

The Office of the International Labor Organization
The Office of the Pan American Health Organization

*The Initiative for Extension of Social Protection in Health
to Excluded Groups in Latin America and the Caribbean*

**SYNTHESIS OF CASE STUDIES OF MICRO-INSURANCE AND OTHER
FORMS OF EXTENDING SOCIAL PROTECTION IN HEALTH IN LATIN
AMERICA AND THE CARIBBEAN**

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Social Protection in Health to Excluded Groups in Latin America and the Caribbean
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FOREWORD

There is consensus in the Americas as to the growing importance and size of the population with no coverage under social security health services, mainly in the informal sector in urban and rural areas. In certain countries coverage is very limited, both in terms of the number of persons protected and the contingencies covered.

In view of this situation, and in keeping with the objectives of the World Summit on Social Development (Copenhagen, 1995), the International Labour Office (ILO) and the Pan American Health Organization (PAHO) have started an initiative seeking alternative forms of health care coverage for excluded population groups. Accordingly, these alternatives should be effective, sustainable, and proven.

The ILO/PAHO meeting in Mexico (29 November – 1 December 1999) is the starting point for this initiative.

The ILO, working through its Social Security Department, Strategies and Tools against Social Exclusion and Poverty (STEP) Program, Regional Office for the Americas and the Caribbean (Lima), and PAHO, conducted the following studies:

1. Overview of the Exclusion of Social Protection in Health in Latin America and the Caribbean;
2. Out-of-pocket Health Expenditure in Latin America and the Caribbean: The Efficiency Rationale for Extending Social Protection in Health;
3. Elements for the Comparative Analysis of Extension of Social Protection in Health in Latin America and the Caribbean;
4. Synthesis of Case Studies of Micro-insurance and other Forms of Extending Social Protection in Health in Latin America and the Caribbean;

These studies will serve as the basis for the discussion during the Mexico meeting.

In addition, ILO and PAHO have prepared a document detailing their position regarding the extension of social protection in health for excluded populations in Latin America and the Caribbean.

Synthesis of Case Studies of Micro-Insurance and Other Forms of Extending Social Protection in Health in Latin America and the Caribbean

This report concerns the “Synthesis of Case Studies of Micro-Insurance Experiences and Other Forms of Extending Social Protection in Health in Latin America and the Caribbean”. Accordingly, its objective is to characterize experiences of this type and to identify their potential and limitations for extending coverage¹.

¹ This document was prepared under the guidance and supervision of the ILO and PAHO/WHO. The Social Security Department, its STEP Program, the Regional Office for Latin America and the Caribbean as well as the ILO Offices in Lima and Santiago, participated on behalf of the ILO. The Organization and Management of Health Systems and Services Program, Division of Health Systems and Services Development participated on behalf of PAHO/WHO. The Latin American Center for Health Systems Research (CLAISS) was entrusted with the corresponding studies and research.

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SYNTHESIS AND ANALYSIS OF MICRO-INSURANCE EXPERIENCES AND OTHER MEANS FOR EXTENDING SOCIAL PROTECTION IN HEALTH IN LATIN AMERICA AND THE CARIBBEAN

I. INTRODUCTION

This report analyzes and synthesizes several Micro-insurance experiences and other types of interventions geared toward extending social protection in health to excluded groups in the Region of the Americas. The objective of this report is to characterize these experiences in order to identify their potential and limitations, as well as to suggest proposals for interesting areas for research, which would facilitate greater knowledge of these types of interventions.

This document begins with a brief characterization of the experiences studied to familiarize the reader with the kinds of activities that have been carried out in the Region, with a view to increasing the population's access to social protection in health. This is followed by a typology of analysis, which is used to review the experiences and serve as a guide for reviewing the cases and identifying elements that enhance or hinder their feasibility.

Based on the proposed typology, the context of the experiences is described, identifying their most relevant characteristics and, insofar as possible, describing their trends and groupings. This study employs specific hypotheses that focus on financial and institutional sustainability and contribute to greater equity in health, with a view to identifying the potential and opportunities of these experiences for the rest of the Region and extending social protection in health.

The report closes with conclusions derived from the analysis and a proposal for areas of research on the potential and risks observed with respect to these initiatives. Accordingly, the aim is to increase knowledge and thus facilitate the development of more efficient and equitable intervention models for extending social protection in health throughout the Region.

II. BACKGROUND

As part of the joint ILO/PAHO initiative, a review and analysis was conducted of several experiences in Latin America and the Caribbean. These efforts focused on the experiences of social security systems and other sectors of society in the extension of health coverage for excluded groups. Study of this topic is essential for expanding knowledge and promoting suitable strategies to increase the population's access to social protection in health.

In their search for information on experiences in the Region, the ILO and PAHO identified and preselected experiences, established contact with the responsible organizations, selected cases, reached agreements with the responsible organizations on the preparation of study modalities, and prepared and analyzed cases.

The identification of experiences was based on criteria associated with financing terms (different degrees of self-financing); beneficiary characteristics (emphasis on systems that cover excluded populations and/or the poor), whether affiliation was voluntary or automatic (whether the subscriber's family was covered); and the existence of mechanisms for subscriber management and participation in decision making.

The present synthesis involves 11 individual studies, which were all based on the common data-collection instrument "Guide for Case Studies of Health Insurance Systems ("Micro-insurance"). The guide established the methodology for conducting the studies and facilitated comparison of the information provided by those responsible for observing and describing how these systems operate. The aim of the studies was not to evaluate cases, but to provide greater insight as to how the insurance systems operate, thus contributing to a better understanding of the experiences and glean useful information for the benefit of the countries of the Region.

The studies were meant to help clarify the characteristics of these systems and should not be construed as a representative sample.

The synthesis and analysis of the cases should:

1. facilitate the preparation of a typology for analyzing the cases studied;
2. provide a list of characteristics common to all the cases studied or to distinguishable subgroups of cases;
3. provide analysis of the opportunities and challenges in the Region with respect to the extension of social protection in health, which clearly arise or seem to arise from the cases analyzed from the standpoint of financial and institutional sustainability; and

4. prepare a proposal for a research agenda in specific areas, based on the need for better information and analysis. Such a proposal would be used to confirm or invalidate preliminary findings on the opportunities and challenges previously addressed in point 3, and to confirm or invalidate the hypotheses regarding whether some or all of the experiences identified are feasible alternatives for efficiently and equitably extending social protection in health in Latin America and the Caribbean.

The relevance of this study and moreover, that of the joint activities that ILO and PAHO hope to carry out, derives from the situation in the Region with respect to the levels of exclusion from social protection in health¹. Despite the efforts of Latin American governments to guarantee universal access by their populations to health services, a significant number of people with inadequate resources do not enjoy access to health care².

Given the magnitude of the economic resources that families must disburse to obtain health goods and services through purely out-of-pocket expenditures (direct payments), copayments, and voluntary contributions to private insurance plans—which constitute a particularly heavy burden for low-income families—there is an efficiency and equity rationale³ that highlights the need to explore ways to expand coverage, especially through insurance or Micro-insurance schemes for sectors excluded from national social security systems.

¹ Overview of the Situation of Exclusion from Social Protection in Health in Latin America and the Caribbean.

² Elements for the Comparative Analysis of Extension of Social Protection in Health in Latin America and the Caribbean.

³ Out-of-pocket Health Expenditure in Latin America: The Efficiency Rationale for Extending Social Protection in Health.

III. BRIEF DESCRIPTION OF THE CASES UNDER STUDY

The following is a brief description of the 11 case studies analyzed to provide a better understanding of the experiences.

COESPERANZA HEALTH COOPERATIVE (ESS) – COLOMBIA

The Coesperanza Health Cooperative (ESS) of Sogamoso was founded in 1995 under the framework of a governmental initiative formalized in 1993 with the enactment of Law 100 creating the General System of Social Security in Health. ESS began as a type of cooperative association. Its objective is to provide access to health care for the urban and rural poor with no health coverage in 30 municipalities of Boyacá Department and three peri-urban areas of Bogotá. Practically 100% of ESS financing comes from the State in the form of a per capita payment. ESS has 42,000 beneficiaries and offers health service coverage at all levels of care.

IPTK UNIVERSAL HEALTH INSURANCE – BOLIVIA

This health insurance scheme was established in 1996 as an initiative of the Tomás Katari Polytechnic Institute (IPTK), a non- governmental organization (NGO) devoted to social development in Potosí Department and the city of Sucre. Its objective is to provide health coverage to the population without access to health care in the poor sectors of Sucre and surrounding area. IPTK is the institution responsible for this insurance plan, which is financed primarily with contributions from international cooperation agencies. The scheme covers 2,027 subscribers who pay a monthly premium that covers only administrative expenses. In addition, beneficiaries must make co-payments on the benefits provided, which are mainly primary care consultations, prescription drugs, care in childbirth, laboratory tests, and certain surgical procedures.

NATIONAL DEVELOPMENT FOUNDATION – HONDURAS

This health system was created in August 1990 and is the responsibility of the National Development Foundation, an NGO providing primary health care at its eight primary care centers in Tegucigalpa, the capital. The objective of the organization is to improve the standard of living among the poorer sectors of the population, collaborate with social and health programs of the State and other organizations and, in general, to engage in activities promoting social development. The system is financed through user fees for the health services provided, and through donations from cooperating partners and international organizations. There is no formal mechanism for subscribing to the system.

MUTUAL SOCIETY OF SUGARCANE WORKERS (Amutraba) – DOMINICAN REPUBLIC

Amutraba was founded in October 1995 on the heels of the Haitian Workers' Socio-cultural Movement (MOSCTHA). Amutraba is a mutual society that seeks to improve the living conditions of Haitian workers from the *Bateyes*, small rural populations involved in the harvest of sugarcane. Its insurance plan is financed primarily through contributions from national and international social assistance organizations, in addition to a small premium paid by members. Amutraba's sphere of activity covers 20 *bateys* associated with three sugar mills in the National District and the province of Monte Plata. At present, it has 510 subscribers and 2,500 beneficiaries. This latter figure includes subscribers and their families, who have access to a primary care benefits package, mainly medical consultations and basic examinations. Beneficiaries must finance a portion of services from external providers. There are also pecuniary benefits, which consist of credits for productive activities and a system for financing funeral services.

COMMUNITY HEALTH FUND – BOLIVIA

The Community Health Fund of the municipality of Tupiza was established in 1996 as a joint initiative of the municipality of Tupiza (Potosí Department), the Tupiza Health District (Public Health System), and the community. Its aim is to meet the health needs of high-risk urban and rural families in the municipality, facilitating access to health providers by replacing benefit copayments with an annual fixed contribution to be paid by members. The bulk of the financing comes from state contributions through the municipality and the Public Health System. Currently, the fund has 3,245 beneficiaries with access to a benefits package that includes complete primary and secondary care at public sector health centers and hospitals.

JOSÉ PEDRO VARELA POLYCLINIC SYSTEM – URUGUAY

This health insurance plan was created in 1983 from the José Pedro Varela Mutual Assistance Housing Project (Complejo de Viviendas por Ayuda Mutua José Pedro Varela). The cooperative association has one polyclinic with sub-clinics in three locations, originally created independently in order to improve access, mainly in physical terms, to primary health care for residents in two neighborhoods of Montevideo. The benefits plan is a single plan which is the same for all its 6,440 members, and includes primary and specialized ambulatory care (scheduled and emergency medical consultations), prescription drugs, and laboratory tests through an agreement with an external provider. Member fees, in the form of monthly contributions and copayments for specialized consultations, provide financing for practically 100% of the system.

RURAL MUTUAL ASSOCIATION – NICARAGUA

The Rural Mutual Association's health insurance plan was established in 1995, as an initiative of the Farm Workers Association (ATC)—and operates in four rural munic-

palities of Nicaragua (Matagalpa, Jinotega, Tuma La Dalia, and San Ramón). The system is financed through contributions from a Belgian assistance organization, worker contributions (financed in equal parts by workers and employers), and from the sale of prescription drugs and health services, which consist basically of primary level care. There are approximately 6,750 beneficiaries, including subscribers and their families.

SOLANO COMMUNITY INSURANCE – ECUADOR

The insurance plan is administrated by the community organization “Health Committee of the Solano Health Subcenter” in the province of Cañar, and was initiated in March 1998 under a project known as the “Primary Health Care Project.” The project is a joint initiative between the governments of Ecuador and Belgium, who contribute most of the financing for the system. The remaining resources are generated from member contributions and copayments. The Health Insurance System (HIS) offers a benefits package, which includes primary and secondary care at public health centers. The HIS was created to increase equity, access, and community participation. There are 242 beneficiaries, primarily from the rural population of Solano Parish.

