SSS schemes nor CBSP mechanisms are in a position to achieve universal coverage in the short term. However, they can both cover certain but different population groups and should therefore both be used in coverage extension strategies.

In addition, as Table 1 summarizes, they display quite distinctive strengths and weaknesses in terms of coverage, financing, administration and benefit provision, which indicates that these mechanisms should not only be developed in parallel but that linking the two provides more than just the sum of the two. Well-designed linkages between these two instruments have a high potential to accelerate the extension of social protection. However, there has been insufficient study of the potential types of linkages as well as insufficient analysis and comparison of existing experiences so far. The following section will make a first contribution to addressing this lack of knowledge through providing a typology of potential linkages as well as innovative empirical examples that could be observed in various countries.

# 4. Towards a typology of linkages

Five types of linkages can be identified, namely to improve financial sustainability, to improve operations and administration, linkages in governance structures, synergies in health service provision and at the level of policy planning. An overview of this typology is provided in Table 2.

**Table 2.** *Typology of potential linkages*

| |
|---|
| **1. Financial linkages**<br>• Tax subsidies<br>• Redistribution between statutory and community-based schemes<br>• Financial consolidation (risk transfers, re-insurance, guarantee fund)<br>• Joint pooling to broaden risk pool |
| **2. Operational/administrative linkages**<br>• Technical advice<br>• Exchange of information/good practice<br>• Sharing of management functions:<br>  - Marketing/registration<br>  - Contribution collection<br>  - Claims processing/procedures<br>  - Fraud prevention and control<br>• Information system linkages<br>• Regulation and/or control |
| **3. Governance linkages**<br>• Representation on boards or other institutional decision-making bodies |

**4. Linkages in health service provision**

- Contracting linkages:
  - Definition of benefit package
  - Prevention and health education / promotion
  - Provider payment mechanisms (type of mechanism and prices)
  - Co-contracting with providers
  - Improvement and assurance of the quality of care
- Access to health services delivery networks / providers

**5. Policy planning linkages**

- Joint participation in the design and implementation of national social protection strategies
- Similarity in core policy design principles
- Policy coherence to avoid unintended by-effects through imbalanced incentive structures

## 4.1 Financial linkages

CBSP mechanisms face challenges regarding their financial sustainability and are often in need of financial support in view of the low ability to pay of the population to be insured. Equitable access to health care schemes therefore requires some external resources to ensure sufficient financing and sustainability.

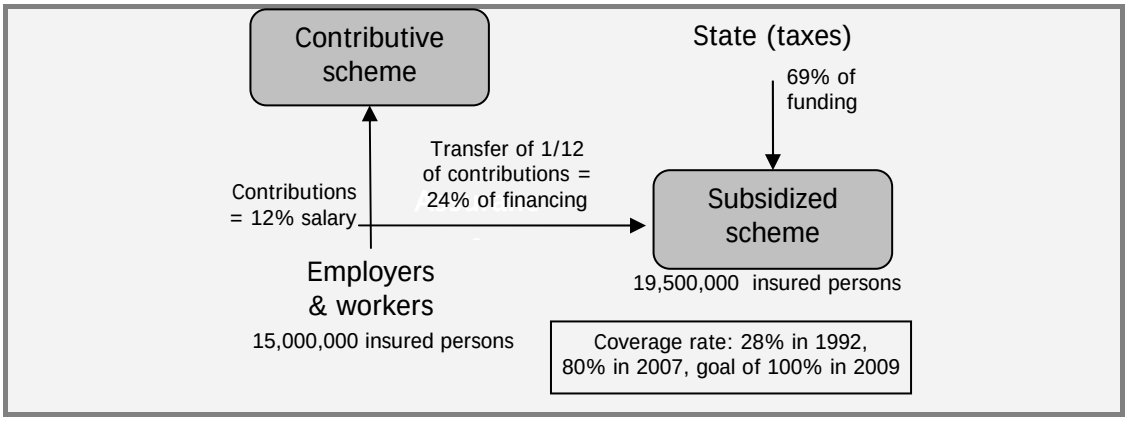
These resources can consist of cash transfers from governments to schemes taken from general revenue but could also be based on a redistribution of funds between statutory and community-based schemes. Temporary sustainability challenges due to small risk pools and fluctuating contribution incomes can be compensated through financial consolidation mechanisms (e.g. through re-insurance or a guarantee fund) that can, once again, be backed by the government but also by the statutory scheme(s).

