Extending health care coverage: Potential linkages between statutory social security and community-based social protection

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Abstract

The extension of social health protection in developing countries is widely recognized as a priority. Various financing and institutional methods can be used in pursuing this objective, but none of them can achieve universal coverage in the short term. Based on an analysis of the respective strengths and weaknesses of social health insurance and community-based health care schemes, this article demonstrates the high potential of coverage extension strategies that use a pluralistic institutional approach to establish linkages and exploit complementarities optimally. A typology of potential linkages among different methods is presented and their value added illustrated using country examples.

Introduction: The urgent need to extend coverage

Access to adequate social security and health care protection are two fundamental human rights.[1] However, these rights are far from being achieved in many low- and middle-income

1. United National Universal Declaration of Human Rights, Articles 22 and 25.

countries, not least in sub-Saharan Africa and some parts of Asia. This problem is exacerbated by uneven needs. The living and working conditions of informal economy workers and rural populations expose these groups more to health and accident risks; however, these are the groups most often excluded from social security and health care protection.

Exclusion from social health protection can have a devastating impact on the individual and his or her family. The World Health Organization (WHO) estimates that every year 100 million persons enter into a vicious circle of ill health and poverty as the result of health care costs (WHO, 2005). What is more, the absence of social security 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 as a means to better protect hundreds of millions of people, especially in developing countries, against poverty and ill health. And it should have positive knock-on effects for economic growth and social development too.

Towards extending coverage: Making the most of different methods

Various financing and institutional methods are at the disposal of policy-makers working towards the extension of access to health care coverage. Social health insurance, tax-financed universal health care systems, private health insurance and community-based schemes have been implemented to protect individuals against the risk of ill-health in various countries (Gottret and Schieber, 2006; ISSA, 2008).

Each country must choose the coverage extension strategy and tools most adapted to its national circumstances (ILO, 2001; ISSA, 2004). However, experience has shown that each one of the methods cited above has its specific advantages and disadvantages. Each approach is specifically adapted to cover certain population groups but has weaknesses in covering others. Each also has specific strengths and weaknesses in providing health care coverage in a long-term and sustainable manner. Consequently, no single approach provides a panacea for the sustainable extension of health care coverage to the entire population.

These observations lead to two crucial conclusions. First, urgent action to extend health care coverage should adapt pluralistic approaches that build on the respective advantages of

various methods depending on the target groups to be covered and the existing infrastructure. Second, coverage extension should be pursued by exploiting the complementarities of different institutional methods through an integrative approach that avoids opposition, duplication or competition between different schemes.

At first glance, these conclusions would appear to increase the complexity of coverage extension strategies. But they actually increase the potential for extending coverage through more targeted actions that build on synergies and the respective advantages of different methods. Internationally, there is increasing agreement that pluralistic coverage extension strategies are most suited to achieving the sustainable and rapid extension of social health protection to diverse population groups. In this vein, the International Labour Office has rightly called for a more rational use of pluralistic financing mechanisms (ILO, 2007a).

A crucial step towards a more rational use of pluralistic mechanisms, but a dimension that has not yet been sufficiently considered in the literature, is the establishment of greater coherence between the different institutional methods used. To this end, this article proposes the concept of “linkages” between different institutional methods that are necessary both during the policy formulation and implementation phases.

Linkages: A new tool to ensure the extension of sustainable coverage

This article has two aims: first, to underline the high potential of coverage extension strategies that build on linkages between various extension mechanisms and, second, to respond to the existing empirical and conceptual gaps that surround this important concept. By doing so, the hope is to contribute to moving international debates a step further forward towards exploiting the hitherto underutilized potential of pluralistic approaches for the extension of social health protection.

The focus of this article is placed on extending health care cover provided under statutory social security (SSS) schemes and community-based social protection (CBSP) mechanisms, with the aim of developing a typology of potentially promising linkages between such schemes and mechanisms. Individually, SSS schemes and CBSP mechanisms have their own specific advantages and disadvantages in terms of their capacity to provide health care cover to 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 offer important potential.

Using the findings of a study jointly undertaken by the International Social Security Association (ISSA), the International Association of Mutual Benefit Societies (AIM) and the International Labour Organization's (ILO) Strategies and Tools Against Social Exclusion (STEP) programme, innovative empirical examples of some possible types of linkages will be presented.[2]

Mechanisms for coverage extension

Statutory social security schemes

Statutory social security (SSS) schemes are here defined as compulsory social health insurance schemes financed by contributions (mainly from workers and/or employers). In view of their financing and administrative processes, they require a certain degree of employment formality of their target population.