TRENQUE LAUQUÉN MUNICIPAL SOCIAL WELFARE (OSMU) – ARGENTINA

Organizations that participated in the creation of the Health Insurance System (HIS) in 1992 were the Mayoralty of Trenque Lauquén, a predominantly urban area in the province of Buenos Aires; the city’s hospital; and the municipality of Trenque Lauquén. The latter is responsible for administering the system. The OSMU system was designed to provide health care coverage to the population not covered by traditional social programs. The benefits plan, which can be accessed by the 18,000 OSMU beneficiaries, includes primary and secondary care and highly complex services (excluding certain chronic diseases.) The OSMU system is financed by member contributions and copayments, community works projects by members with limited resources, and contributions from the provincial and municipal governments.

CGTG COOPERATIVE HEALTH SERVICES – GUATEMALA

In 1996, the General Workers Association of Guatemala (CGTC), a labor union, created the Health Insurance System (HIS) and is responsible for its administration. CGTC members are the primary beneficiaries of this insurance plan. It is financed through member contributions and those of other CGTC activities. The plan was designed to provide basic medical care to CGTC workers with the least amount of coverage, who mainly work in the informal sector. These workers are located primarily in urban and peri-urban areas of the municipality of Guatemala. The benefits package includes primary ambulatory care, prescription drugs, and laboratory tests for its 4,740 beneficiaries.

FARMER'S INSURANCE – PERU

The municipality of Sama-Las Yaras is a rural district located on the coast of the province of Tacna, and is responsible for administering the Farmer's Insurance (Seguro del Agricultor). The Local Health Administration Committee (CLAS) participated in the creation of this insurance plan in 1995. This institution administered this system until 1997, and presently acts as a service provider. The initial objective of the insurance plan was to expand member benefits. Currently, its aim is to extend health and social security benefits to the lowest-income groups of the area's rural population. Today, it has 206 beneficiaries with access to primary care services, prescription drugs, childbirth services, and medical examinations. The insurance plan is financed through member and state contributions, with the latter being more significant. There are no copayments for services.

IV. ANALYSIS PARAMETERS FOR EXPERIENCES STUDIED

Below is a typology for classifying the experiences studied, in terms of their contribution to extending health insurance coverage to excluded groups. It includes the elements considered to be most relevant and is in keeping with the original case study selection criteria established by ILO and PAHO.

The typology was designed to orient the reader regarding important factors that make it possible to adopt positions and decide on actions related to the cases studied, as well as other initiatives geared toward extending health coverage to excluded groups.

1. The Efficiency and Equity Rationale

Essentially, there are two major lines of argument for justifying the existence and development of Micro-insurance systems or other means for extending health care coverage. Namely, efficiency with respect to the use of out-of-pocket health expenditures by the poorest sectors of the population, and equitable access, which contributes to protecting excluded groups. These two approaches facilitate the evaluation of experiences.

The reasons why efficiency was considered in developing this typology were taken from the paper "*Out-of-pocket Health Expenditure in Latin America: The Efficiency Rationale for Extending Social Protection in Health*"⁴ and are as follows:

1. *efficiency gains in expenditures by individuals based on arguments of classical insurance theory*, which are justified by the random nature of incidence of disease and the financial risk that comes about as a result of expenditures associated with meeting the demand for health services. The available evidence showing that the poorer segments of the population have greater price-demand elasticity for health services leads to the conclusion that the separation of contribution and consumption facilitated by insurance schemes will mean more adequate consumption of health services, compared with the model in which these users must directly absorb all the costs of services at the moment they need medical attention;
2. *efficiency gains from grouping beneficiaries and from organizing expenditures and contributions*. This allows for generating profits through economies of scale by reducing uncertainty in forecasting future expenditure,

⁴ Out-of-pocket Health Expenses in Latin America and the Caribbean: Arguments for Efficiency in Extending Social Protection in Health. Document prepared by CLAISS, at the request of ILO and PAHO.

making it possible as a result to reduce the cost of the premium.⁵ A second benefit comes from the fact that being able to ensure a stable financial flow to purchase health services reduces the uncertainty of providers, making it more attractive for them to commit to an offer that provides stable benefits. In addition, this association increases the negotiating capacity of the affiliated group with the providers in terms of price, opportunity, and quality;

3. *efficiency gains from organizing the implicit subsidies to informal sector workers* who take advantage of public benefits intended for indigents and those who are poorer. The marginalization of certain groups of workers from formal health coverage schemes, which leads them to not contribute their compulsory premiums to these systems, could be reduced in these cases. This condition only is possible if the insurance system is in some way integrated with the rest of the system, avoiding the duplication of subsidies.

In addition, it becomes necessary to analyze and draw lessons from these cases—with respect to how such efforts contribute to greater equity in health. Although it is debatable whether these limited experiences make a contribution to equity, their analysis is considered relevant with respect to how they contribute to:

1. generating *increased health coverage* for excluded groups, particularly the poor;
2. structuring a more financially secure demand for health care providers on the part of excluded and low-income groups, which *are entitled to demand quality health care*. Accordingly, this helps to reduce the quality assurance gap between these groups and the rest of society.

2. Financial and Institutional Sustainability of Micro-insurance

Another fundamental area in orienting future support for activities to expand coverage of social protection in health concerns the conditions for guaranteeing the viability over time (i.e., institutional and financial sustainability) of the experiences under study.

2.1 Financial Sustainability

With a view to analyzing financial sustainability, the following condition has been defined: Coherence and capacity to adapt must exist between *determining it's system's*

⁵ The existence of very small insurance schemes, where the factor that determines the variance of future expenditure can be significant, could invalidate this benefit, either because the premium that should be paid to obtain comprehensive coverage is very high or because the package that can be offered to make the premium affordable is unattractive.

income; specifically, this refers to premiums and other contributions, and the costs incurred from providing benefits to users and the benefits package.

Factors contributing to the analysis of financial sustainability are:⁶

1. premiums adjusted to risk insofar as possible;
2. composition of financing sources;
3. actions designed to avoid adverse selection;
4. an explicit benefits plan in keeping with the premium;
5. use of copayments to discourage unnecessary demand;
6. existence of reinsurance arrangements;
7. means to control technical costs; and
8. portfolio size that accommodates sustainability.

2.2 Institutional Sustainability

The institutional sustainability of the systems under study was also evaluated, taking the following factors into account:⁷

1. institutional property;
2. member participation in determining the benefits package and premium;
3. integration and/or coordination with the rest of the health system;
4. system capacity to adapt and develop;
5. capacity for technical and financial management based on an administrative model consistent with the objectives of a health insurance system; and
6. technical assistance received.

3. Increases in the Available Supply of Health Care Services

Finally, considering the efficiency and equity implications described above and analyzing the experiences under study, one of the main reasons for the development of

⁶ See Annex 5 for more information.

⁷ See Annex 5 for more information.

these systems has been ***the need to increase the availability of the supply of service providers***, which would improve access to health care by excluded populations. Moreover, it is important to consider "increasing the supply by service providers," even though this is not considered sufficient for justifying the existence of Micro-insurance plans. Thus, it will be analyzed as a complementary result.

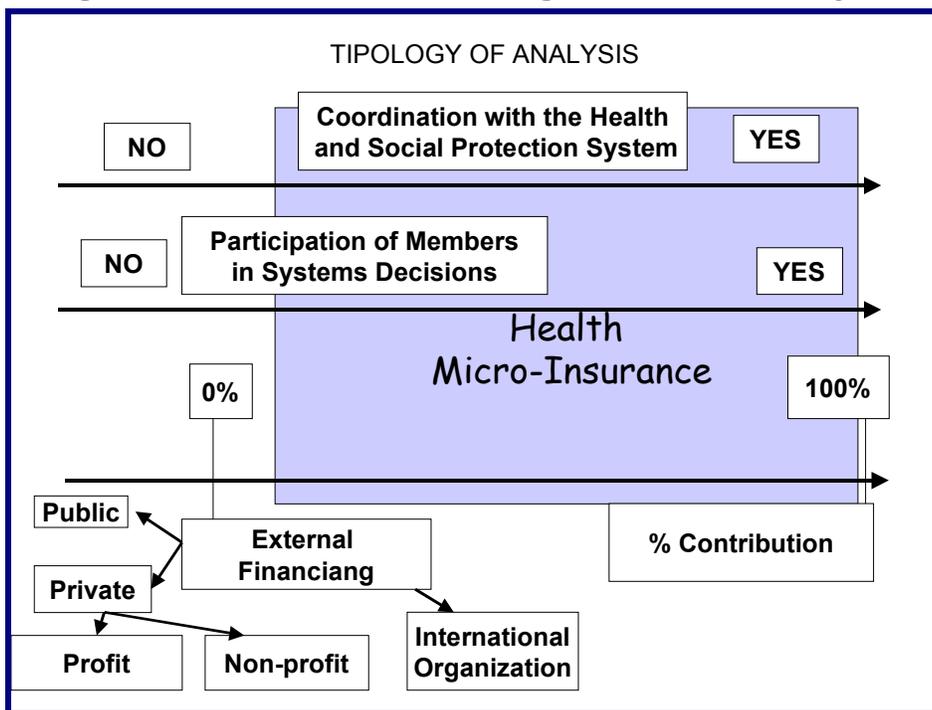
4. Micro-insurance Typology and Other Mechanisms for Social Protection in Health

A typology has been prepared to classify experiences. Essentially, this typology takes three variables into account:

1. *financing sources*. This refers to direct member contributions in terms of a base premium or contribution, which can account for 100% of financing ("self-financed Micro-insurance"). On the other end of the spectrum, there is what can be referred to as "pure external contributions," which may or may not be a subsidy, and where members make no contribution;
2. *member participation*. Member participation, or the lack thereof, in the relevant decisions of the system will be analyzed; for example, in defining benefits packages, in the criteria for determining the amount of premiums, in defining changes in target populations, etc.;
3. *coordination with other areas of the health and social protection system*. This aspect considers the capacity of the system under analysis to coordinate and integrate with national social protection policies and the existing health care network in order to increase health coverage. This variable is considered relevant because, assuming that these systems can be important in the transition from excluding individuals from social protection in health to creating permanent mechanisms for accessing health coverage, these systems should somehow be related, coherent, and included in the national social policy framework of each country.

Based on the aggregate set of variables included in this typology, a diagram of the overall analysis follows to serve as a guide for reviewing cases. However, it should also be borne in mind that Micro-insurance, or other forms of extending social protection in health, applies to cases some degrees of self-financing, some level of member participation, and that are either partially or totally integrated with national health and protection systems as a whole.

Figure1: Overall Schematic Diagram of Cases Analyzed



Source: CLAISS

To the extent that information is available, all the information analyzed for all the categories described makes it possible to obtain two types of relevant indicators for characterizing Health Insurance Systems (HIS):

- Average behavior or behavior by subgroups in the sample of cases;
- Trend over time for the experiences studied.

V. ANALYSIS OF CASES IN TERMS OF EQUITABLE ACCESS AND EFFICIENCY GAINS

As noted above in the discussion of methodology, an important aspect of this type of social protection effort is its contribution to equity in access to health services, a concept that is especially relevant in the case of health. The working hypothesis to be confirmed is that creation of these Micro-insurance systems has contributed to an increase in health equity, regardless of how they are organized and whether or not they are consistent with the specific characteristics of an insurance system as defined in this document.

It is important to recognize that the case studies outlined above contain no objective data from which to draw definitive conclusions regarding the two questions analyzed in this section. Accordingly, the analysis is based on the opinions expressed by administrators and users of the health protection systems as a good approximation.

1. Contribution to Equity

1.1 Classification of Cases in Terms of Gains in Health Care Coverage

In general, the evidence suggests that all the projects studied have increased health care coverage of the target groups. This appears logical considering that the majority of these initiatives by definition are directed to population groups with limited income and little or no access to health services. Based on available information, it is possible to distinguish those cases where there has been a marked increase in coverage from those where the increase has been relatively minor.

The experiences of Colombia, the Dominican Republic, Ecuador, Nicaragua, and Peru fall into the first category. In all of them, the reports indicate that members have increased their access to health care. It is interesting that in these cases, the target populations live in rural areas or areas distant from urban centers where an adequate health services infrastructure exists; this, along with their low level of income, constituted their principal barrier to access. In the Dominican Republic, in particular, there has been an obvious improvement in coverage since the Haitian workers previously had no right to health care because of their illegal status. Similarly, the Colombian initiative involves creation of an "extramural" health care system that brings providers closer to where the users live.

At the other extreme is the project in Uruguay, which serves a middle-to-low-income population that did not previously have major problems of access. The only barriers were their distance from health care centers and the copayments that must be made in the formal social security system, which ultimately meant that this initiative could offer better conditions of access.

The rest of the projects fall in the middle. They are directed mainly to populations who live in the cities or on the urban periphery, or who belong to groups with some level of organization, so that these initiatives are able to offer some level of access to health services.

1.2 Classification of Cases in Terms of Gains in Health Care Quality

It appears that the majority of the projects studied have managed to improve the quality of care to which beneficiary populations have access, particularly relative to the situation that existed before the creation of these social protection systems.

