2006 | ASIAN DECENT
2015 | WORK DECADE

International Labour Organization

SERIES:

SOCIAL SECURITY EXTENSION INITIATIVES IN SOUTH ASIA

SRI LANKA:
YASIRU MUTUAL PROVIDENT FUND SOCIAL SECURITY SCHEME
(ALL SRI LANKA)

"EMPOWERING THE EXCLUDED GROUPS"

ILO Subregional Office for South Asia

INTRODUCTION

The fourteenth Asian Regional meeting of the ILO recently organized in Busan, Republic of South Korea (August 29th – September 1st) endorsed an Asian Decent Work Decade (2006-2015), during which concentrated and sustained efforts will be developed in order to progressively realize decent work for all in all countries. During the proceedings, social protection was explicitly mentioned as a vital component of Decent Work by a number of speakers including the employers and workers representatives. The need to roll out social security to workers and their families in the informal economy, to migrant workers and to non regular workers in the formal economy was also perceived as a major national social policy objective. The need to enter into a more intensive dialogue with respect to the design and financing of national social security systems to equip them to cope with the new requirements and challenges of a global economy also emerged as a major outcome of the meeting.

The challenge of providing social security benefits to each and every citizen has already been taken up in various South Asian countries. Several Governments have already pledged in their National policies and programmes to extend social security measures and to ensure through various mechanisms the welfare and well-being of all workers, and most particularly those operating in the informal economy. In line with this commitment, several new initiatives were taken by countries such as India, Sri Lanka and Bangladesh focusing mainly on the promotion of new health insurance mechanisms, considered as the pressing need of the day. At the same time, and given the huge social protection gap and the pressing demand from all excluded groups, micro-insurance schemes driven by a wide diversity of actors have proliferated across the sub-region. While a wide diversity of insurance products has already been made available to the poor, health insurance is still found lagging behind in terms of overall coverage and scope of benefits, resulting in the fact that access to quality health care remains a distant dream for many.

Given this context, the ILO's strategy was to develop an active advocacy role aiming at facilitating the design and implementation of the most appropriate health protection extension strategies and programmes. Since any efficient advocacy role has to rely on practical evidence, the ILO first engaged a wide knowledge development process, aiming at identifying and documenting the most innovative approaches that could contribute to the progressive extension of health protection to all. One such innovative and promising approach is the broad demand-driven social security programme developed by Yasiru Mutual Provident Society in Sri Lanka.

BACKGROUND

Sri Lanka with its fairly well developed country-wide free health services had until recent times coped with such requirements to a considerable extent. However, like in many developing countries that had adopted open economc policies, the merging situation had caused considerable strain on the provision of state financed health services to the entire population.

Other risks and conditions of social insecurity have also exerted pressure on coping capacities of families in the low income and poorer groups.

A comparatively steady expansion of profit oriented private sector health services in the urban centres, similar to the pattern evident in many other developing countries is now taking place. Coupled with it, is the widening pattern of private practice by the doctors in the public sector and a steadily increasing trend of patients from different social and economic strata accessing their consultation services.

In practice, more and more people have to pay to get medical treatment. General tests such as blood and urine tests are often not available in the state hospitals. In addition, patients have to meet the cost of drugs recommended by them. The need to buy prescribed drugs in case of shortages in state hospitals and clinics causes much strain on those in the low income and poorer groups leading them even to get into debt to meet such costs.

The National Health Policy that was drafted in 1997 already recognized the changes in the making and recommended among the five important areas that the policy focused on: the need to attend resource mobilization and management including financing mechanisms and sharing between public and private sector.

The considerable demand for some health micro-insurance mechanisms that can address the protection needs of the poor was already recognized by several studies and surveys.(such as a study commissioned by ADB, covering both the demand and supply side. Still young and experimental, several schemes have been initiated across the country, and among these, the novel and innovative model created by Yasiru.

Yasiru Mutual Provident Society is the micro-insurance wing of the All Ceylon Community Development Council, an NGO registered in 1993 that is working with social mobilization and organization of the poor in various districts of Sri Lanka. Yasiru evolved from the concept of the funeral society, reflecting the need for a more comprehensive coverage. It was legally established as a mutual society under the Societies Act in 2000. In Sri Lanka, a cooperative entity can be constituted as a cooperative or a mutual society. The mutual society form was preferred because it involved less government intervention.