In developing countries, SSS schemes have often been successful in covering civil servants and formal sector workers. However, they have limitations in covering informal economy workers. These limitations stem mainly from the fact that, typically, informal economy workers are without documented employment contracts, have irregular and varying income and that covering these workers implies high transaction costs in administration. The contribution rates payable to SSS schemes that finance comprehensive benefit packages are also more in line with the contributory capacities of formal economy workers who commonly share the total contribution due with their employer. As a result of relatively high levels of standardization, SSS schemes also have limitations in readily adapting their administrative processes and benefit packages to the varying needs and capacities of different population groups.

Once established, SSS schemes often achieve relatively high levels of administrative sophistication, including the use of techniques such as performance management. They also

2. The study covered a total of ten countries across three regions (Asia, sub-Saharan Africa, and Latin America) and a country report was prepared for each based on a standard set of guidelines. The countries included in the study were: Argentina, Burundi, Colombia, Ghana, India, Laos PDR, People's Republic of China, Philippines, Rwanda and Uruguay. The country reports are publicly available on the ILO's Global Information on Micro Insurance (Gimi) platform; see http://www.ilo.org/gimi/ShowMainPage.do.

tend to be financially sustainability (ISSA, 2006). Computerization and performance-based management procedures, allowing for efficiency, a usually large risk pool, and a steady contribution flow, contribute to this stability while also ensuring a relatively high degree of contracting power when negotiating service contracts with health service providers.

The success of social health insurance schemes very much depends on the degree of political backing for the compulsory nature of the scheme. This dependence on political commitment, not least to ensure enforcement and compliance, exposes social health insurance schemes to a political risk that can influence sustainability. With political commitment, large-scale coverage extension through social health insurance can be achieved, but it takes considerable time (Carrin and James, 2005). In many countries, the short-term extension of coverage to the informal economy constitutes the main challenge.

Community-based social protection

This article works with a wide definition of community-based social protection (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 (cooperatives, non-governmental organizations, associations or micro-finance institutions) that, among other objectives, facilitate the access of their members to insurance mechanisms.

CBSP insurance mechanisms are usually small-scale and decentralized and often include a close participation of insured persons in their management. Typically, they offer less stringent administrative processes and use targeted definitions of benefits and contribution rates defined according to the capacities and needs of specific population groups, such as rural workers or certain occupational groups or community members. These features allow them to more effectively cover groups that, because of their specific characteristics, are difficult to cover by, and often excluded from, statutory schemes. In cases where informal economy workers adhere to existing civil society institutions (such as cooperatives or trade unions) that participate in endeavours to extend social protection, but which do not directly manage a scheme, administrative process can be eased and transaction costs in registering members and collecting contributions can be significantly reduced (Dror and Jacquier, 1999).

Relatively low contribution rates that are affordable for informal economy workers dictate that CBSP insurance mechanisms provide a limited benefit package. Furthermore, they face a

number of administrative and sustainability challenges once established. The level of administrative and information technology (IT) sophistication is often low and contribution flows are difficult to predict because the voluntary nature of membership can lead to high drop-out rates. The often small risk pool engenders an important sustainability risk in instances 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 often relatively small pool size means that their contracting capacity and power can be quite limited (ILO, 2007b).

The decentralized and flexible nature of CBSP mechanisms offers great potential to extend coverage at the community level. They are also independent from national politics. However, with enrolment being voluntary and their geographic reach being limited, it is difficult for these mechanisms alone to achieve a large-scale extension of coverage. The extension of coverage under existing mechanisms beyond their current borders therefore constitutes an important challenge (Jacquier et al., 2006).

Possible synergies

Recent experience – confirmed by an examination of their main institutional characteristics – shows that neither SSS schemes nor CBSP mechanisms are in a position to achieve universal coverage in the short term. However, both do cover certain but different population groups and, therefore, both should be used in coverage extension strategies.