This conclusion is based on information in the section that presents the opinions of those responsible for administering the systems as well as of the users themselves⁸. The cases in which the two sets of opinions affirm this positive view are Colombia, Bolivia-Tupiza, Nicaragua, Ecuador, Argentina, and Guatemala. In all of these, to a greater or lesser extent, it is reported that people are generally satisfied with the care provided through the system and with the resulting improvement in their access to services. Two of these projects, Colombia and Argentina, incorporate complex care in their benefit plans, which is a strong indicator of improved quality of care. A constant theme in the opinions expressed is that users want more benefits included in their benefit plans, particularly specialist care, which most of the systems did not include initially.

The experiences of Bolivia-IPTK, the Dominican Republic, Uruguay, and Peru fall into a second group. In these cases only the opinions of administrators were available; they agreed that creation of the systems has improved access to higher-quality care. These opinions clearly should be given less weight than the opinions of users, so it is less certain in these cases than in the preceding ones that there has been a change in the quality of care.

Finally, in case of Honduras, information is not available from which to draw conclusions about the quality of care.

2. Contribution to Efficiency

Theoretical hypotheses have been set forth concerning the contribution that these projects could make to greater efficiency in the use of out-of-pocket expenditures.

In this regard, in light of the tenets of classical insurance theory, an interesting finding relates to the assumption that the condition of being insured should increase consumption of health services, especially in the poorest population. Although relevant quantitative information cannot be obtained in all cases, the perception of an increase

⁸ Although the data is qualitative, the coincidence of views among the different informants lends reliability to the findings.

in the consumption of health care is a constant theme in the comments of users in all the reports, and is also confirmed by the providers.

As far as the gains in efficiency that can be realized by negotiating collectively with health providers, the majority of cases highlight successes achieved by health system administrators in this regard, such as by obtaining better prices or greater access to care or by adopting payment mechanisms that shift part of the risk to providers (per-capita payments). In addition, as mentioned in the discussion of equity, users have favorable impressions regarding improvements in their quality of care.

Finally, with regard to efficiency gains for the system as a whole, although there are no explicit data on this point it can be assumed that the majority of these projects do contribute in this regard by reducing the implicit subsidies that the State gives to workers in the informal sector who do not contribute to the formal social security system. This is because these local initiatives have managed to have workers in the informal sector contribute to a health insurance system and in return receive a benefit package (health plan). It is possible that the effect may be the inverse in the case of Uruguay, where the population covered by the health insurance system already had coverage in the formal system. This effect may also be absent in the Dominican Republic, where the Haitian population was previously excluded from receiving care through the public health network.

All analysis of efficiency gains excludes the case of Honduras, whose experience cannot be treated as a health insurance model.

VI. ANALYSIS OF CASES IN TERMS OF FINANCIAL AND INSTITUTIONAL SUSTAINABILITY

In drawing conclusions from this synthesis of 11 case studies from around the Region, the following methodological limitations should be kept in mind:

- despite the extensive work done by the ILO and PAHO in identifying cases, there exists the possibility of bias. The cases studied may not be sufficiently representative of the most common experiences in Latin America, or for some reason they may present characteristics that other cases not studied do not have and that may be relevant to the objectives of the ILO and PAHO as they seek to orient future actions. For one thing, more than half the experiences studied have been in existence only a short time, a fact that affects conclusions regarding both their financial and institutional sustainability;
- although the use of a common methodology in drawing up the case studies made it possible to include the same type of information in the different reports, there are still some differences with respect to form and content. There are, moreover, significant differences in the depth of analysis, which in some instances means that the basis for conclusions on certain relevant questions differs from one case study to another;
- in addition, in most of the cases homogeneous data simply are not available due to the lack of adequate information systems. A particular problem with the financial information is that, in many cases, when such data exists it is not separated out from data on the other activities of the organizations responsible for operating the Micro-insurance schemes.

1. Financial Sustainability

As mentioned above in the section on analytical typology, the hypothesis to prove with regard to financial sustainability is that those Micro-insurance projects that are financially sustainable—with respect to the existence of a deficit and the coherence and/or adaptability of income and expenditures—are those that to some extent manage risk. In order to measure the latter, the following factors are discussed below: the determination and evolution of the premium, the composition of financing sources, the existence or not of actions to avoid adverse selection, the characteristics and evolution of the benefit package, the existence or not of copayments, the existence or not of reinsurance mechanisms, the cost of benefits and mechanisms of payment to providers, and the size and evolution of the portfolio of members and beneficiaries of the systems.

1.1 Determining Premiums

As regards financing through the collection of contributions, which are in effect the premiums of these insurance systems, it was found that in general the determination of contributions did not take into account factors related to the risk of the target populations or groups.

In eight of the cases analyzed, the premium is fixed and independent of the number of people in the member's family (in the majority of cases immediate family members are beneficiaries of the system). Only in case of Bolivia-IPTK, where the contribution is per person, and in Ecuador (from the second year on), is the size of the family group taken into account.

A system in which the premiums or contributions are set at different levels is Argentina's Obra Social project, but the difference relates only to members' incomes.

Another system that sets different premiums, although they do not come from contributions, is the one in Colombia, where the following categories are defined: children under 1 year, women aged 15 to 44, and all others. This could be seen to some extent as a system of premiums based on the risk of the different groups within the beneficiary population.

Honduras is a special case. There are no premiums; rather, members make their contributions by paying for benefits at subsidized prices. It is important to note that, from the perspective of this study, this experience is not actually an insurance system but an arrangement in which a nonprofit provider sets prices in such a way as to promote increased consumption of services by a population excluded from the formal health care systems.

Another point in regard to the determination of premiums is their relation to the associated risks and the cost of the benefit plan. In most cases it was found that the premiums do not cover these risks, so that financing of the system is principally supported by the other sources of funding (external contributions).

Nonetheless, in a number of cases there have been adjustments of the premiums or contributions to bring them in line with the cost of the plans. These adjustments have not resulted from any study or analysis of costs but instead have responded to the existence of persistent deficits, which signal clearly that the initial amounts did not cover the risks of the target populations. The cases in which premiums have been adjusted are Bolivia (IPTK and Tupiza), Ecuador, and Peru. In the Dominican Republic and Nicaragua there are suggestions that the premium be increased to deal with rising costs. On the other hand, in the case of Guatemala the premium has been adjusted arbitrarily, without considering the costs of the system. Finally, in the case of

Uruguay, the contribution is adjusted based on an explicit analysis of estimated expenditures for the period⁹.

Notwithstanding the adjustments that some systems have made in the premiums, the projects under study can currently be grouped in several categories: those in which the premium is very low in relation to the costs of the system and is really just a symbolic payment (Bolivia-IPTK and the Dominican Republic); those with medium-sized premiums that represent only a small percentage of the financing (Bolivia-Tupiza, Ecuador, Nicaragua, and Peru); those with medium-sized premiums that sustain more than 50% of the system (Argentina and Guatemala); and those with premiums large enough to finance the insurance and as a result cover the risk (Colombia and Uruguay). Only those systems in the latter category incorporate, explicitly or implicitly, criteria compatible with insurance theory in setting their premiums.

1.2 Composition of Financing Sources

The 11 cases analyzed show a variety of financing schemes. They range from systems financed 100% through beneficiary premiums and contributions, as in the case of Uruguay, to those financed almost 100% by external (State) contributions, as in Colombia.

Between these extremes two groups can be identified: those in which external contributions account for the larger share of financing, and those in which, by contrast, premiums and copayments account for the larger share. Of the nine intermediate cases, eight are in the first group and only one in the second.

In order to draw any conclusions from this classification, other specific characteristics of each case must be taken into account. For example, among the schemes that receive external contributions it is possible to make further distinctions based on the origin of the contributions. This is important inasmuch as it can generally be assumed that contributions from the State are more sustainable than those that originate in funding from international cooperation agencies. Those systems in which the State contribution plays a key role are Colombia, Ecuador, Peru, Bolivia-Tupiza, and Argentina; the rest are sustained through international donations. The Guatemalan case is special because the funding that sustains the system comes from the labor union itself; that is, the insurance scheme is an extension of the union's activities.

⁹ In Uruguay the premium is adjusted according to the CPI/inflation.

Table 1: Description of cases according to Financing Source

External financing only	Mainly external financing			Mainly private financing	Self-financed
State	State	NGO	International Cooperation		
Colombia	Bolivia-Tupiza Ecuador Argentina Peru	Honduras	Dominican Rep. Nicaragua Bolivia-IPTK	Guatemala	Uruguay

Source: Prepared by CLAISS on the basis of case studies.

1.3 Measures aimed at Avoiding Adverse Selection

None of the systems studied had systematic or explicit mechanisms that would enable them to select risks and, as a result, avoid adverse selection. The only difference found was the practice in some cases of carrying out an assessment of the population before setting up the system—a practice intended more to reveal the principal characteristics of the previously defined target groups than to draw distinctions within them by category of risk. Based on information in the reports, it is not possible to affirm or reject the hypothesis that those institutions having information about the risk of possible target populations would have catered to those segments where an “affordable” premium could be adjusted to the risk revealed by the assessment.

In general, studies are not done on the health status of individual members or their dependents (mainly their immediate family); nor are efforts made to systematize the information that can be obtained from providers about the principal uses of the insurance.

There is no differentiation of plans or benefits for different groups of users, nor do co-payments differ according to categories of risk. The only system where these elements are reported is in Argentina, and even there the measures do not seem to be expressly aimed at risk selection but rather seek to offer more alternatives to middle-class segments of the member population who prefer to exercise free choice.

A comparative analysis of the populations (only in relation to sex, age, and per capita consumption in those studies where such data was available) does not show any significant differences that would suggest that the beneficiaries of these systems have lower levels of risk than the general population. Rather, the evidence points the other way, making it possible to conclude that in terms of results the administrators of these insurance schemes are not engaging in risk selection.

On the question of adverse selection, as noted above, almost all the cases studied involve population groups with levels of health risk greater than those of the general population, with some diversity.

Nonetheless, it should be recognized that there is a marked tendency to select as target groups low-income or even impoverished populations; this means that adverse selection exists by definition, inasmuch as these groups have very limited access to health care and worse living conditions than the general population. The exception to this pattern is the case of Uruguay, where the covered population is not predominantly poor.

In any case, when the members and beneficiaries of the systems are compared to the target groups or populations as a whole, there is no evidence of significant differences with regard to risk. The exceptions are the system in Ecuador, which reportedly includes a large number of people with chronic health problems, and the one in Peru, where the beneficiary group includes a greater proportion of children and elderly people than the rest of the population, a circumstance that clearly would impact on costs¹⁰.

1.4 Benefit Packages

The benefit packages offer primary care in six of the 11 cases studied (Honduras, Uruguay, Guatemala, Peru, Nicaragua, and the Dominican Republic). The latter three include some additional services such as care during childbirth, dental care, and pecuniary benefits¹¹.

In a second group, the benefit plans also include secondary care, typically surgical interventions of low complexity. This group includes three schemes, the two systems studied in Bolivia and the insurance studied in Ecuador. It should be noted, however, that the available information suggests that access to secondary care is not always prompt, either because of limitations on the part of the providers, who are mostly in the public sector¹², or because the Micro-insurance schemes have not fully utilized the services available owing to their lack of integration into the network of care. This ultimately means that coverage is less complete in the area of secondary care than in primary care.

Finally, in the experiences of Colombia and Argentina, the plans explicitly include coverage for complex care or catastrophic benefits, although the Argentine system excludes some benefits associated with chronic diseases.

In almost all the cases, therefore, the plans offer partial coverage mainly focused on the kinds of daily health events that occur frequently and can be treated at low cost. Although it cannot be objectively confirmed that these partial packages are designed

¹⁰ This situation has been especially evident in the past year: due to the increase in the premiums, those members who have opted to continue with this insurance are undoubtedly those who have the greatest risk and generate the most health expenditure, since they are the ones who would likely find the higher premium acceptable.

¹¹ Ambulance transport service, for example.

¹² In the case of IPTK, secondary care is provided mainly by the private sector.

so as to meet the principal needs for health coverage (as seems to be true in Uruguay), in many cases it appears that the guarantee of primary care (when it is not otherwise available) may be most important.

Moreover, if the country's larger health system guarantees implicit reinsurance by the State through the provision of secondary and tertiary care in state hospitals, it is possible that the design of the partial plans may meet the most pressing needs of the population¹³.

In 10 of the 11 cases, a single plan is offered. In Argentina there exist two plans, one for members who are direct contributors and the other for members financed by the municipal contribution. Members in the former category have access to private providers, while those in the latter have access only to providers in the public sector. This arrangement is designed to attract contributors with the ability to pay through the use of two plans offering different benefits.

With respect to members' knowledge about the plans, there appears to be a good level of knowledge in all cases. In general the plans are well explained, their content made known through various channels of information.

With respect to changes in the plans, the benefit packages have been revised in only six cases. In five the benefits were increased (Bolivia-IPTK, Nicaragua, Uruguay, Colombia, and Guatemala), while in one they were decreased (Bolivia-Tupiza). An interesting point regarding the benefits offered by the systems is that in almost all cases the users request that the benefits be expanded, mainly to include outpatient specialist care.