In 2001, the new entity signed an exclusive contract with Interpolis RE association which was part of a Dutch banking insurance group known as the Rabobank group. This agreement allowed it to receive regular technical assistance which included the development of a computerized system covering the claims processing function together with a member data base. This association also led to a very first experience of re-insurance, first covering the life insurance component, later on extended to the health insurance component as well.

Offering a composite benefit package covering, life, disability and hospitalization expenditures, Yasiru first operated though its main local sponsor, ACCDC with its numerous subsidiary district offices that could reach to multiple rural development societies, savings and credit groups, rural farmer and funeral aid societies.

The scheme started its operations by targeting the members of qualified community based organization. An individual was only given Yasiru membership if he/she met the criteria of being enrolled in a funeral aid society, a popular CBO in villages. Subsequently, membership was opened to those who were members of other suitable and reputed CBOs that were functioning in the same areas. These village level organizations often have a membership between 60 - 100.

For a CBO to qualify to join the Yasiru scheme, it has to meet a set of predetermined criteria. For this purpose, they should have annual audited financial statements, an elected board of management, a democratic structure of governance, an up to date operational accounting system and a successfully managed micro-credit programme.

From 2003, more partners joined the programme which led to a regular increase of the membership now totaling 76,000.

Yasiru current development plans are as follows:

- Link up with a Government Farmers insurance scheme with an outreach of 2 million
- Link up with co-operative societies and their apex organizations
- Expand its activities in other districts in order to cover 200,000 people through a wide network of partner organizations

TARGET POPULATION

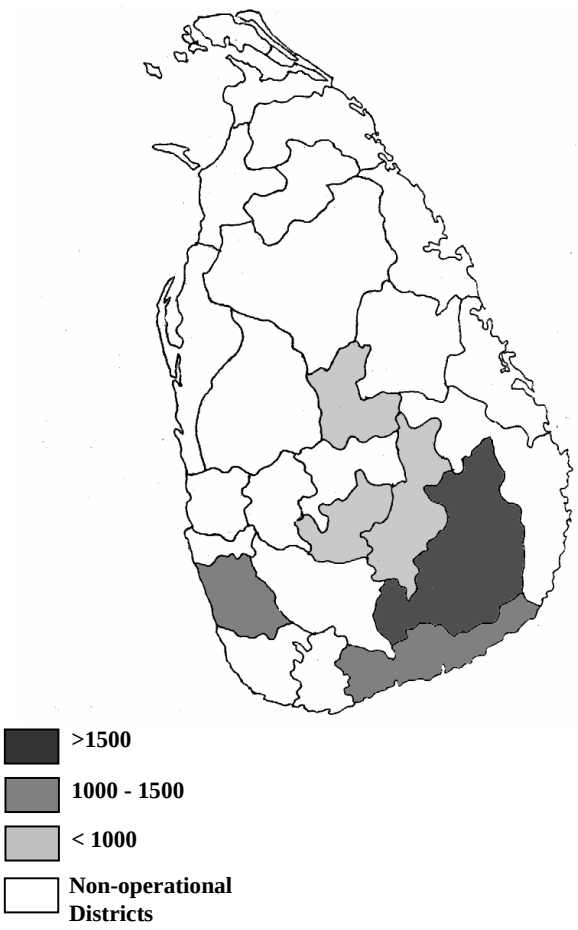
Yasiru targets the poorest segments of the population found predominant in rural areas. A majority of members are involved in agriculture, estate work or other casual labour. According to Yasiru animators, the average income per member ranges from Rs 1,500 to Rs 3,000 per month.

The scheme is currently being operated in six districts spread over four provinces in the southern and central parts of the island.

As an average, 26% of the households in Sri Lank belong to the "poor" category, as defined as those belonging to the lowest four deciles of per capita expenditure and who spend more than 50% of their income on food.