A close linkage between SSS schemes and CBSP mechanisms to improve the financial sustainability of the latter can be envisaged through joint pooling of funds with a view to broadening risk pools. In this case, CBSP mechanisms are relieved of one of the most important challenges they are facing.

Examples for financial linkages can be found in a number of countries. Colombia's subsidized health insurance scheme, for example, combines tax subsidies and the transfer of contributions from statutory schemes to stabilize the financing of health care for the poor and for vulnerable groups (Box 1).

**Box 1**

As a part of the reform of the healthcare system in Colombia in 1993, a special subsidized scheme was introduced to finance healthcare for the poor and vulnerable groups (including their families) who are unable to pay contributions to the general insurance scheme. The funds for this special scheme are raised through taxes (national and regional transfers – 69 per cent of the funding) and a solidarity contribution collected under the contributory social insurance scheme (24 per cent of the funding). These funds are then channelled to several institutions, including 7 mutual benefit associations federated in a national organization Gestarsalud, which now covers 60 per cent of the market, compensation funds (cajas de compensación - 20 per cent of the market), and several private commercial insurance companies that also cover 20 per cent of the market. Today this successful subsidized scheme covers 19.5 million people.




National solidarity between the formal sector and the informal economy is also fostered in Ghana where the National Health Insurance Fund that provides subsidies of premiums for the poorest members is partly financed by social security contributions from formal sector employees. Since redistribution at the national level may not be sufficient in countries with low income, it is also useful to consider international redistribution such as in Ghana where under a Global Social Trust pilot project funds are transferred from Luxembourg to provide a cash benefit supporting health check-ups for indigent pregnant women and mothers with children under the age of five.

Financial linkages contributing to financial sustainability can for example be found in Rwanda where joint pooling has been adopted for secondary and tertiary care. In Ghana, one of the functions of the National Health Insurance Fund is to reinsure district mutual health insurance schemes against random fluctuations of costs. In Laos, joint pooling between the SSS scheme and CBSP mechanisms is now under consideration.

## 4.2 Operational/administrative linkages

While the SSS scheme can bring valuable advice and support to the community-based mechanism on all technical and operational questions related to the administrative processes of insurance schemes (e.g. identification, registration, claims processing, IT systems, etc.), CBSP mechanisms such as organized groups or community-based organizations can also make an important contribution to facilitating some of the core

administrative processes of statutory schemes. This support is particularly valuable for statutory schemes intending to expand their coverage to informal economy and agricultural workers, and consists of reducing the often high transaction costs involved in the identification and registration as well as in the collection of contributions from these workers.

Organized groups or community-based organizations are social institutions where informal economy workers have access to support services that are necessary for improving household productivity and income. Through these types of organizations, informal economy workers have access to various services, including marketing of products, purchasing of inputs, credit, savings and insurance, etc.

Extending social health insurance through organized groups can be more efficient than individually targeting informal economy workers, for these groups can easily reach the target population and facilitate a series of administrative procedures (such as marketing, registration, contribution collection, information, claims processing, monitoring and control) at relatively low administrative costs. Important linkages with regard to these management functions have for example been implemented in the Philippines where community-based organizations market voluntary membership in the statutory scheme, register workers and collect contributions on behalf of the statutory scheme (Box 2)

**Box 2**

In 2003, Philhealth, which is administering social health insurance for the private-sector in the Philippines, begun to work with CBSP mechanisms in order to extend its voluntary scheme to more informal economy workers under a project called POGI. Around 15 per cent of the target population newly joined the Philhealth scheme under this project. Building on some of the lessons learnt during this project, it was replaced by a new scheme under the name of KaSAPI that targeted community-based organizations with at least 1,000 members in 2005/2006. Under this new program, these organizations market the Philhealth scheme, register workers and collect contributions on behalf of Philhealth. 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 per cent of the group size is enrolled in Philhealth and an even more preferential rate applies if at least 85 per cent become members. At the same time Philhealth tried to adopt its systems and processes to the realities of the informal economy, e.g. it relaxed its documentary requirements to ease registration and made its payment schedule more flexible.

A potentially even more effective procedure to ensure affiliation of informal economy and agricultural workers can be automatic affiliation of all members of an organized group (trade union, cooperative etc.) to a scheme. The contributions can be deducted from the production sales or the taxes paid by workers instead of being deducted from individualized payroll. These procedures have many advantages: automatic affiliation facilitates the coverage of a large percentage of the target population; it also leads to little adverse selection problems and low drop out levels; expensive marketing campaigns can also be avoided. Automatic deduction of the premium avoids having to collect premiums among the members. Moreover, since contributions are linked to sales figures or turnover, some redistribution is introduced into the scheme.