1.5 Applying Copayments

As a means of sustaining the systems financially and/or reducing overutilization of the Micro-insurance, copayments have been established in eight of the systems analyzed. There are no copayments in the cases of Bolivia-Tupiza, Ecuador, and Peru¹⁴.

In the cases where copayments are required, it is possible to distinguish between those systems that apply a single equal copayment to all beneficiaries and those that apply different copayments to members in different categories or apply them only to certain benefits. The former group includes Colombia, Bolivia-IPTK, Honduras, and Argentina.

The second group includes the Dominican Republic, which applies copayments only to benefits that must be purchased from external providers. Similarly, in the Uru-

¹³ Further analysis is needed on this question.

¹⁴ Although copayments were not applied in Colombia initially, legal changes were made to introduce them for hospitalizations and other benefits with a view to moderating consumption by the members.

guayan system copayments are required only for consultations with specialists. Drugs and laboratory examinations are subject to copayments in the Nicaraguan system.

Finally, in case of Guatemala, only those beneficiaries who are family members of the contributor must make copayments.

In terms of the evolution of copayments required from members and/or users of the systems, in seven of the eight cases where this mechanism is applied, adjustments have been made since copayments were first implemented (only Honduras has not made changes). These adjustments have consisted of increasing the copayments or applying them to benefits that did not previously require them. In four of the seven cases where copayments were increased, the reason for the change appears to relate to the financial sustainability of the systems, in order to finance an expansion of benefits (Nicaragua and Uruguay) or to deal with high-cost benefits or cost increases (Dominican Republic, Nicaragua, Guatemala).

It can therefore be concluded that the application of copayments is motivated mainly by the exigencies of financing the systems, and not by a desire to contain costs by avoiding unnecessary consumption of benefits.

There exist other mechanisms with objectives similar to that of the copayment. In the cases studied such mechanisms are formally applied only in Tupiza-Bolivia, where the first day of hospitalization is not covered, and in Argentina, Colombia, and Ecuador, where resort to secondary care must be authorized by personnel of the insurance unit.

1.6 Reinsurance

With regard to the participation of the insurance systems studied in some system of reinsurance or guarantee fund, only one of the 11 meets shows the characteristic. Colombia in effect has a reinsurance system for catastrophic diseases. In this case, it takes the form of a legal obligation defined within the Colombian health system.

The remaining insurance schemes do not participate in any formal system of reinsurance. Rather, the State provides implicit reinsurance in the sense that all members of these social protection systems can resort to the public health care network when necessary and receive care at no charge to their insurer. The State thus functions as reinsurance provider.

Nonetheless, access to the health care offered by the State is not equal in all cases. There exist various types of restrictions, one being the poor quality and coverage of the care networks available to these population groups. An extreme example of this situation is in the Dominican Republic, where the beneficiaries of the bateye workers association are denied access to care because they are Haitians who live illegally in

the Dominican Republic. This is the only situation in which there is no reinsurance at all.

1.7 Managing Technical Costs

Generally speaking, the systems do not possess clear, homogeneous, synthetic information about benefit costs that would make it possible to do a provisional comparative analysis. Nonetheless, certain trends can be identified on the basis of available information.

In most of the cases there is insufficient evidence to conclude that substantial cost increases have resulted from overuse or adverse selection. In those cases where increases in the cost of benefits are reported, these would seem to stem from circumstances unrelated to use: for example, wage increases or inflation. In the case of Peru, there has in fact been a significant increase in per capita technical costs, mainly due to rising costs for drugs, which in turn may have to do with the nonexistence of member copayments and the shift of responsibility from the provider to the municipio. Also in the case of Bolivia-Tupiza, costs rose substantially (50%) despite the existence of a cost control system involving evaluation by health workers at the time of entry.

In general, in all those cases where leadership of the system is in the hands of providers, there appears to be no institutional policy aimed at controlling the growth of costs, since the perspective is not that of an insurer.

With respect to the mechanisms used by the systems for making payments to providers, which can be useful tools for containing technical costs while maintaining quality, the cases can be classified as follows:

In one group, the mechanism used is the per capita payment. Four of the 11 cases are in this group (Colombia, Ecuador, Peru, and Argentina), and in all of them the payments are for primary care services.

The most common payment mechanism, used by six of the systems, is the per-benefit or per-service payment. In Colombia and Argentina this is used for secondary-level and complex care. Two systems pay for primary care services with this mechanism (IPTK and Tupiza, both of Bolivia). The systems in Uruguay and Nicaragua purchase services from external providers in this way.

The rest of the systems, in which the institutions have their own primary-care facilities, pay their staff members fixed salaries for a given period.

In some cases there is an overlap of providers and payment mechanisms (Uruguay, Bolivia-IPTK, Nicaragua).

1.8 Portfolio Size and Penetration of Cases Analyzed

The coverage achieved by the Micro-insurance schemes, in relation to the size of their target populations, is low. In all cases there is a low percentage of coverage and no improvement in the penetration of target groups is observed over time. This clearly affects the sustainability of the insurance schemes, since small portfolios do not allow an adequate distribution of risk.

The cause of the low coverage is unclear, but reasons mentioned by the investigators include the following:

- low interest and knowledge on the part of potential members and beneficiaries, who in general have low educational levels and do not assess their health care options adequately;
- failure to make sufficient information available to the target groups;
- skepticism about the effectiveness of these schemes;
- absence of an insurance-oriented culture in the target populations;
- increase in premiums and/or economic inability to pay the premiums;
- labor mobility that prevents members from using the provider network made available by the scheme.

Although the majority of the initiatives specify penetration of the population as one of their principal objectives, they generally do not describe any deliberate efforts to achieve this in the management of the insurance.

It can be assumed that the size of the portfolios, which are mostly small, may seriously affect the viability of these schemes. One way in which they can protect themselves against that risk is by defining packages of low-cost basic benefits while staying away from catastrophic coverage. This, however, goes against the objectives that were set when the health insurance systems were created and perhaps also against the expectations of the population as to what health insurance will deliver.

Finally, in none of the cases analyzed were financial studies conducted to determine the minimum portfolio needed to finance the insurance—one of the most critical elements in achieving an adequate balance between contributions/income and benefit package/expenditures. The exceptions are the cases of Colombia, Nicaragua, and Uruguay.

The following table summarizes available information on the evolution of the size of the portfolio (based in most cases on the number of members) and the degree of penetration of the target group:

Table 2: Size of portfolio and penetration in cases analyzed

System	1996	1997	1998	1999	Total target population and/or % of penetration
Colombia	32,000	-	37,500	42,300	Law requires 50,000
Bolivia-IPTK	1,200	-	2,027	-	N/A (approx. 10%)
Honduras	-	-	-	-	N/A
Dominican Rep.	-	-	206	510	8,789
Bolivia-Tupiza	2,005	6,125	4,380	3,245	25% to 30% of the total
Uruguay	-	-	-	6,440	100%
Nicaragua	824	1,142	1,236	1,125	9,000
Ecuador	-	-	-	242	23.6% of the target population
Argentina	-	-	-	18,038	N/A (approx. 50%)
Guatemala	-	-	1,150	948	16,000
Peru	1,012	886	206	-	10%

Source: Prepared by CLAISS on the basis of case studies.

2. Institutional Sustainability

This section examines elements that characterize the projects in terms of their management capacity and their coherence with the rest of the health system. These are factors that affect their future viability and their ability to serve as models for a transition toward more permanent systems of insurance or social protection in health for excluded groups.

2.1 Institutional Ownership

With respect to ownership, the 11 cases studied fall into the following groups:

The first group consists of institutions that have their origins in the users themselves through community-based organizations such as unions, cooperatives, mutual benefit societies, etc. This group includes Colombia, Uruguay, Nicaragua, Guatemala, and the Dominican Republic.

The cooperative association of Colombia differs from the rest in that it is part of the formal social security system of the State, administering a subsidy with clearly defined rules. In the other four cases there is no formal linkage with state agencies.

A second group consists of systems that were created or are administered by non-profit institutions that provide health services; examples include Bolivia-IPTK and Honduras.

Finally, in the four remaining cases (Bolivia-Tupiza, Peru, Argentina, and Ecuador) the State has direct participation, especially through the municipios and to a lesser extent through administrators in charge of public health services delivery.

2.2 Member Participation

On the question of member participation in management, an examination of the cases reveals an interesting association that should be studied in more depth. In the majority of the cases where the members participate actively in institutional management, through assemblies that intervene in decisions about the insurance systems, the systems show a satisfactory financial performance (Colombia, Bolivia-Tupiza, Uruguay, Guatemala, and Nicaragua).

The case of the Dominican Republic, where there is also moderate member participation, departs slightly from this pattern. In this case the activities of the insurance system are not separate from those of the MOSCTHA association, and thus no debt figures are specified in the report; but it is reported that the insurance operation has generated a surplus.

As far as the hypothesis that greater institutional sustainability is associated with greater participation, there are no conclusive data concerning greater social control over the “moral hazard.” However, this connection is apparent in the case of Nicaragua, where the members themselves spontaneously raised this point.

It is likewise difficult to establish a firm connection between greater member participation and a benefit package optimally tailored to the needs of the user population.

In three cases there is a clear association between greater member participation and the definition of health packages that include benefits beyond primary care: dentistry in Nicaragua, catastrophic care in Colombia, and secondary care in Bolivia-Tupiza. In all three cases the member population actively sought expansion of the health benefits offered.

At the same time, there is one case—Uruguay—where despite a high level of participation, the benefit package was restricted to include only primary care¹⁵. Finally, an inverse situation exists in the cases of Ecuador, Argentina, and Bolivia-IPTK: despite limited participation by members, their benefit packages cover complex care.

It is possible in some cases to argue that there exists “complementarity” between the Micro-insurance and alternative means of access to health services, but this assertion needs to be studied in greater depth.

Finally, with respect to the possibility that systems with greater member participation may achieve better penetration of the target population, the findings are similarly inconclusive, as seen in Table 2.

¹⁵ It is possible that in this case the rest of the state network for complex care is sufficient and the members do not need better access to specialists, but available information is not sufficient to affirm such conclusions.

In general terms it appears that greater member participation is associated with greater penetration of the population. However, several cases cast doubt on this hypothesis, such as Guatemala and the Dominican Republic, where it is possible that other barriers serve to hinder affiliation (insufficient income to pay premiums, for example), and where participation does not reach the desired level. By contrast, in the Argentine case there exists a relatively high percentage of penetration even though not all the participation mechanisms required by law have been implemented.

Table 3: Relation between member participation and penetration of the target population

Country	Penetration achieved (%)	Participation
Colombia	85% ¹⁶	+++
Bolivia-Tupiza	30%	+++
Uruguay	100%	+++
Dominican Rep.	6%	++
Nicaragua	12.5%	++
Guatemala	6%	++
Bolivia-IPTK	10%	+
Argentina	50% (estimate)	+
Ecuador	23.6%	+
Peru	10%	+
Honduras	No information	+

Source: Prepared by CLAISS on the basis of case studies.

2.3 Coordination with the Rest of the Health and Social Protection System

Analysis of this variable, which contributes to the institutional sustainability of the projects, takes into consideration the following aspects: presence of a state contribution, coordination with and use of the available health care network (public or private), and existence of explicit reinsurance. Table 3 shows the variations among the cases in regard to these questions.

Generally speaking, it appears that those initiatives that arose within the framework of national policies with the backing of the health sector (Colombia, Argentina, Peru, and Bolivia-Tupiza) present a high degree of integration, since in addition to receiving state contributions they also utilize the available health care network, and at least the first two have explicit reinsurance with the rest of the social protection apparatus in health.

At the other extreme are those initiatives that originated with financing derived from international cooperation or with self-financing. They tend to create their own health care networks and thus are articulated very poorly (if at all) with the rest of the health system. Several of these cases have a historical basis: in Uruguay, for instance, the

¹⁶ The goal of 50,000 members is specified by law.

initiative arose during a period of dictatorship when the collective itself took the decision to create its own network of care; efforts toward integration are under way, but cultural barriers on the part of group members hinder this process.

Table 4: Coordination of projects with the rest of the health system

Country	State subsidy	Articulation with network of care	Reinsurance	Articulation
Colombia	YES (100%)	YES (100%)	YES	+++
Argentina	YES (+80%)	YES (100%)	YES	+++
Bolivia-Tupiza	YES	YES (public network, and purchases when not available)	NO (implicit)	++
Peru	YES (municipal)	YES (public network)	NO (implicit)	++
Ecuador	NO (State pays the health workers)	YES (public network)	NO (implicit)	++
Guatemala	NO	Uses own network	NO (implicit)	NO
Bolivia-IPTK	NO	Uses own network and private purchases	NO (implicit)	NO
Uruguay	NO	Uses own network and private purchases	NO (implicit)	NO
Nicaragua	NO	Uses own network and private purchases	NO (implicit)	NO
Dominican Republic	NO	Own provider	NO	NO
Honduras	NO	Is provider	NO (implicit)	NO

Source: Prepared by CLAISS on the basis of case studies.