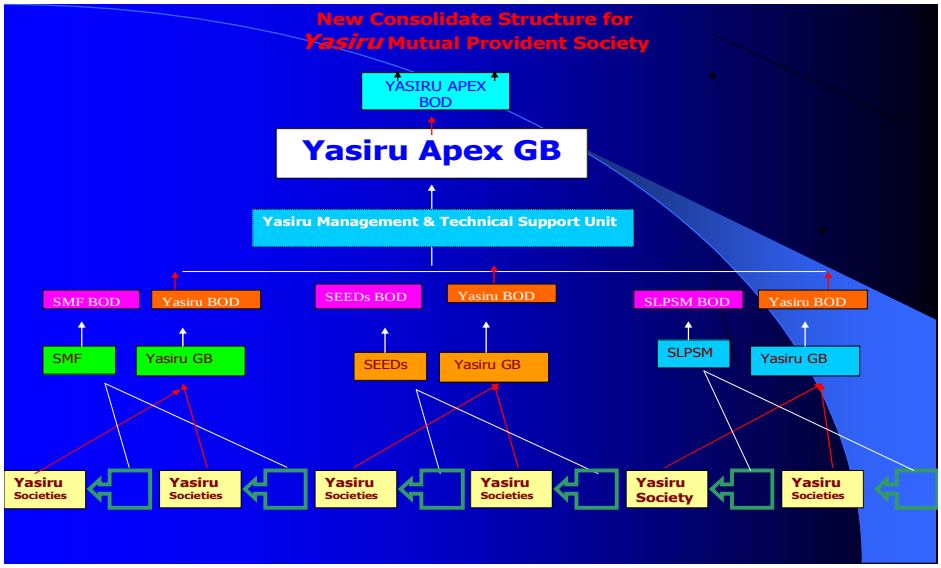
Of the six districts covered by the scheme, the majority with one exception have a percentage of poor households well above the national average:

Kalutara	20%
Badulla	27%
Numwara Eliya	29%
Hambotata	30%
Matale	46%



ORGANIZATION

Members of Yasiru are the policy holders and they, along with the nine partner organizations are represented in the Board of Directors.



THE INSURANCE PLAN

Eligibility

Membership is open to all adults aged from 18 to 65 years and covers children of the members aged between 90 days – 18 years. Additional dependents between 17 and 75 years may be covered if the household income is less than SLr 3,000. However, a maximum of 3 persons aged 65-75 can be covered.

Exclusions

The scheme excludes households with a monthly income above SLr 3,000. Also excluded are cases of suicide and contagious diseases.

Plan Benefits

The insurance plan covers the following events with benefits according to the level of monthly premium paid by each family:

- Accidental death of a member
- Accidental permanent disability of a member
- Natural death of a member
- Death of a member's dependent
- Member/dependent's hospitalization, for a maximum of 30 days
- Traditional or similar treatment cost per day for a maximum of 15 day

There is no actual maturity benefit included in the scheme but there is a mechanism for profit sharing. Yasiru opens a savings account for each new member where his/share of the yearly profit – 40% of any profit is credited to members' accounts - is deposited. When a member reaches the age of 65, or terminates the membership, he/she will receive the credit balance of the account, provided that the membership has lasted for more than five years.

Benefit Restrictions

Natural death of the insured:
Before reaching the age of 70 years but after more than 2 years of continuous membership, the full benefit will be paid. If the membership is less than 2 years, 50% of the benefit will be paid.

Hospitalization and/or temporary total disability of the member or children of the member:
The payment is only for the first 30 days only once a year and only for one person after a six-month waiting period

General Overview

Starting date	2001
Ownership profile	Registered Society – Societies Act
Target group	Small scale farmers & low income group
Outreach	6 districts in South & Central Sri Lanka
Intervention area	Rural
Risks covered	Risk package: Health, life, disability
Premium family/Year	Rs. 10 -100/month
Co-contribution	-
Total premium	Rs. 10-100/month
No of insured	75,000
Percentage of women	68%

Operational Mechanisms

Type of scheme	In-house
Insurance company	No
Insurance year	Open all year
Insured unit	Individual and Family
Type of enrolment	Voluntary
One-time enrolm. fee	No
Premium payment	Monthly
Easy paym. mech.	No
Waiting period	30 days

Scope of Health Benefits

Tertiary health care	No
Hospitalization	
Deliveries	No
Access to medicines	No
Primary health care	No

Level of Health Benefits

Hospitalization	Flat daily indemnity
Special conditions	Coverage extends to traditional treatment

Service Delivery

Health prevent./educ. Programmes	No
Prior health check-up	No
Tie-up with H.P.	No
Type of health prov.	Public HP
Type of agreement	No
No of associated HP	-
Access to health care services	Free access
Co-payment:	NA
HC payment modality	NA

The following limitations also apply in the event of permanent loss of function of:

Arm or hand	75%	Eye	35%
Thumb	25%	Both eyes	100%
Index finger	15%	Hearing in one ear	25%
Leg or foot	70%	Hearing in both ears	60%
Big toe	10%	Smell and/or taste	10%
Every other toe	3%	Psychological abilities	100%

Premium / Benefits

Risks	Size of Family	Minimum Rs. 10/month	Maximum Rs. 100/month
1	Death after the age of 18 and before 65 due to accident	6,000	60,000
2	Death after the age of 18 and before 65 due to natural causes	3,000	30,000
3	Sudden death before reaching the age of 18	3,000	3,000
4	Sudden death between the age of 65 and 75	3,000	3,000
5	Permanent disability after three month before the age of 65 due to accident	12,000	120,000
6	Hospitalization cost per day for a maximum of 15 days	30	300
7	Traditional of similar treatment cost per day for a maximum of 15 days	15	150

Members are classified according to their family situation. In each category, members can choose among 5 levels of premium which range from Rs. 10 to rs.. 150 per month

Categ.	Size of Family	Monthly Premium				
1	Household with no children	10	20	30	50	100
2	One parent with children	10	20	30	50	100
3	Household with children	15	30	45	75	150
4	Other adult over 18 years	5	10	15	25	50

Plan Distribution

Yasiru's activities at the field level are carried out through its various partner organizations in small groups and community-based organizations. Yasiru also hired SLPSM staff at all levels to distribute the insurance plan, to develop awareness activities to mobilize new clients, collect premiums, handle claims and provide assistance to the overall administration of the scheme.

Service Delivery

Since the scheme is based on the payment of a flat hospitalization indemnity to the member, there are neither contractual arrangements nor even direct discussions and contacts with the various public health facilities that are being used by the members.

Administration

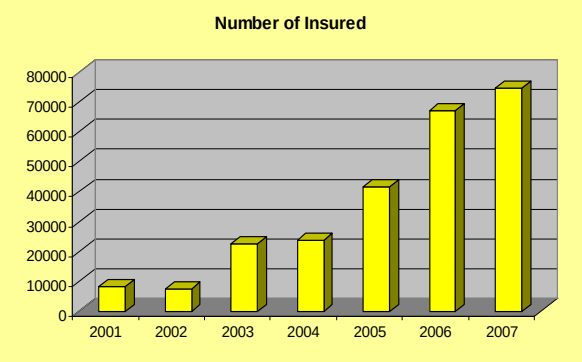
The Board of Directors of Yasiru manages and controls the scheme.

MAIN ACHIEVEMENTS

Coverage

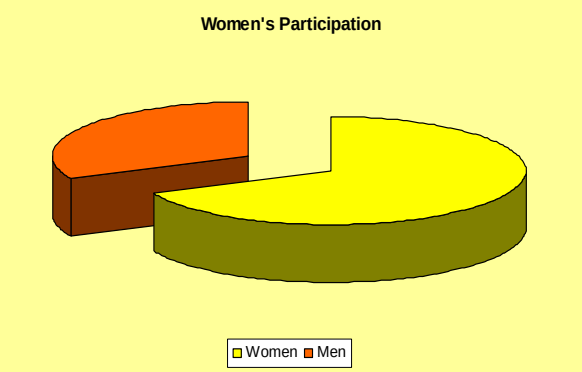
Since the inception of the scheme, the number of insured recorded a steady growth

Year	N°Ins.	% Change
2001	8,151	
2002	9,472	+ 16%
2003	22,609	+ 138%
2004	23,780	+ 5%
2005	41,416	+ 74%
2006	66,868	+ 61%
2007	74,445	+ 11%



Women's Participation

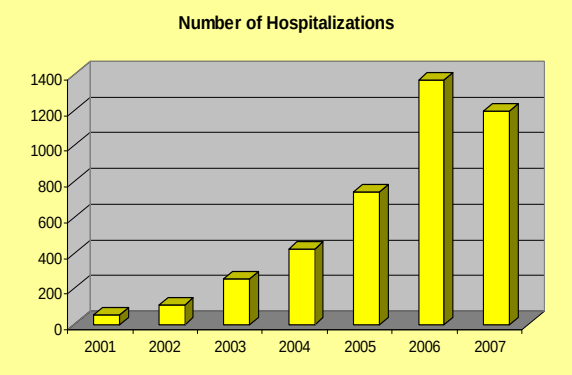
About two thirds of Yasiru members are women which reflects their larger participation in the various community based organizations active at the local level