While such procedures of affiliation and payment of contributions are already used in several schemes in India (e.g. dairy cooperatives) and Latin America (e.g. coffee cooperatives), or

are planned to be used in schemes that are being implemented in Mali, Burkina Faso (e.g. cotton cooperatives) and Senegal (e.g. transportation workers for which the premium will be charged at each trip, i.e. when the truck or car leaves the station), these are until now mostly used to ensure membership of schemes managed by the organized group or community and not on behalf of statutory schemes.

The joint development and sharing of trained technical management teams or the outsourcing of administrative functions can contribute to increase the efficiency of CSPB schemes and compensate for its administrative weaknesses. Empirically, no direct support from statutory schemes to administrative functions of CBSP schemes could be identified. Administrative functions are largely outsourced to professional organizations. In Senegal, for example, a professional centralized Insurance Management Unit to which the planned or existing health insurance schemes will outsource some of their technical management functions is being designed. In India, this role is mainly played by for-profit-companies (third party administrator - TPA) that assume most of the administration of an insurance scheme in exchange for a commission of 5 per cent fixed by law.

Where statutory and community-based mechanisms both operate their own health insurance schemes, the exchange of information on insured persons, contributions paid and claims can be greatly facilitated by a compatibility and connection between the IT systems of different schemes. Most often, but not always, this will be ensured through a transfer of system knowledge from the statutory scheme to the community-based scheme in order to ensure coordination and coherence as well as service provision planning. In Laos PDR, for example the compulsory Social Security Organization (SSO) and the community based health insurance schemes have important similarities in their major design characteristics and administrative systems. The basic information systems on membership identification and utilization of health care benefits of the two schemes are similar, with more computerization in the SSO and increasing computerization in community-based health insurance schemes. The systems allow, for example, the comparison of utilization and use of capitation funds by the provider between the two schemes. These similarities will increase the chances of eventual mergers, and allow the creation of broader risk pools and possible redistribution between different income and risk groups.

Monitoring and evaluation of the community-based scheme through the statutory scheme can also be envisaged as an effective means to ensure administrative coherence. Regular reporting as part of supervision and control can ensure that the statutory scheme is in a position to include information on the coverage and financial development of community-based schemes in its decision-making and business development. In Uruguay, the Ministry of Public Health has a controlling function for collective health organizations. However, it must be ensured that the reporting not only goes one way.

## 4.3 Governance linkages

CBSP mechanisms, given their democratic and participatory nature, have an important knowledge of the specific needs and priorities of specific population groups and are well integrated at the local level. They are potentially strong representatives of informal economy population groups providing the information and knowledge necessary for extending coverage to them at a larger scale. Such knowledge covers local constraints and group characteristics as well as experiences with the implementation of certain measures such as health education or the identification of the poor potentially eligible for subsidies etc. SSS

schemes often fall short of such knowledge, which hampers the design and implementation of measures to extend coverage to the informal economy. As trusted representatives, CBSP mechanisms can also improve the confidence into schemes at the local level and work towards reducing fraud, adverse selection and over-consumption of health services on behalf of the SSS scheme.

The representation of CBSP mechanisms and informal economy workers on the decision-making of SSS schemes and in the coverage extension policy-making process is therefore crucial. But also the representation of the formal sector in CBSP schemes can be of value to better understand their functioning and to explore potential mutual assistance.

Despite their potential, such linkages at the governance levels can only rarely be found in practice. In the Philippines, for example, a representative of the Basic Sector of the National anti-poverty commission sits in as a member of the board of Philhealth, the statutory health insurance scheme. The Basic Sector represents and works for informal economy workers. In India, the Yeshasvini Co-operative Farmers Health Insurance Trust (a scheme with 2 millions farmers affiliated in 2007) allows representatives of both the government and the cooperative sector to attend its board meetings.

## 4.4 Linkages in health service provision

The objective of social protection in health is to provide access to at least an essential package of health services with the aim to improve the health status of a given population. The provision of this package involves several challenges for any scheme: the definition of the package based on various criteria of needs, priorities, cost-effectiveness etc., the pricing of the various services through contracting processes with health care providers and ideally also quality assurance as to the services provided to insured persons.