In a majority of the cases it appears that the creation and development of the insurance scheme reflects the need to supply missing links in the chain of social protection in health that had excluded these populations from coverage by the formal systems. Most of the systems analyzed seek to remedy the lack of health providers, which tends to be the principal need expressed by the members.

2.4 Origin and Capacity for Adaptation

Three of the projects have their origin in the reform of the health sector and decentralization of its activities (Colombia, Argentina, Ecuador). Others were created with major participation of the municipio in response to local problems of concern to authorities (Bolivia-Tupiza and Peru).

Still another group arose out of local initiatives by the affected groups (Dominican Republic, Guatemala, Uruguay, Nicaragua), as well as by local providers (Honduras, Bolivia-IPTK). These initiatives typically have received support from international cooperation, at least for their start-up, and in some cases this cooperation continues to support current implementation (Nicaragua, Bolivia-IPTK, Honduras, Dominican Republic).

Most of the systems appear to be making some effort to respond to the emerging concerns of members, as well as to search for alternative solutions that would enable them to expand the benefits offered. However, they have been generally slow to adapt to the demands of their members and also to changes in the environment.

There are apparent differences between the projects depending upon their leadership. In those systems where leadership is in the hands of a representative of the sector (physician or health team—provider or director), the approach to management reflects a provider perspective (Peru initially, the Dominican Republic, Bolivia-IPTK, Nicaragua, Honduras, Ecuador). In those cases where representatives of the members are in charge, the predominant vision is more oriented toward management of a health insurance scheme (Bolivia-Tupiza, Guatemala, Uruguay).

In the case of Argentina, where an intendant is in charge of the initiative, the leadership is medical but has a perspective different from that of a provider. The leadership in Colombia, especially in the initial stage, came from a nursing auxiliary who had extensive experience in community work and was also supported by the mayor. Although in this case a health worker (not a provider) took the lead, this person's efforts focused on developing a project that would guarantee health protection to its members.

2.5 Technical and Administrative Management

In the area of management there are a set of procedural elements that indicate the level of organization of the health protection systems analyzed for this study. The reason for considering them is that, logically, an institution or system with formal organization and clearly established procedures of operation and information will have greater ability to control its financial and membership activities, and as a result will enjoy greater institutional sustainability into the future.

For each of the 11 cases, the analysis first looked at whether creation of the system was preceded by studies of the population context and whether steps were taken to define the objectives of the system and the needs of the population. In eight of the 11 cases it was reported that such contextual studies were carried out and provided a basis for determining objectives and needs. In only three cases (Ecuador, Argentina, Peru) were these studies not conducted.

Similarly, the study looked at whether financial feasibility studies were carried out before the systems were set up in order to project the size of individual premiums required to finance the systems, given the benefit plan. Such analyses were done only in Honduras, Bolivia-Tupiza, Ecuador, and Guatemala.

Another element of interest is the implementation of explicit information activities directed to potential members or beneficiaries of the systems. Such activities, when properly carried out, can be a tool for increasing penetration of the target group and

thus increasing financing through greater income from premiums. These activities were carried out in 10 of the 11 cases, the exception being IPTK in Sucre, Bolivia.

Concerning the provision of credit to members or beneficiaries in order to facilitate their access to health services, only three of the systems have such arrangements: the Dominican Republic, Nicaragua, and Argentina.

Another relevant variable is the level of administrative expenditures as a percentage of total expenditures. Unfortunately, only two of the cases present objective information on this point: Colombia (15%) and Nicaragua (35%).

One of the legal aspects that should be considered is the formalization of the systems in accordance with the legal standards of the respective countries, through the granting of legal status and the existence of statutes and regulations. In four of the 11 cases the projects are formally established institutions that have legal status, statutes, and/or rules of procedure. These are Colombia, the Dominican Republic, Bolivia-Tupiza, and Argentina.

Looking at another tool for financial management, only four of the 11 systems keep separate information systems for the delivery of health services and the function of insurance. These are Colombia, Ecuador, Argentina, and Peru.

The study also analyzed the existence of documents and records related to membership (member registries, credentials, payment records, and monitoring of benefits), as well as accounting records. With respect to the former, administrators of all the systems report having them, although few of the investigators studying the cases had access to them. With respect to traditional financial reports, it appears that in four of the projects accounting records are not maintained (Dominican Republic, Bolivia-Tupiza, Ecuador, and Peru). All the others keep accounting records, in most cases under the supervision of accounting professionals or technicians.

On the other hand, all the cases have internal control systems in operation, although some appear quite rudimentary; these are mainly intended to safeguard the resources of the systems.

Finally, there is the question of direct communication with other social security institutions at the local, national, and international levels. Four of the systems—in Colombia, the Dominican Republic, Uruguay, and Guatemala—have formal participation in federative organizations, which can be seen as a source of information and occasional technical assistance.

In order to draw some overall conclusions from the various findings related to management, the table below presents a subjective ranking that attempts to suggest which systems are better organized. In first place is the Colombian case, which incorporates a majority of the management practices that were analyzed. A second group consists of Bolivia-IPTK, the Dominican Republic, Uruguay, Nicaragua, and

Guatemala. A third group, where only some of the management practices are found, consists of Honduras and Bolivia-Tupiza. Ranking last are the cases of Ecuador, Argentina, and Peru, whose systems reflect very few of the management practices described above.

Table 5: Management capacity of cases analyzed

Rank	Cases
1.	Colombia
2.	Bolivia-IPTK, Dominican Republic, Uruguay, Nicaragua, Guatemala
3.	Honduras, Bolivia-Tupiza
4.	Ecuador, Argentina, Peru

Source: Prepared by CLAISS on the basis of case studies.

2.6 External Technical Assistance

Finally, a factor in a number of the projects studied is the role of external technical assistance, either in the initial phase (Bolivia-Tupiza, Ecuador, Guatemala) or at all stages of project implementation (Nicaragua, Dominican Republic, Honduras).

In the case of Bolivia-Tupiza, support received from WHO/PAHO was basically used for technical-financial feasibility studies, project design, and organizational and management advisory services during initial implementation. Financial resources have not been provided for continuing operation. The initiatives in Guatemala and the Dominican Republic also received technical support in the form of expert assistance for the establishment and design of the projects as well as for leadership training.

Several of the other projects have received external assistance that includes not only technical support but also financial resources for their operation (Ecuador¹⁷, Honduras, Nicaragua). Except in Ecuador, the administrators of these systems as well as their beneficiary populations assign relatively great importance to the continuation of international cooperation as a means of ensuring the sustainability of the schemes.

In the rest of the cases no external technical assistance (national or international) was reported.

On the one hand, the role of technical assistance can be seen as positive when it is used for training local personnel in the skills needed for competent administration of the projects. On the other hand, continued reliance on international financing can be a factor that hinders the replicability of the experiences within the framework of efforts to extend social protection coverage in Latin America and the Caribbean.

¹⁷ The PHC project that supports this initiative provided financial resources only at the beginning.

The table below presents a comprehensive summary of the parameters used to analyze the projects in terms of their institutional sustainability. Although it is not a totally objective analysis, since the variables utilized are not equivalent, it does suggest certain conclusions with regard to the cases studied.

Table 6: Situation regarding institutional sustainability

Case	Participation	Coordination	Origin and capacity for adaptation	Management	External technical assistance	Total
Colombia	+++	+++	+++	+++		12
Guatemala	++		++	++	++	8
Bolivia-Tupiza	+++	++	++	+	-	7
Uruguay	+++		++	++		7
Argentina	+	+++	+++			7
Ecuador	+	++	++		+	6
Nicaragua	++		+	++	+	6
Peru	+	++	++			5
Dominican Rep.	++		+	++	-	4
Bolivia-IPTK	+			++	-	2
Honduras	+			++	-	2
Total	20	12	18	16	0	

Source: Prepared by CLAISS on the basis of case studies.

Ranked first is the project in Colombia, whose performance is quite positive in all of the areas analyzed. Next comes an intermediate group consisting of Guatemala, Bolivia-Tupiza, Uruguay, Argentina, Ecuador, and Nicaragua. At middle-to-low levels in the ranking are the projects in the Dominican Republic, Peru, Bolivia-IPTK, and Honduras, which generally have weak member participation, limited integration with the rest of the system, fair or poor capacity for adaptation over time, and fair management capacity.

In considering institutional sustainability in the projects analyzed, a very important variable is the integration of these projects into national health systems and networks. This is a factor that should be given consideration in the future if the decision is made to support these initiatives.

The table below associates the tally of institutional sustainability factors in each case with penetration of the target population and size of the beneficiary portfolio.

Synthesis of Case Studies of Micro-insurance and other Forms of Extending Social Protection in Health in Latin America and the Caribbean

Table 7: Summary of the institutional situation of cases studied

Case	Institutional sustainability score	Penetration	Portfolio size	Institutional situation
Colombia	12	85%	42,300	+++
Guatemala	8	5.9%	948	++
Uruguay	7	100%	6,440	+++
Argentina	7	50%	18,038	+++
Bolivia-Tupiza	7	30%	3,245	++
Ecuador	6	23.6%	242	++
Nicaragua	6	12.5%	1,125	+
Peru	5	10%	206	
Dominican Rep.	4	5.8%	510	
Bolivia-IPTK	2	10%	2,027	
Honduras	2	Not applicable	Not applicable	Not applicable

Source: Prepared by CLAISS on the basis of case studies.

Based on a comprehensive analysis of the experiences studied, it can be concluded that the projects in Colombia, Uruguay, and Argentina incorporate factors that permit their future viability. In an intermediate situation are the projects in Bolivia-Tupiza, Guatemala, Ecuador, and Nicaragua. These four could utilize their potential within the framework of health policies in those countries that promote state responsibility for financing social protection efforts, and could operate in ways that complement national efforts; this underscores the importance of the articulation and integration of these projects with the larger systems, especially in case of Guatemala. Finally, the remaining projects, those in Bolivia-IPTK, Peru, and the Dominican Republic, present a set of factors that may hinder their future viability unless they continue to receive the level of external support they have had up to now, a circumstance that is not desirable as model for other initiatives.

Because it is not an insurance model, the Honduran project has not been included in this analysis. Its viability depends upon the existence of a demand capable of financing the (subsidized) benefits offered, and thus this case must be analyzed in a different way.

VII. CONTRIBUTION TO THE AVAILABILITY OF HEALTH SERVICES

With regard to the availability of health services (public or private providers) in most cases there is no mention of supply problems as a determining factor in the creation of systems. Ultimately, however, this factor is indeed a major element in the description of the origin and development of such initiatives (increase in the supply of medical services).

In most cases the supply available when the systems commenced operations has been maintained. It can be concluded that their activities have had no impact on providers. An exception to this would be the cases of the *Seguro del Agricultor* of Tacna, Peru and the *Asociación Mutua del Campo* of Matagalpa, Nicaragua, where an increase in the supply associated with the operation of insurance systems has been noted.

In this regard it can be concluded that one of the advantages of establishing such insurance systems, in terms of efficiency, is a more or less stable flow of expenditure for volume purchases. This has not been associated with an administrative policy explicitly geared to strengthening supply in areas with deficiencies.

Another important issue related to the supply of health services is ownership. Seven of the cases under study have primary care centers that belong to the system itself or to the institution that administers it. IPTK-Bolivia, Uruguay, Guatemala, and Honduras use proprietary posts, despite the existence of a public and private health care network to which they could be linked. This situation, in the cases reviewed, affects the capacity and interest of these projects in linking with health care networks at the local or subnational levels.

Only Argentina, Ecuador, Tupiza-Bolivia, and Colombia purchase benefits for their beneficiaries and establish agreements with available health care centers.

Some members of the first group complement their primary level supply with nonprofit or private providers (especially laboratories).

The systems providing secondary level coverage (IPTK-Bolivia¹⁸, Tupiza-Bolivia, Ecuador, Colombia, and Argentina) essentially use the public sector supply of services, although when these are lacking they resort to agreements with private providers. Private provider services are also contracted for the tertiary or highest level of complexity (Colombia and Argentina).

The Dominican Republic has a basic network of primary care service; only rarely does it purchase some benefits of greater complexity. It has no linkages with the na-

¹⁸ Offers only what its own providers can supply; does not use the public sector.

tional health care network. In Peru, modifications to the health insurance scheme when its administration was transferred from the public provider to the municipio have made it possible to increase the supply of benefits; this gives members the possibility of receiving care from a private provider with whom there is an agreement for complementary benefits not offered by the public provider, and indicates that an effort is being made to link with the rest of the system.