In addition, as Table 1 summarizes, both approaches display quite distinctive strengths and weaknesses in terms of coverage, financing, administration and benefit provision. This indicates that these schemes and mechanisms should not only be developed in parallel but that linking the two should provide outcomes greater than the sum of the individual parts. Well-designed linkages between the two instruments have a high potential to accelerate the extension of social health protection. However, to date, there has been insufficient study of the potential types of linkages as well as insufficient analysis and comparison of existing experiences. The following section will make a first contribution to addressing this knowledge gap through providing, both, a typology of potential linkages and selected innovative empirical country examples.

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

	SSS schemes	CBSP mechanisms
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 common characteristics (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 limited levels of benefits, but well adapted to the needs of the 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 and administration		
Management	Sophisticated computerization and management processes, including performance management. 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 the target group. Low transaction costs and a 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	Strong purchasing power and contracting capacity – agreements at a national/regional level.	Contracting power and agreements at the local level.
Policy planning		
Advocacy	Top-down policy approach.	Bottom-up with/without policy support.

Source: Developed by the authors.
Note: The key dimensions compared here were selected by the authors with the intention to reflect the main differences between schemes.

Towards a typology of linkages

Five types of linkages within pluralistic approaches are identified by the authors: linkages to improve financial sustainability, linkages to improve operations and administration, linkages in governance structures, linkages to realize synergies in health service provision and linkages at the level of policy planning (Table 2).

Table 2. *Typology of potential linkages within pluralistic approaches*

1. Financial linkages
Tax subsidies
Redistribution between statutory and community-based schemes
Financial consolidation (risk transfers, re-insurance, guarantee fund)
Joint pooling to broaden the risk pool
2. Operational and administrative linkages
Technical advice
Exchange of information/good practice
Sharing of management functions:
Marketing and registration
Contribution collection
Claims processing and procedures
Fraud prevention and control
Information system linkages
Regulation and control
3. Governance linkages
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 and 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 and 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 side-effects through imbalanced incentive structures

Source: Developed by the authors.

CBSP mechanisms face challenges regarding their financial sustainability and often need financial support because of the low ability to contribute of the population to be insured. Realizing more equitable access to CBSP mechanisms therefore requires some external resources to ensure sufficient financing and sustainability.

The external resources allocated to community-based mechanisms may consist of government cash transfers taken from general revenue, but might also be based on a redistribution of funds between SSS schemes and CBSP mechanisms. Periodic and temporary sustainability challenges that are the result of small risk pools and fluctuating contribution incomes can be dealt with through financial consolidation mechanisms, such as re-insurance (Dror and Preker, 2002) or a guarantee fund. These consolidation mechanisms may also be backed by the government as well as by SSS schemes.

A closer linkage between SSS schemes and CBSP mechanisms to improve the financial stability of the latter could be envisaged through the joint pooling of funds. By so doing, this would lessen the burden of one of the most important challenges facing CBSP mechanisms. Such a linkage would also broaden the risk pool for both.

Examples of financial linkages can be found in a number of countries. Colombia's subsidized health insurance scheme, for instance, combines tax subsidies and the transfer of contributions from statutory schemes (Mercado Arias, 2007). Forming part of the country's 1993 health care system reform, the subsidized scheme was introduced to finance health care for the poor and vulnerable groups (including their families) who are unable to pay contributions to the general insurance scheme. The funds for the subsidized scheme are raised through taxes (national and regional transfers equating to 69 per cent of the total required funding) and a solidarity contribution collected under the contributory social insurance scheme (1/12 of annual contributions paid to the social insurance scheme, equating to 24 per cent of the subsidized scheme's total required annual funding). These funds are then channelled into several institutions, including seven mutual benefit associations federated in a national organization (*Gestarsalud*, covering 60 per cent of the market), compensation funds (*cajas de compensación*, covering 20 per cent of the market), and several private commercial insurance companies (covering 20 per cent of the market). Notably, health care coverage has risen from 28 per cent in 1992 to more than 80 per cent of the country's population in 2007.

In 2007, the subsidized scheme alone successfully covered 19.5 million people. With the combined efforts of the contributory social insurance scheme and subsidized scheme, the objective is to realize universal coverage by the end of 2009.