Linkages between CBSP mechanisms and SSS schemes can contribute to improving the sustainable access to health services for the populations covered by the respective schemes. CBSP mechanisms, due to their small-scale nature, often lack market power in contracting with providers. SSS schemes, however, usually have such market power and co-contracting may therefore be an important way forward.

Information is key in the definition of the right basket of services and in contracting processes. This involves knowledge on what is essential for the various parts of the population, on the cost-effectiveness of different procedures in different settings, the expected utilization rates and costs of services. Due to their centralized nature, SSS schemes sometimes lack information on the concrete needs and priorities of the population in terms of health services while CBSP mechanisms lack information on cost-effectiveness and other sophisticated items. An exchange of information and potentially a joint definition of the package of services can therefore benefit both CBSP and SSS schemes and avoid waste and inefficiencies. In Colombia, for example, the health service package is defined on a statutory basis involving all health insurance schemes and is evaluated and adjusted on an annual basis.

Clearly, contracting is a process that involves important transaction costs where each scheme contracts separately with a certain number of providers. Some CBSP mechanisms such as in India currently use external service providers to develop networks of accredited hospitals and to handle the contractual relationships on their behalf. Developing a national

policy of contracting or making the contracts including price structures of SSS schemes available for the use of CBSP mechanisms can reduce these transaction costs. Where this is not possible, contracting guidelines including key features can also be of assistance for small schemes. In Burkina Faso and in Senegal, ILO/STEP has initiated a process for the development of a contractual approach between mutual health organizations and public health care providers. This process begins with an inventory of contracting experiences. Working groups then draft proposals that are discussed by all the stakeholders involved. The goal of the approach is to harmonize contractual practices.

Opening existing health care providers run or contracted by SSS schemes to additional contracts by CBSP mechanisms based on similar terms can also be of use. This is also a valuable help to health care providers that do not need to adapt to diverse types of contracts and can more easily comply with the procedures and standards. It is also important that the provider payment is aligned where the same providers contract with different schemes, as the provider otherwise has an incentive to favour the members of some schemes over those of other schemes. Finally, quality assurance processes could either be combined or information be exchanged. The SSS scheme usually develops quality assurance methods and tools that could be adapted and transferred to the CBSP mechanisms.

## 4.5 Policy planning linkages

Whatever the type of scheme or the mix of schemes adopted in a country, integrated and coherent planning at the policy level is important in order to avoid unintended consequences. If coherent planning is lacking and core design features of various schemes operating in parallel in one country are not coordinated, policy objectives may not be achieved. Linkages in the policy planning of different schemes are therefore crucial.

For example, the extension of contributory schemes, in particular on a voluntary basis, may be hindered by the parallel existence of subsidized or free access schemes. This has been shown for example in the Philippines where the success of the first project to extend the reach of the voluntary insurance scheme to the informal economy through working with cooperatives (see Box 2) was limited due to, among other reasons, the presence of another program that meant to cover the poorest families through a new subsidy scheme from the national government. Faced with a choice between free health care and a contributory scheme, most families opted for the former.

The utilization of different provider payment mechanisms in different schemes may create unintended financial incentives for providers to favour the members of one scheme over the members of other schemes. Different regulations with regard to family coverage, benefit packages, co-payments etc. between different schemes may distort the decision of workers and may constitute considerable barriers to a potential merger of different schemes.

Actual differences in core design features between different schemes operating in the same country frequently stem from the dispersion of responsibilities for the various schemes. Whereas Ministries of Labour are often responsible for policy formulation for statutory schemes, Ministries of Health usually supervise community-based schemes. Subsidized schemes for indigents often depend on the Ministry of Interior. Under such circumstances, government commitment not only means to push for the extension of coverage, but also to ensure an integrated policy planning and coordination between different governmental

actors. A lack of such coordination may seriously endanger the achievement of policy objectives. Laos provides a positive example for functioning policy planning linkages (Box 3):

**Box 3**

A high level of policy coherence as well as good practice exchange between schemes has been achieved in the efforts to extend coverage in Laos. The statutory scheme and the voluntary community-based schemes were not only introduced at roughly the same time in 2001, but the major components of both schemes are similar: benefits and exclusions, provider payment as well as the basic information systems on membership identification and utilization. In the short-term, the aim of these linkages is to create a positive environment of coherence rather than competition, with each scheme learning from each other and to avoid that providers favour insured persons in any of the schemes. In the long-term, the similarity of design components is crucial to spread knowledge and experience about social security in both the formal and the informal economies and increase the chances of a future merger. The merger between statutory and community-based schemes has been formulated by the Ministry of Health as a long-term objective.