VIII. CATEGORIZATION OF CASES AS MECHANISMS FOR EXTENDING SOCIAL PROTECTION IN HEALTH

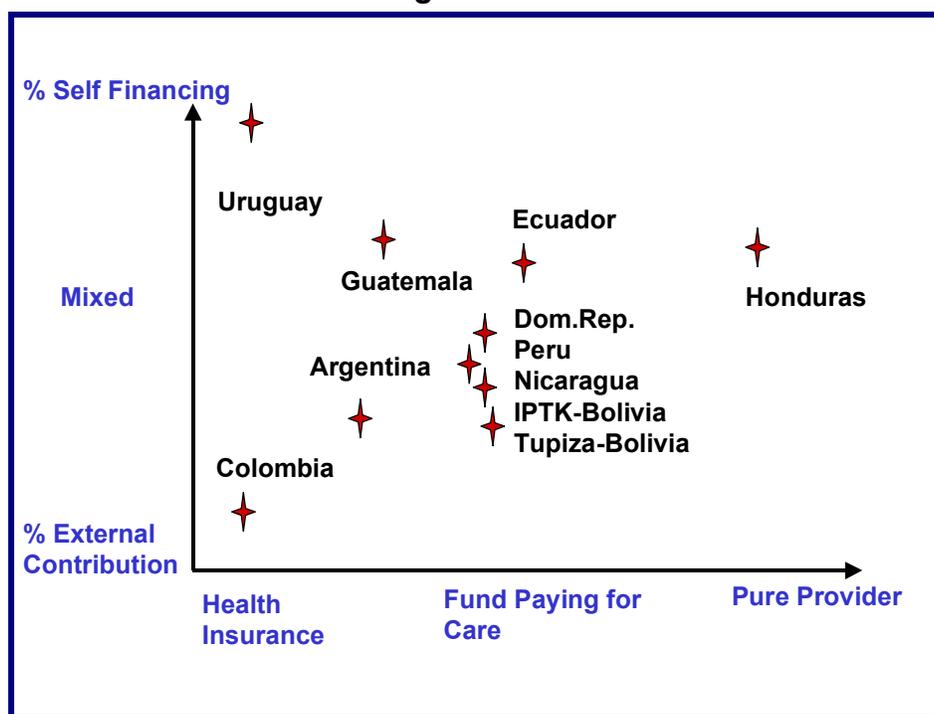
In keeping with the typology, the cases below are analyzed on the basis of the following variables: source of the financing, member participation in management, and degree of linkage to the health system as a whole.

Sources of Financing and the Management Model

How the financing is delivered and administered is also a major factor in differentiating systems. Indeed, with regards to the functioning of external contribution the Colombian case should be noted: external financing comes almost entirely from the State (although some resources are collected from traditional social security systems) but delivery takes the form of a fixed contribution per subscriber, which in practice amounts to a payment financed by the State.

In the rest of the systems, the payment, regardless of origin, is not associated with the premium or any specific item, but is designed largely to finance the providers (supply subsidy) or the annual financial deficits. The following figure summarizes this classification:

Figure 2: Relationship between the Composition of Financing and the Management Model



Source: Prepared by CLAISS on the basis of case studies.

By correlating the two dimensions—the degree of self-financing and the management model—two cases with extreme levels of self-financing stand out clearly as classical models of health insurance management (Uruguay with 100%, and Colombia, with close to 0%). Guatemala and Argentina are in an intermediate situation, closer to the insurance administration model. These are followed by a set of cases with management models geared more toward the payment of factors (supply subsidy), in which some are in fact owners of the network of providers, and with variable degrees of self-financing; the majority of the cases studied fall in this group. Finally, there is Honduras, which in our analysis does not fit into the pattern of extending social health coverage, but rather is a pure provider that offers subsidized prices to a target population for whom it is interested in providing care. The next figure summarizes this classification.

Summary of Typology of Cases Studied

In view of the fact that the variables of participation and linkage have already been analyzed, what follows is a table summarizing these characteristics in the cases studied.

As shown in the table, only four cases fit the conceptual definition provided in chapter IV (Colombia, Argentina, Tupiza-Bolivia, and Ecuador).

Another group of experiences is characterized by the absence of linkage with the health system and social security, (Uruguay, Guatemala, the Dominican Republic, IPTK-Bolivia, Nicaragua); in the case of Peru it is necessary to increase the effective participation of the members in decision-making. Finally, as noted, Honduras does not correspond to a case of social protection in health.

Table 8: Typification of Cases as Mechanisms for Social Protection in Health

Case	Self-financing	Participation in Management	Coordination with the Health System
Colombia	Nearly 0%	+++	+++
Uruguay	100%	+++	
Argentina	30%	+	+++
Tupiza-Bolivia	21%	+++	++
Guatemala	80%	++	
Dominican Rep	35%	++	
IPTK-Bolivia	24%	+	
Nicaragua	33%	++	
Ecuador	60%	+	++
Peru	28%	+	++
Honduras	Does not correspond	+	

Source: Prepared by CLAISS on the basis of case studies.

IX. CONCLUSIONS OF THE CASE SYNTHESIS

At the very least, this analysis helps draw a picture of the major characteristics of these cases in the expansion of coverage in LAC and the Caribbean. An effort is made to verify certain hypotheses of efficiency and equity. However, it should be noted that there are likely to be multivariable correlations that may distort the conclusions presented, with regard to correlations between two variables only. Ideally, comparisons should be made between systems functioning under similar conditions, with and without the presence of one of the variables under study, in order to explore that variable's impact in isolation. Obviously, this is not possible.

On the other hand, despite the efforts of ILO/PAHO to homogenize the information compiled in the case studies by using a standard tool to characterize the cases, great heterogeneity can be detected in the quality and depth of the information obtained by the researchers. This is the result of the differing realities in which these cases occur.

With regard to the constraints on this synthesis, the typology used suggests that only four cases of extension of social protection in health match all the parameters that were defined for this synthesis, and that another, larger set of cases reflects a mix of initiatives with varying degrees of development, that seek to achieve the goals of extending coverage of social protection in health in groups excluded from the formal systems.

On analytically verifying the hypotheses of the contribution of these cases to equity in health, it can be stated that most of the cases analyzed contributed to making health care access more equitable in the countries or geographic areas where they took place, thus allowing population groups to obtain greater and better health care services.

This improvement seems to be independent of the organization and operating modes of the systems. Its intensity is instead determined by certain characteristics of the target groups, such as rural residence, income levels, and membership in organized groups.

These cases do not seem to consider making the out-of-pocket expenditure of such populations more efficient as an objective. Nevertheless it is possible to conclude¹⁹ that these cases do indeed achieve progress in this regard, largely because the poorer populations appear to increase their consumption of health services. In general, there is improvement in terms of the cost, timeliness, and quality of the benefits in the negotiations with the providers. Although there are no objective data, it is possible to agree that many of the workers registered in the health insurance schemes

¹⁹ It is important to note that the financial information available is heterogeneous and does not permit solid conclusions to be drawn.

are informal workers who, prior to these cases, did not pay premiums and received free care in the public services. This contributes to a reduction in the implicit subsidies of the State for this item.

With regard to financial sustainability, and the parameters that contributed to its analysis, it was observed that nine of the systems need large external contributions to ensure their future viability (with Uruguay and Honduras excepted).

The studies reviewed lead to the conclusion that six of the cases do not engage in risk management and are primarily designed to increase access to health care for population groups who lack access to health services due to low income or other social reasons.

In such cases, external contributions (subsidies in certain cases) are unrelated to either the number of beneficiaries or members or risk. This makes it impossible to develop an institutional administration consistent with the operating characteristics of the health insurance system.

As we suggest in these cases, financial sustainability is precarious; it is maintained only by the institutions willing to increase their contributions in each period to make up the deficits. This situation is worse in the cases supported by international cooperation contributions (the Dominican Republic, IPTK-Bolivia, and Nicaragua). An extreme case of a health insurance system that is unviable in the medium term is the *Seguro del Agricultor* Tacna-Peru, which has run a financial deficit since it was founded.

This situation is due to the fact that almost all these systems target low-income populations. This in turn is reflected in the scant capacity to collect premiums that would sustain them over the long run, especially since these populations generally have higher a health risk profile than the general population.

In addition, the low premiums are not adjusted to any factor related to the risk of potential beneficiaries. This could ultimately help to reduce the deficits, although it would still not turn around the general defunding situation. Hence the need for external contributions (particularly from the State) to guarantee their existence. In general the premiums or quotas are calculated by taking into account only determinants of the members' income.

In this regard the size of the beneficiary portfolio of Micro-insurances and their efforts at increasing penetration are major issues, especially if these models target very low-income populations who spend very little directly on health. Study of this subject should be intensified in order to provide recommendations for future interventions aimed at extending social protection in health.

Although it is not possible to draw definitive conclusions, the available information shows that the two institutions or systems with financial sustainability are Colombia

and Uruguay. On the one hand, because they have no deficit, or only a marginal deficit. And on the other hand, in spite of not managing risk explicitly, these systems do reveal some coherence and adaptation in terms of the revenues and expenditures associated with the risk of the target populations.

Argentina and Guatemala are cases with financial sustainability, very low deficits, and where better risk management could guarantee sustainability in the longer term.

The remaining cases do not project financial sustainability under the parameters used in the analysis, without continued State support or international cooperation.

Taking into account only the financing variable, we can point out that the institutions that are not financially sustainable (most of them, as indicated) are so not because they do not manage risk²⁰, but because of the low income of the target populations who cannot pay the premiums needed to make the system sustainable. Even if the institutions were to manage the risk of their portfolios and use cost control mechanisms (with regard both to members and service providers) definancing would decrease, but self-financing would still not be achieved. This is why external contributions (especially from the State) are relevant. This conclusion is strengthened by corroborating that the two successful cases (in terms of financial sustainability), do collect reasonable premiums (from the members in Uruguay, and from the State in Colombia) to permit financing of the benefit packages they offer.

From the perspective of conditions to guarantee institutional sustainability it was observed that only three cases have their future viability assured (Colombia, Uruguay, and Argentina). Another important group of cases are in an intermediate situation, the linkage with the health system as a whole and with the country's social security system being the most critical variable. Finally there are three cases (Peru, the Dominican Republic, and IPTK-Bolivia) whose institutional sustainability is doubtful. Apart from not being linked to the rest of the system, the administrative capacity of two of them is limited. They depend largely on international cooperation and have not developed adequate mechanisms to promote the participation of their members in management. This places in doubt the local technical and administrative capacity to sustain these cases once external support is withdrawn.

From the perspective of the relationship between these cases and the local and sub-national health care networks, in some cases it was noted that the presence of proprietary providers (often with idle installed capacity) thwarts the proper linkage of these projects with the available care network. Nevertheless, this is not the case with projects that have been forced to develop their own providers in order to cope with the absence of the local health network.

²⁰ Even when this factor is taken into account in the analysis of these experiences, as noted above.

Overall, the case studies and this synthesis demonstrate the need to continue and intensify activities connected to these types of experiences. To a great extent, their potential is yet to be validated; however, this potential is sufficiently important to justify the effort that such validation requires. The next stage could be devoted simultaneously to research, concrete field activities in the form of pilot cases, and increased exchange of the knowledge gained from experience at the regional level. This stage will make it possible to obtain evidence for deciding whether or not to invest more in the replication of such systems and, furthermore, of the methodological groundwork needed to do so if required.

With respect to the research agenda we suggest the following:

- developing research protocols would be of great help in measuring and objectifying the fulfillment of certain hypotheses concerning the efficiency of out-of-pocket expenditures in health and the contribution to equity of this type of health insurance schemes;
- the variables that affect the penetration of these efforts in their target groups should be investigated more thoroughly, identifying factors that underlie the purchase of health insurance (personal, cultural, etc.) which would make it possible to orient strategies for the dissemination of this type of action;
- it is also important to delve further into the issue of state subsidies of local insurance schemes where social protection coverage has increased. What is the role of the relevant actors participating in these initiatives? What is their real contribution to the integration of these cases into the health system as a whole? How does the activity of the State affect their viability over time? Is Micro-insurance the best way of applying state subsidies to expand coverage to excluded groups? Is this an intermediate strategy for definitively integrating these groups into formal mechanisms of social protection? These are major questions for which answers should be found;
- the size of the beneficiary portfolio turns out in theory to be a critical variable in Micro-insurance schemes (due to the impossibility of adequately distributing risk across the set of beneficiaries). Can factors be identified to scale membership pools to more optimal sizes, and which would better guarantee the financial and institutional viability of these cases? Is it possible to design a set of tools that support the management of such models, in the sense of adjusting the premium to the benefits?
- some of these cases are an interesting source of information about the capacity and potential of poor and excluded population groups to self-manage their own approaches to overcoming the barriers the health system sets in before them. This subject is worth examining in depth, in terms of identify-

ing institutional conditions (leadership, credibility in target groups, satisfaction of needs, etc.) and weaknesses that jeopardize the future viability of these cases, in order to help achieve greater accountability by these groups and use these cases as models to broaden the social integration of these excluded groups;

- it would be interesting to examine the contribution of this type of system in the field of health as a whole, particularly in prevention and education activities;
- furthermore, if possible, it would be interesting to identify failed cases, to learn how to support and orient new cases and avoid repeating their mistakes.