National solidarity between the formal sector and the informal economy is also fostered in Ghana where the National Health Insurance Fund subsidizes premiums for the poorest. The subsidy is partly financed by social security contributions from formal sector employees (Grüb, 2007). Again in Ghana, one of the functions of the National Health Insurance Fund is to reinsure district mutual health insurance schemes against random cost fluctuations. Financial linkages contributing to financial sustainability are also found in Rwanda where joint pooling has been adopted for secondary and tertiary care (Fischer, 2007). And in Laos PDR, joint pooling between the SSS scheme and CBSP mechanisms is now under consideration (Ron, 2006).

Since redistribution at the national level may not be sufficient in countries with low income, mechanisms of international redistribution may also be considered. Once more, this is the case in Ghana where, under an ILO 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 younger than age five (ILO, 2002).

Operational and administrative linkages

Statutory social security schemes can bring valuable advice and support to community-based mechanisms on all technical and operational questions related to the administrative processes of insurance schemes: for instance, with regard to client identification, registration, claims processing, and IT system development. In turn, 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 of, and 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 credit, savings schemes and insurance. They can also help organizations, such as agricultural cooperatives, to access services to help better market their produce (i.e. crops) or purchase inputs (i.e. fertilizers).

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 cost. 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.

In 2003, Philhealth, which administers social health insurance for the private sector in the Philippines, began working with CBSP mechanisms. Under an initiative called the Philhealth Organized Group Interface (POGI), the aim was to extend membership of a voluntary scheme to more informal economy workers (Asanza, 2006). The initiative successfully attracted new members to the Philhealth scheme equivalent to around 15 per cent of the target population. Building on some of the lessons learnt during this initiative, POGI was replaced in 2005/2006 by a new programme called Kalusugan Sigurado Abot-Kaya sa Philihealth Insurance (KaSAPI) designed to target community-based organizations with at least 1,000 members. Under the new programme, community-based organizations market the Philhealth scheme, register workers and collect contributions on behalf of Philhealth. The programme offers a discounted premium when an organized group achieves a minimum number of enrolled members under a contract with PhilHealth: an organized group qualifies for the group premium rate if at least 70 per cent of the group is enrolled in Philhealth and an even more preferential rate applies if at least 85 per cent become members. At the same time, Philhealth has tried to adapt its systems and processes to the realities of the informal economy, for instance, by relaxing its documentary requirements to ease registration and making its payment schedule more flexible.

A potentially even more effective procedure to ensure affiliation of informal economy and agricultural workers is the automatic affiliation of all members of an organized group (for

instance, a trade union or cooperative) to a scheme. Under this approach, contributions can be deducted from the production sales or the taxes paid by workers instead of being deducted from individualized payrolls. These procedures have many advantages: automatic affiliation facilitates the coverage of a large percentage of the target population, it leads to fewer adverse selection problems and low drop-out levels, and expensive marketing campaigns can also be avoided. Automatic deduction of the premium avoids having to collect premiums from members, thus avoiding some of the problems this can present. Moreover, since contributions are linked to sales figures or turnover, some redistribution is introduced into the scheme.

While such procedures of affiliation and the payment and collection of contributions have been already implemented in several schemes in India (for example, in dairy cooperatives) and Latin America (for example, in coffee cooperatives), or are planned for schemes being implemented in Mali and Burkina Faso (for example, in cotton cooperatives), these procedures have been predominantly used to ensure membership of schemes managed by organized groups or communities rather than by 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 CBSP schemes and compensate for their administrative weaknesses. Empirically, no direct evidence of support given by statutory schemes to the administrative functioning 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 existing or planned health insurance schemes will outsource some of their technical management functions, is being designed (ILO, 2006). In India, this role is principally played by for-profit companies (third party administrator - TPA) that assume most of the administration of an insurance scheme in exchange for a commission fixed by law (IRDA, 2001).

Where statutory schemes and CBSP mechanisms both operate their own health insurance schemes, the exchange of information on insured persons, contributions paid and claims can be greatly facilitated by the compatibility of, and connection between, the IT systems of the different schemes. Most often, but not always, this will be occur through a transfer of system knowledge from the statutory scheme to the community-based scheme to ensure coordination

and coherence as well as service provision planning. In Laos PDR, for instance, the compulsory Social Security Organization (SSO) and the community-based health insurance schemes have important similarities in their major design characteristics and administrative systems (Ron, 2006). The basic information systems on membership identification and the utilization of health care benefits of the schemes are similar, with more computerization in the SSO and increasing computerization in community-based health insurance schemes. The systems allow, for example, a comparison between the two schemes of their utilization rates and the use of capitation funds by the provider. These similarities increase the chances of eventual mergers, and allow for the creation of broader risk pools and possible redistribution between different income and risk groups.