A lack of policy planning linkages and coherence in a multi-scheme environment can also have a negative impact on the necessary solidarity at the national level. This solidarity between well-off and poorer groups of the population, between the old and the young, between the sick and the healthy is important if universal coverage is to be achieved. But redistribution and solidarity must be organized across all population groups in order to avoid negative repercussions in terms of equity and efficiency. Therefore, the implementation of solidarity mechanisms by the government across and within schemes in a coherent manner is required. This is done in Colombia where the subsidized scheme integrates solidarity based on a coherent national policy planning.

The “Unorganized Sector Workers Social Security draft Bill” under preparation in India is also a good example of policy planning linkages intending to create a coherent and equitable system of social protection at the national level for different population groups (Box 4).

**Box 4**

Over the last few years, the Indian central government as well as various state governments and ministries have shown a stronger commitment to extend health protection benefits to informal economy workers, with several initiatives: welfare funds, subsidized insurance products, social obligations for private insurance companies, state governments health insurance initiatives, etc.

However it is estimated that some 90 per cent of the labour force still does not benefit from any kind of social security. As regards health protection, this exclusion phenomenon still affects some 950 million persons, making of the extension of health protection to all an unprecedented challenge.

An “Unorganized Sector Workers Social Security draft Bill” is currently being finalized at the central level. It will pave the way towards a nation-wide social security system based on the national solidarity principle (with contributions from employers as well as subsidies from central and state governments). It aims to provide a minimum level of social protection benefits to most of the informal economy workers.

The proposal is designed as a global and coherent framework adaptable to both the existing social security mechanisms already implemented in the various states and the financial capacity of the states to contribute to it. As such, it is conceived as a flexible instrument adopting, in the light of its expected wide coverage, a common minimal denominator applicable to all states. State governments remain free to complement the various provisions and benefits.

# 5. Conclusions

Access to health services and social protection is an essential factor for economic and social development and a key condition for reducing poverty. Given the widespread exclusion from social protection in many countries, the extension of coverage is a matter of urgency.

There is, unfortunately, no quick and easy solution to the challenge of extending health care coverage. In many countries, only very limited progress has been made during the past decade. This is despite the fact that there are a number of mechanisms for extending health care coverage. All these mechanisms, however, have their distinctive advantages and disadvantages in terms of their capacity to cover populations in a sustainable manner. None of them alone appears to be able to reach universal coverage in the short term.

While the exact mix between these different mechanisms should depend on each country’s specific circumstances, it appears that a combination of them is most promising to extend health care coverage. And indeed, a parallel development of different mechanisms can be observed in many countries where social health insurance schemes are being implemented for some parts of the population while community-based schemes are created for population groups that cannot yet be covered by the statutory scheme. Often a tax-financed health service also plays a role for some population groups.

This paper argues that the parallel development of these different mechanisms within the same country in an unconnected manner not only misses out important opportunities to better cover populations, but can also be detrimental to coverage where competition and duplication between the different schemes develop. Inefficiencies while resources are scarce and the demand vast should be avoided at all cost.

Taking SSS schemes and CBSP mechanisms as examples, this paper shows that a whole variety of linkages between different schemes both at the policy level and the implementation level can be envisaged. These linkages can function as important stimulus to the extension of coverage. Coherency at the policy level combined with an effort to compensate for the respective disadvantages of schemes through linkages can avoid competition and inefficiencies and can strengthen the capacity of the existing social protection mechanisms to cover a greater share of the population in a sustainable manner. However, while some innovative measures could be identified in a joint empirical ILO/ISSA/AIM study, linkages remain in general largely underdeveloped in practice.

The authors of this paper believe that this should change. This paper has therefore sought to make a conceptual contribution to developing linkages and to providing a number of first empirical examples from a variety of countries. Better connecting different schemes, building coherency between different actions at the national level, developing innovative linkages compensating for organisational, financial or structural weaknesses of various types of schemes will remain an important challenge and will be a focus of the work of ILO/ISSA/AIM also in the future.

**Acronyms**

ISSA: International Social Security Association
AIM: Association Internationale de la Mutualité
ILO: International Labour Organization
STEP: Strategies and Tools Against Social Exclusion and Poverty
SSS: Statutory Social Security
CBSP: Community Based Social Protection

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