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Annex 1: General Aspects of Cases Analyzed

	Objective	Institutional Ownership	Target Group	Pertinent Dates	Affiliation	Geographic Area
Coesperanza Health Cooperative COLOMBIA	Provide health coverage to the population that has none.	Cooperative organization (member contributions)	Population + the poorest groups with no coverage	Government began Health Solidarity Companies Program in October 1993; ESS Sogamoso created in May 1995 and has operated since October 1995.	Beneficiaries are members; affiliation of family group and eligible persons, classified as poor by the SISBEN survey (System for the Identification of Beneficiaries).	Boyacá Department; limited road access; armed conflict
IPTK Universal Health Insurance BOLIVIA	Provide health coverage to the population that has none (expand use of underutilized supply).	NGO (international contributions)	Poorest groups of the population with no coverage	Operations began March 1996.	Beneficiaries are members; individual membership is voluntary.	City of Sucre and surrounding area
National Development Foundation HONDURAS	Provide health coverage to the population that has none.	NGO	Population of the geographic area	Operations began in August 1990.	No affiliation process; anyone can access the system provided that premium has been paid.	City of Tegucigalpa
Mutual Association of Batey Workers (Amutraba) DOMINICAN REP.	Provide health and social security coverage to Haitian workers.	Mutual Association (MOSCTHA)	Haitian workers	Micro-insurance created in October 1995; MOSCTHA created in January 1985.	Beneficiaries are members + family and other eligible persons; individual affiliation is voluntary.	Bateys, rural areas around sugar refineries.
Community Health Fund BOLIVIA	Provide health coverage to the population that has none (organize copayments).	Municipality of Tupiza + State + community	Poorest groups of the population with no coverage	Created in January 1996; operations began in June 1996.	Beneficiaries are members; voluntary affiliation of high-risk families.	Health District of the municipality of Tupiza, province of Sur Chicas, Potosí Department.
José Pedro Varela Polyclinic System URUGUAY	Improve financial and geographic access.	Independently managed polyclinic of a cooperative federation.	Families of the cooperative federation	Operations began in 1983-84.	Beneficiaries are members + family; individual affiliation is automatic for cooperative members and voluntary for other area residents.	La Cruz de Carrasco and Parque Rivera neighborhoods of Montevideo.

	Objective	Institutional Ownership	Target Group	Pertinent Dates	Affiliation	Geographic Area
Rural Mutual Association NICARAGUA	Provide health coverage to the population that has none.	Union-organized independent mutual association.	Agricultural workers and their families	Created and began operations in September 1995.	Beneficiaries are members + family; individual affiliation is voluntary.	Municipalities of Tuma La Dalia, Jinotega, San Ramón and Matagalpa.
Solano Community Insurance ECUADOR	Expand equity and solidarity in health.	Health Committee (community + governments of Ecuador and Belgium).	Population of the geographical area	Primary Health Care Project operational since 1994; Micro-insurance ("prepaid") began operations in March 1998.	Beneficiaries are members; individual affiliation voluntary for head of household and mandatory for other family members.	Geographic area of Solano parish in the province of Cañar.
Trenque Lauquén Municipal Social Welfare ARGENTINA	Provide health coverage to the population that has none (through traditional obras sociales).	Municipality + mayorality + health authority + community	Population with no coverage	OSMU created in 1992 under administration of the municipality.	Various types of members	Province of Buenos Aires
CGTG Cooperative Health Services GUATEMALA	Provide basic medical care to unprotected members.	Union organization	Organized population with no coverage, association members	Began operations in July 1996; began membership process and charging premiums in January 1998.	Beneficiaries are members + family; individual affiliation is voluntary.	Downtown and periphery of the municipality of Guatemala City.
Farmer's Insurance PERU	Provide health coverage to the population that has none.	Municipality + CLAS-PS + community	Population of the geographical area	CLAS-PS began operations in 1995; became primary health care program under municipal administration in 1997.	Beneficiaries are members + family and other eligible persons; individual affiliation is voluntary.	Rural coastal district of Sama-Las Yaras in the province of Tacna.

Annex 2: Summary of Aspects Associated with Equity

	Changes in Health Care Coverage	Quality Improvement (perceived)
Coesperanza Health Cooperative COLOMBIA	Population had no coverage initially (according to survey, due to economic limitations); use of services has increased.	No systematic information on beneficiary perspectives. According to administrators, users are satisfied and all renew their membership. Waiting periods have been reduced and more humane health care has been achieved.
IPTK Universal Health Insurance BOLIVIA	No operating indicators available.	No systematic information on beneficiary perspectives. According to administrators, users are satisfied and receive courteous treatment and immediate care.
National Development Foundation HONDURAS	No operating indicators available.	No information available.
Mutual Association of Batey Workers (Amutraba) DOMINICAN REP.	No operating indicators available.	No systematic information on beneficiary perspectives. According to administrators, Micro-insurance has improved system access and medical care.
Community Health Fund BOLIVIA	System use level has been maintained.	No systematic information on beneficiary perspectives. Focus groups were formed during the study with beneficiaries. Generally, users are satisfied with the system and provided services. Users are unsatisfied with medical specialties and the availability of prescription drugs.
José Pedro Varela Polyclinic System URUGUAY	No operating indicators available.	No systematic information on beneficiary perspectives. According to administrators, users are satisfied with respect to the proximity of facilities, good medical care and hours of operation. System access has increased due to more consultations.
Rural Mutual Association NICARAGUA	No operating indicators available.	According to interviews with beneficiaries, Micro-insurance has improved health status. Users are even willing to pay more if necessary. Users appreciate opportunities to participate in the process, and would like to see more services added to the benefits package.
Solano Community Insurance ECUADOR	No development indicators available.	No systematic information on beneficiary perspectives. During the study, a meeting was held with 20 affiliates and interviews of 4 families were conducted. Users are satisfied with the benefits package and believe that Micro-insurance has increased access to health care. Users say they are poor and have no other alternatives.
Trenque Lauquén Municipal Social Welfare ARGENTINA	No operating indicators available	No systematic information on beneficiary perspectives. According to Micro-insurance surveys, conducted by administrators, affiliates have little information and consider their needs to be met. Micro-insurance has facilitated better access of beneficiaries to medical care. This is reflected in statistics and the number of medical consultations.

	Changes in Health Care Coverage	Quality Improvement (perceived)
CGTG Cooperative Health Services GUATEMALA	No service use indicators available.	According to survey conducted in August 1997, 33% of users considered services as very good; 32% as good; 8% as average; and 1% as bad. Moreover, 88% reported that they were willing to pay premiums for services (formerly no premium required). According to administrators, users are satisfied due to greater system access, low cost and quality, with access to a health post. Areas users identify as unsatisfactory include that there is no access to medical specialties, only one health post, inadequate hours of operation, and few prescription drugs.
Farmer's Insurance PERU	The District has worse health indicators than Tacna, but better than the rest of Peru. There has been a significant increase in system use (consultations, injectables, treatments).	According to the municipality, Micro-insurance has improved access because there are now two service providers. Quality has improved because competition encourages better services. Affiliates wish to stay with the plan, but in its original form (CLAS-PS) or with greater community participation in plan management.

Annex 3: Summary Analysis of Aspects Associated with Financial Sustainability

	Premium	Financing Sources	Risk Selection	Adverse Selection	Benefits Package	Copayment Application	Reinsurance	Technical Cost	Service Provider Payment Mechanisms	Portfolio Size	Conclusion on Financial Sustainability
Coesperanza Health Cooperative COLOMBIA	State per capita contribution based on age and sex. Remains unchanged.	100% subsidy from Subsidized Health Plan (per capita)	None	None.	One package, primary and secondary health care and catastrophic illness (determined by the Cooperative). Changes according to legal modifications.	Low copayments. Change in copayment application to harmonize criteria.	Explicit reinsurance for catastrophic illness.	Cost have increased.	Per capita payment for primary health care, payment for remaining services.	Good level of coverage. Law requires a minimum of 50,000 members; actual number is 42,000.	Yes, highly sustainable
IPTK Universal Health Insurance BOLIVIA	Low-cost premium unrelated to member risk. Covers only administration costs. Premiums have been lowered to increase membership.	Resources provided by NGOs according to Health for All initiative + payment for services + copayments + low-cost premiums.	None	None.	One package, primary and secondary health care. Medical specialties added.	Copayments. Application and amount of copayments has increased.	Implicit public sector reinsurance. *	-	Fixed salaries (agreements with providers) and payment for services with vouchers.	In 1998 there were 2,027 members. There is no estimate as to total potential membership, but low coverage is estimated.	No.

	Premium	Financing Sources	Risk Selection	Adverse Selection	Benefits Package	Copayment Application	Reinsurance	Technical Cost	Service Provider Payment Mechanisms	Portfolio Size	Conclusion on Financial Sustainability
National Development Foundation HONDURAS	None	Payment for services + donations.	None (no affiliation).	None (no affiliation).	One package, primary health care. Remains unchanged.	Copayments. No information regarding changes.	Implicit public sector reinsurance. *	-	Fixed salaries.	-	No.
Mutual Association of Batey Workers (Amutraba) DOMINICAN REP.	Low-cost premium per family unrelated to risk. Remains unchanged. An increase in premiums is under study.	Subsidies + low-cost premiums.	None.	None.	One package, primary health care + other pecuniary benefits. Remains unchanged.	Some copayments are required on services from external providers, justified to cover rising supply costs.	None	-	Fixed daily salaries.	Present membership is 510 with 2,500 actual beneficiaries. Total membership of MOSC-THA is 8,789, which demonstrates low	No.
Community Health Fund BOLIVIA	Low-cost premium per family unrelated to risk. Premiums increased by 100% in 1997 to cover resources. After a 1998 study, premiums were again doubled.	Municipal contributions and member premiums.	None.	None.	One package, supply-based primary and secondary health care. Benefits have been reduced since the creation of basic health insurance.	No copayments, lack of first day of hospitalization costs.	Implicit public sector reinsurance. *	-	Municipality pays providers for services.	coverage. Between 25-30% of the target group has been reached. In 1998 there were 4,379 beneficiaries (929 families). Tupiza has 43,887 inhabitants.	No.

	Premium	Financing Sources	Risk Selection	Adverse Selection	Benefits Package	Copayment Application	Reinsurance	Technical Cost	Service Provider Payment Mechanisms	Portfolio Size	Conclusion on Financial Sustainability
José Pedro Varela Polyclinic System URUGUAY	Fixed premium per family unrelated to risk. Premiums adjusted for inflation in accordance with the consumer price index (CPI).	Fixed monthly premiums + copayments	None	None.	One package, primary health care. Medical specialties added.	Copayments for medical specialties, created to expand benefits without increasing premiums.	Implicit public sector reinsurance*	Costs have increased to rising prices.	Hourly payment and payment for specialty services.	Present membership is 1,717 with 6,440 beneficiaries. 100% of the group has been reached thus, membership is automatic.	Yes, highly sustainable.
Rural Mutual Association NICARAGUA	Fixed premium per member unrelated to risk. A study is underway to determine if premiums should be raised to cover costs.	Belgian assistance + cost of premiums divided equally among workers and employers + payment for services.	None.	None.	One package, primary health care (payments based on service). A dental benefit has been added.	Copayments on prescription drugs for family members (100%). Copayments have been increased to cover rising costs and expanded benefits.	Implicit public sector reinsurance. *	No significant variations.	Fixed salaries and payment for the purchase of services.	Present membership is 1,125 with approximately 5,625 beneficiaries (five per member). There are 30,000 workers in the area, 9,000 of which are association members.	No.

	Premium	Financing Sources	Risk Selection	Adverse Selection	Benefits Package	Copayment Application	Reinsurance	Technical Cost	Service Provider Payment Mechanisms	Portafolio Size	Conclusion on Financial Sustainability
Solano Community Insurance ECUADOR	Low-cost premium per member unrelated to risk. Since May 1999 premiums have been based on the number of family members to be covered. Moreover, premiums have risen to offset the rising costs of prescription drugs.	State contribution (providers), Belgian assistance + service costs + member contributions.	None.	Members with chronic health problems.	One package, supply-based primary and secondary health. Remains unchanged.	No copayments	Implicit public sector reinsurance. *	-	Per capita payment for primary health care.	Present members/beneficiaries total 242. The total population of Solano is 1,316.	No.
Trenque Lauquén Municipal Social Welfare ARGENTINA	Premium based on income categories. Indigents pay no premium (covered by municipality). Since 1995, premiums are adjusted according to member income.	Member premiums + municipal contributions for indigents.	Periods of low deficiency. Two plans (+ - MLE).	None.	Two plans, primary and secondary health care, and complex benefits (some chronic illnesses excluded).	Restricted copayments; copayments have increased.	Implicit public sector reinsurance. *	Cost have increased.	Per capita payment, payment for services, daily payment for hospitalization, according to service and provider.	Present beneficiaries total 18,038. According to the report, today coverage reaches 50%.	Yes, but low.