The monitoring and evaluation of community-based schemes by 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, for example, the Ministry of Public Health has a controlling function for collective health organizations. However, there should also be a requirement to encourage reporting in both directions.

Governance linkages

In their design, CBSP mechanisms are democratic and participatory in nature and well integrated at the local level. As a result, CBSP mechanisms hold important knowledge of the specific needs and priorities of specific population groups. These mechanisms therefore have an inherent potential to act as strong representatives of informal economy population groups, providing the information and knowledge necessary for extending coverage to such groups on a large scale. Such knowledge covers local constraints and group characteristics as well as experiences with the implementation of certain measures, for example health education initiatives or the identification of poor individuals and families potentially eligible for subsidies. SSS schemes often lack such knowledge, which hampers the design and implementation of measures to extend coverage to the informal economy. Perceived as trusted representatives, CBSP mechanisms may also help build confidence in statutory social security schemes at the local level and support efforts working towards reducing levels of fraud, adverse selection and over-consumption of health services on behalf of SSS schemes.

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

Despite their potential, such linkages at the governance levels are only rarely found in practice. In the Philippines, for example, a representative of the Basic Sector of the national anti-poverty commission sits as a member of the board of Philhealth, the statutory health insurance scheme (Asanza, 2006). The Basic Sector represents and works for informal economy workers. In India, the Yeshasvini Co-operative Farmers Health Insurance Trust (which by 2007 covered 2 million affiliated farmers) allows representatives of both the government and the cooperative sector to attend its board meetings (ILO, 2007c).

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 of improving the health status of a given population. The provision of this package involves several challenges for any scheme, but the definition of the package is generally based on various criteria including: needs, priorities, and cost-effectiveness; the pricing of the various services through contracting processes with health care providers; and, ideally, quality assurance underpinning the services provided to insured persons.

Linkages between CBSP mechanisms and SSS schemes can contribute to better ensuring sustainable access to health services for the populations covered by the respective schemes. CBSP mechanisms, because of their small-scale nature, often lack market power in contracting with providers. SSS schemes, however, usually have this 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 CBSP mechanisms and SSS schemes, not least by avoiding 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 (Mercado Arias, 2007).

Clearly, the contracting process may involve important transaction costs where each scheme contracts separately with a certain number of providers. Some CBSP mechanisms, such as certain 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 transaction costs. Where this is not possible, contracting guidelines including key features can also be of assistance for small schemes. In Burkina Faso and 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 (Soumare, 2006). Working groups then draft proposals that are discussed by all the stakeholders involved. The goal of the approach is to harmonize contractual practices.

Allowing and encouraging existing health care providers, whether run or contracted by SSS schemes, to contract with CBSP mechanisms using terms similar to those offered to SSS schemes can also be beneficial. This is also beneficial to health care providers because they do not need to adapt to diverse types of contracts and can more easily comply with existing procedures and standards. It is also important that provider payments are aligned in cases where the same provider contracts with different schemes, to avoid providers otherwise offering preferential conditions that favour the members of some schemes over those of others. Finally, quality assurance processes should be combined or information exchanged. Most SSS schemes usually have quality assurance methods and tools that could be adapted and transferred to CBSP mechanisms.

Policy planning linkages

Whatever the types of scheme or the mix of schemes adopted in a country, integrated and coherent planning at the policy level is important to avoid unintended consequences. If

coherent national planning is lacking, and the core design features of the various schemes operating in parallel are not coordinated, national policy objectives may not be achieved. Linkages in the policy planning of different schemes are therefore crucial.

For example, the extension of contributory schemes, especially on a voluntary basis, may be hindered by the parallel existence of subsidized or free-access schemes. This was so in the Philippines. In this particular case the success of an initiative to extend the reach of a voluntary contributory insurance scheme to the informal economy through working with members of cooperatives was limited because of, among other reasons, the presence of another programme subsidized by national government and designed to cover the poorest families. Faced with a choice between free health care and a voluntary contributory scheme, most families opted for the former (Asanza, 2006).