Number of Hospitalizations

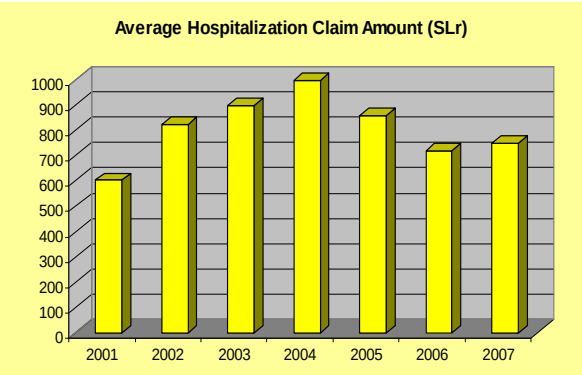
The scheme succeeded to keep the incidence ratio at a low rate, well below the rates observed in other health insurance schemes

Year	N°Insur.	N°Cl.	Cl. Incid.
2001	8,151	51	0.6%
2002	7,472	109	1.4%
2003	22,609	257	1.1%
2004	23,780	422	1,7%
2005	41,416	744	1.8%
2006	66,868	1,368	2.0%
2007	74,445	1,192	1.6%



Over the years, the average length of stay at the hospital recorded a small decrease which translated in a lower claims cost per insured

Year	N°Cl.	Aver. Cl.	Tot. Cl.
2001	51	602	30,702
2002	109	824	89,816
2003	257	900	231,300
2004	422	995	419,890
2005	744	869	646,536
2006	1,368	717	980,856
2007	1,192	740	882,080



CHALLENGES

The insurance plan still has to address the following main challenges:

- In the short term, community mobilization and sensitization and education campaigns remain a pressing need;
- The institutionalization process still need to be strengthened;
- Long term strategies aimed at developing leadership capacities need to be planned and organized;
- Many more local organizations need to be involved in order to allow for the progressive extension of the scheme across the country;
- Enlargement of the benefit package to other risks should be considered in order to answer to members' demands;
- Efforts remain to be developed in order to reach full financial sustainability;
- In order to increase the insurance benefits for the members, a system of co-contribution needs to be negotiated and set in place.

THE LINKAGE EXPERIENCE

Developing efficient partnership arrangements is already seen as a key element for the successful implementation of any health insurance scheme targeting the disadvantaged groups. Evidence also suggests that building efficient linkages between community-based initiatives and government programmes in order to exploit their respective strengths is another major requirement. This necessary synergy may be developed at various levels.

Scope of Linkages	
Financing:	No
Operations:	No
Service Delivery:	☺
Governance:	No
Policy Planning:	☺
Legal Framework:	No

The Yasiru scheme has played a pioneering and inspiring role in developing the first example of a people-led organization providing various social security benefits to the poor. It has also succeeded to translate for the first time the concept of reinsurance for the poor into reality. Having built over time the necessary knowledge and skills in this new field, it is now better prepared to develop the necessary partnership arrangements with public departments and other key actors that could bring it to new highs.

1. Financing

The scheme does not benefit from any Government support and is still depending on some external subsidies while striving to achieve full financial sustainability.

2. Operations

Operations only involve so far a wide network of NGOs and various community-based organizations.

3. Service Delivery

The scheme has recently initiated contacts with some state hospitals to discuss the possibility to avail better services and to facilitate the paper work which is to be submitted to support any claim.

4. Governance

The scheme is the first example in the country of a mutual and self-managed insurance scheme with no intervention whatsoever of public department.

5. Policy Planning

Some consultations are under way to discuss the possibility to link up with several interventions sponsored by the Government such as the poverty alleviation programme called “Samurdhi”.

6. Legal Framework

Provisions of the insurance Act do not apply to a mutual provident fund. However, there is already some indication that new micro-insurance regulations may soon be drafted in Sri Lanka.

CONCLUSION

So far, micro-insurance penetration in Sri Lanka remains almost inexistent with only a few schemes having dared to venture into this new field. This is expected to change soon and this can take different forms. One is the demand-driven model developed by Yasiru that evolved over time in order to better serve its members. Quite another one is the supply-driven products that are now being aggressively marketed among the same target groups by the first insurance companies looking at new profit opportunities. The present situation makes even more urgent to take up the challenge of extending social security benefits to larger segments of the population, with a clear vision and principles such as in the case of the Yasiru scheme.

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