	Premium	Financing Sources	Risk Selection	Adverse Selection	Benefits Package	Copayment Application	Reinsurance	Technical Cost	Service Provider Payment Mechanisms	Portfolio Size	Conclusion on Financial Sustainability
CGTG Cooperative Health Services GUATEMALA	Fixed premium unrelated to member risk (was not the case initially). Arbitrary adjustment of premiums.	Member premiums + payment for prescription drugs and examinations + CGTG contributions.	None	None.	One package, primary health care. Benefits increased to attract members.	Copayments for prescription drugs and examinations have increased with a view to system sustainability.	Implicit public sector reinsurance. *	-	Fixed salaries.	As of August 1999, membership totaled 948 with approximately 4,740 (five per member). CGTG has 16,000 members (+ their families).	Yes, but low.
Farmer's Insurance PERU	Fixed premium unrelated to member risk. Premiums adjust to the cost of services; they have been rising.	Municipal contributions + member premiums.	None	More children and the elderly.	One package, primary health care (+ childbirth services). Since under municipal management, medical specialties, ambulance, and laboratory services were added in response to demand.	No copayments. Per capita payments.	Implicit public sector reinsurance. *	Costs have increased.	Per capita payment.	In 1998 there were 83 members and 206 beneficiaries. Rate of members/beneficiaries of the target group: 1996 - 56.2%; 1997 - 47.9%; 1998 - 10.6%.	No.

	Premium	Financing Sources	Risk Selection	Adverse Selection	Benefits Package	Copayment Application	Reinsurance	Technical Cost	Service Provider Payment Mechanisms	Portfolio Size	Conclusion on Financial Sustainability
Case Summary	Eight systems use fixed premiums regardless of the number of family members to be covered; one system bases premiums on income categories; one system bases premiums on risk factors; one system charges no premium.	Two systems financed mainly by premiums; nine systems financed mainly by state subsidies and other sources; one system with 100% state financing.	Only one system employs risk selection, although it is minimal.	Generally, there is no evidence of pronounced adverse selection.	Six systems offer only primary-level care benefits packages; three systems have added secondary care; two systems have added complex services.	Three systems have no copayments; four systems have equal copayments; four systems require copayments for some services.	Only one system has explicit reinsurance.	Some costs have increased due to the rising prices of provider supplies and salaries.		Low coverage of target group. Low increase in annual membership. Only one system has achieved satisfactory levels.	

(*) Note: "implicit public sector reinsurance" refers to the fact that persons whose health problems disqualify them from coverage under Micro-insurance plans may seek care from public providers at no cost.

Annex 4: Summary Analysis of Administrative Aspects

	Coesperanza Health Cooperative COLOMBIA	IPTK Universal Health Insurance BOLIVIA	National Development Foundation HONDURAS	Mutual Association of Batey Workers (Amutrabá) DOMINICAN REP.	Community Health Fund BOLIVIA	José Pedro Varela Polyclinic System URUGUAY	Rural Mutual Association NICARAGUA	Solano Community Insurance ECUADOR	Trenque Lauquén Municipal Social Welfare ARGENTINA	CGTG Cooperative Health Services GUATEMALA	Farmer's Insurance PERU
Implementation Process											
Identification of Needs	YES	YES	YES	YES	YES	YES	YES	NO	NO	YES	-
Definition of Objectives	YES	YES	YES	YES	YES	YES	YES	NO	NO	YES	-
Study of Context	YES	YES	YES	YES	YES	YES	YES	-	NO	YES	NO
Financial Feasibility Study	NO	NO	YES	NO	YES	NO	NO	YES	NO	YES	NO
Definition of Benefits Package	YES	NO	-	YES	NO	NO	YES	YES	NO	YES	NO
Target Group Information Activities	YES	NO	YES	YES	YES	YES	YES	YES	NO	YES	YES
Additional Benefits											
Health Credits	NO	NO	NO	YES	NO	NO	YES	NO	YES	NO	NO
Cost Savings Systems for Health	NO	NO	NO	YES	NO	NO	NO	NO	NO	NO	NO
Financial Aspects											
Administration Costs on Income	15%	-	-	-	-	-	35%	-	-	-	-
Internal Regulations	YES	NO	NO	NO	NO	YES	YES	NO	NO	NO	NO
Legal Aspects											
Legal Capacity	YES	NO	YES	YES	YES	NO	NO	NO	NO	NO	NO
Legal Control Systems	YES	NO	NO	-	-	-	YES	NO	NO	-	NO
Operating Statutes	YES	NO	NO	YES	YES	-	YES	NO	NO	NO	NO

	Coesperanza Health Cooperative COLOMBIA	IPTK Universal Health Insurance BOLIVIA	National Development Foundation HONDURAS	Mutual Association of Batey Workers (Amutraba) DOMINICAN REP.	Community Health Fund BOLIVIA	José Pedro Varela Polyclinic System URUGUAY	Rural Mutual Association NICARAGUA	Solano Community Insurance ECUADOR	Trenque Lauquén Municipal Social Welfare ARGENTINA	CGTG Cooperative Health Services GUATEMALA	Farmer's Insurance PERU
Internal Regulation	YES	NO	NO	-	-	YES	YES	NO	YES	YES	NO
Separation of Functions between Insurer and Providers	YES	NO	NO	NO	NO	NO	NO	YES	-	-	YES
Accounting Administrators	ACCOUNTANT	ACCOUNTANT	ACCOUNTANT	ACCOUNTANT	ACCOUNTANT	ACCOUNTANT	ACCOUNTANT	TREASURER	ACCOUNTANT	-	PHYSICIAN/ TREASURER
Documentation of Activities											
Membership Documentation	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Accounting Documentation and Indicators	YES	YES	YES	NO	NO	YES	YES	NO	YES	YES	NO
Information Systems	YES	YES	YES	NO	YES	YES	YES	NO	-	YES	NO
Activity Reports	YES	YES	YES	NO	NO	YES	NO	-	-	YES	NO
Forms	YES	YES	NO	-	-	YES	YES		-	-	YES
Control Systems											
Internal Controls	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
External Auditing	NO	YES	-	-	-	NO	NO	NO	-	NO	NO
Others											
Participation in Federations	YES	YES	NO	YES	NO	NO	NO	NO	-	YES	NO

ANNEX N° 5: Detailed Description of the Case Analysis Parameters

The following are the key elements for describing the experiences in extending social health protection in terms of conditions that would guarantee the long-term viability (that is, institutional and financial sustainability) of the cases under study.

Financial Sustainability

To analyze financial sustainability, we have decided to define a set of parameters that help to identify this condition in the case studies:

1. **Premium:** information that characterizes the premiums paid by members will be reviewed, noting whether they are characterized as:
 - premium with risk adjustment: implies that the premium is based on some technical criterion to account for the individual risk of each member and family group member, or, if not, whether it is adjusted as a function of some calculation of the average risk of the user portfolio;
 - premium unadjusted for risk: in this case a variety of health risk criteria are used for collecting the premium; these could be a function of the income of the member or the member's family group, or a fixed premium unrelated to risk and income;
 - also evaluated will be whether the premium is adjusted to the benefits that the insurance system offers its users;
2. **Composition of Financing:** identifying all financing alternatives is important in characterizing financial sustainability. This takes into account the direct premiums of members and other financing sources generically known as the "external contribution," which includes potential public financing (from the national or subnational levels), international cooperation, and private sector contributions (for-profit and non-profit enterprises). Cases financed mainly with external financing from international cooperation will be considered less sustainable over time and thus, less replicable.
3. **Actions Aimed at Avoiding Adverse Selection:** Each case study will review the use of practices that allow the insurer to possess a portfolio of beneficiaries whose characteristics indicate that the insured population is "equivalent" to the average of the general population, and compare the portfolio with the applicable target group in each case. This includes reviewing whether the insurer has any type of screening mechanism differentiated by risk for income, exclusions, collection of premiums by risk or observed expenditure, etc. Based on this analysis, the insurance case studies will be classified according to whether they:

- engage in activities to avoid adverse selection;
 - not actively engaged in such activities, and adverse selection occurs anyway;
 - engage in such activities, and adverse selection does not occur.
4. **Benefits Plan:** two major categories of analysis are envisaged for this study:
- **extent of benefits:** identifying whether the benefits plan offered by the health insurance is **comprehensive** (whether it includes everything) or **partial**. For partial plans, it will be determined whether the benefits offered are **ordinary** health services (high frequency and low cost) or **catastrophic** benefits (low frequency and high cost);
 - **definition of benefits:** for each case analyzed this area will evaluate whether the plan offers **explicit** benefits that are known by the members, or, if not, whether the plan offers **implicit** benefits.
5. **Copayments:** the copayment is seen as a tool that influences the demand for health services, seeking to reduce unnecessary consumption of benefits by passing on at least part of the cost of the services to individuals. Analyzing this parameter is considered relevant. However, this is not always easy to do, nor is directly identifying whether copayments are actually used for this purpose. Thus, cases will be classified according to whether:
- They use copayment¹: this analysis will include whether it is possible to evaluate the proper use of this tool to contain unnecessary demand.
 - They do not use copayment.
6. **Reinsurance:** refers to identifying whether each Micro-insurance case studied takes measures for the proper management of financial risks, either by creating a reserve fund, reinsuring itself against catastrophic events, or by implementing procedures to assess and minimize risk. Furthermore, it will be evaluated whether the context allows the beneficiaries of Micro-insurance schemes to obtain health care coverage in another system (public or private). In this field the categories to describe are whether there is:
- **explicit reinsurance:** cases that take action in advance to minimize the risks of their portfolio will be reviewed;

¹ With regard to collection of the direct payment of beneficiaries on obtaining a given health benefit.

- **implicit reinsurance:** indicating that somehow the context and ultimately, the State assumes the broader risk of the beneficiary population of the Micro-insurance;
 - **no reinsurance** for that population.
7. **Technical Cost:** one impact it is hoped to discover, in terms of the existence of Micro-insurance on efficiency, is the advantages to be derived from collective negotiations with providers concerning the price of benefits. This benefit can be neutralized, however, if measures are not taken to avoid moral hazard. Patterns in the per capita cost of the annual benefits granted to the beneficiaries will be analyzed as a summary measure of efforts by insurance management in this regard.
- An effort will be made to explain, with the information available, whether changes over time in the per capita technical cost are associated with an improvement in the package of benefits offered. Should this condition be ruled out, this information will make it possible to corroborate the presence of adverse selection behavior by the beneficiary population. This will also include the analysis of mechanisms for payment to providers as one of the determinants of technical cost, considering as categories whether:
- mechanisms for payment to providers include mechanisms to spread risk;
 - mechanisms are based on the payment of benefits.
8. **Size of the Portfolio:** if possible, an effort will be made, based on the cases studied, to characterize the size of the Micro-insurance portfolio.

Institutional Sustainability

The elements that help to respond to the challenges of institutional sustainability are as follows:

1. **Ownership:** this covers the issue of who is responsible (legally and administratively) for the initiative. Under this condition we propose to classify the cases studied according to the following ownership categories:
 - community, in any of its manifestations;
 - health care provider (public or private, for-profit or not-for-profit);
 - government institution (national, regional, or local);
 - industry or workplace.

- The subject of ownership is important. It is related to strength or weakness in the linkage of these cases with the rest of the system, member participation or lack thereof in decision-making, and the permanence of the financing source.
2. **Member Participation:** an attempt is made to characterize cases with regard to the actors who influence decision-making in the management of Micro-insurance, and the leadership involved. The hypotheses to be tested with regard to how member participation contributes to the institutional success of the system are as follows:
 - there is a high degree of social control, with an impact on the control of moral hazard;
 - the process of defining the benefits package is better adjusted to the needs of the membership group;
 - greater understanding of the target population allows for increased penetration of the group.
 3. **Linkage and/or Integration with the Rest of the Health and Social Protection Systems:** an attempt is made to identify the degree of linkage and/or integration of the cases into the more comprehensive health systems. To this end, special attention will be paid to:
 - state subsidies, which suggest that the State has an interest in the development of the case;
 - purchase of services from the network of available public and private providers, and whether a parallel health care network is created;
 - explicit reinsurance exists, when this case is inserted in the most comprehensive system for social health protection and is covered against catastrophic events;
 - implementation areas of the cases studied correspond to links of the health system that are too weak to guarantee the health insurance for the excluded population; the system acts with a perspective of complementarity.
 4. **Origin and Capacity for Adaptation Over Time:** the potential and viability of these cases also depends on the conditions in which they were created and their capacity to adapt over time to the requirements of the members. The leadership which gave rise to these systems, and how it has developed its capacity to relate to other relevant actors, are major factors to be analyzed.

5. **Technical and Administrative Management:** The quality of the administrative/financial and technical management with regard to quality control and opportunity of access to health services for the beneficiaries is one case factor analyzed as an element contributing to institutional sustainability
6. **External Technical Assistance:** one factor to be analyzed with respect to institutional sustainability is the size and duration of external technical assistance (national or international). This also serves as an indicator of the feasibility of replicating the cases studied. To be taken into account:
 - technical assistance in the design of the system;
 - technical assistance in start-up;
 - technical assistance in implementation;
 - total participation of outside experts in developing the system.