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 others. Different regulations with regard, for instance, to family coverage, benefit packages, co-payments, and also between different schemes, may distort the decisions of workers and may constitute considerable barriers to the 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 must not only mean pushing for the extension of coverage, but also mean ensuring integrated policy planning and coordination between different governmental actors. A lack of such coordination may seriously jeopardize the achievement of policy objectives.

A high level of policy coherence as well as good practice exchange between schemes has been achieved in efforts to extend coverage in Laos PDR (Ron, 2006). 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 – benefits and exclusions, the provider payment as well as the basic information systems on membership identification and

utilization rates – are similar. In the short term, the aim of these linkages is to create a positive environment of coherence rather than competition, with mutual learning among schemes. A further aim is to avoid the possibility of providers offering preferential treatment to insured persons in any one of the schemes. In the long term, the similarity of design components should be crucial to the spread of knowledge and experience about social security in both the formal and the informal economies while increasing the likelihood of mergers and scheme consolidation. The merging of 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 detrimental impact on solidarity, which is necessary at the national level. Maintaining solidarity between more well-off and poorer population groups, between the old and the young, and between the sick and the healthy is important if universal coverage is to be achieved. But solidarity and redistribution 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 coherent national policy planning (Mercado Arias, 2007).

The content of the Unorganized Sector Workers Social Security Bill, enacted in 2007 in India, presents another good example of policy planning linkages, with the intention of creating a coherent and equitable system of social protection at the national level for different population groups.

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. This has been pursued through several initiatives, including: welfare funds, subsidized insurance products, social obligations for private insurance companies, and State government health insurance initiatives. However, it is estimated that some 90 per cent of the Indian labour force still does not benefit from any kind of social security. As regards health protection, the exclusion phenomenon affects some 950 million people, making the extension of health protection to all in India an unprecedented challenge.

The Unorganized Sector Workers Social Security Bill paves the way towards a nationwide social security system based on the principle of national solidarity (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 informal economy workers. It proposes the design of a global and coherent framework that is adaptable to the existing social security mechanisms already implemented in the various States and the financial capacity of States to contribute. As such, it is conceived as a flexible instrument that will ensure a common minimum level of social protection that is applicable to all States nationwide. State governments remain free to complement the various provisions and benefits (ILO, 2007c).

Conclusions

Access to health services and social protection is essential for economic and social development and for reducing poverty. Given the high levels of exclusion from health services and social protection found 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 limited progress has been made during the past decade. This is despite the fact that there are a number of mechanisms available 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 capable of providing universal coverage in the short term.

It would seem that a combination of these different mechanisms offers most promise for the extension of health care coverage. However, defining the appropriate mix between these different mechanisms will depend on each country's specific circumstances. Indeed, the parallel development of different mechanisms can be observed in many countries, with social health insurance schemes being implemented for some parts of the population while community-based schemes are created for difficult-to-reach population groups that cannot yet be covered by the statutory scheme (Ron, 2007). Additionally, a tax-financed health service may also play a role in providing coverage for some population groups.

The parallel but unconnected development of different mechanisms within a given country may not only miss important opportunities to better cover populations, but may also be

detrimental to coverage where competition and duplication between the different schemes develop. In a context of scarce resources and vast unmet demand, inefficiencies must be avoided at all cost.

Using SSS schemes and CBSP mechanisms as examples, this article has sought to underline that a whole variety of linkages between different health care schemes at the policy and the implementation level can be envisaged. These linkages can function as important stimuli to the extension of coverage. Coherency at the policy level, combined with efforts to compensate for the respective disadvantages of SSS schemes and CBSP mechanisms through linkages, can avoid competition and inefficiencies. It can also strengthen the capacity of existing social health protection mechanisms to cover a greater share of the population in a sustainable manner.

The findings presented here suggest that the concept of linkages should be adopted as a component element of coverage extension strategies. Clearly, at the national level, how to better connect different institutional mechanisms, build coherency between different actions, and develop innovative linkages compensating for the organizational, financial or structural weaknesses of different types of schemes presents an important set of challenges. Much more research is needed to understand all the possibilities of, and how to more effectively implement, linkages under different conditions and between various institutional mechanisms. Nonetheless, the concept of linkages constitutes an important step forward towards exploiting the full potential, and avoiding some of the risks, of pluralistic health care strategies. Collaboration between international agencies and associations of CBSP mechanisms at the international level in research and capacity building will also be instrumental in this process (International Alliance for the Extension of Social Protection, 2005).

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