

# **Health Microinsurance: A Comparison of Four Publicly-run Schemes Latin America**

**CGAP Working Group on Microinsurance**  
**Good and Bad Practices**  
*Case Study No. 18*

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## **Good and Bad Practices in Microinsurance**

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1. A **series of case studies** to identify good and bad practices in microinsurance
2. A **synthesis document** of good and bad practices in microinsurance for practitioners based on an analysis of the case studies. The major lessons from the case studies will also be published in a series of **two-page briefing notes** for easy access by practitioners.
3. **Donor guidelines** for funding microinsurance.

## **The CGAP Working Group on Microinsurance**

The CGAP Microinsurance Working Group includes donors, insurers, and other interested parties. The Working Group coordinates donor activities as they pertain to the development and proliferation of insurance services to low-income households in developing countries. The main activities of the working group include:

1. Developing donor guidelines for supporting microinsurance
2. Document case studies of insurance products and delivery models
3. Commission research on key issues such as the regulatory environment for microinsurance
4. Supporting innovations that will expand the availability of appropriate microinsurance products
5. Publishing a quarterly newsletter on microinsurance
6. Managing the content of the Microinsurance Focus website:  
[www.microfinancegateway.org/section/resourcecenters/microinsurance](http://www.microfinancegateway.org/section/resourcecenters/microinsurance)

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## Acronyms

BM	Teacher Welfare Insurance (Bienestar Magisterial) in El Salvador
CAPO	Aggregated Certificates for Benefits Granted
DFID	Department for International Development
DISA	Regional Health Division in Peru
GDP	Gross Domestic Product
GNP	Gross National Product
GTZ	German Technical Cooperation
HIPC	Heavily Indebted Poor Countries
IDB	Inter-American Development Bank
ILO	International Labour Office
ISSS	The El Salvadoran Institute for Social Security
MAR	Resource Allocation Mechanism in Bolivia
MDG	Millennium Development Goals
MSPAS	Ministry of Health and Social Assistance in El Salvador
MSPBS	National Ministry of Public Health and Social Welfare in Paraguay
NGO	Non-governmental Organization
PAHO	Pan American Health Organization
PHC	Primary Health Care
SBS	Basic Health Insurance in Bolivia
SEG	Free School Health Insurance in Peru
SI	Integral Insurance in Paraguay
SIDA	Swedish International Development Agency
SIS	Integral Health Insurance Plan in Peru
SMI	Mother-Child Insurance in Peru
SMI	Maternal-Infant Health Insurance in Peru
SNMN	National Maternal and Child Insurance in Bolivia
SPS	Public Health Insurance in Peru
SUMI	Universal Maternal and Infant Insurance in Bolivia
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
WHO	World Health Organization

## Executive Summary

Latin America, the region with the highest social inequalities, faces the challenge of guaranteeing all citizens an adequate level of health care in terms of access, quality and opportunity, regardless of their individual or current ability to pay. In contradiction with legal regulations in most countries, approximately 220 million people in Latin America and the Caribbean lack social protection against the risks of illness. Health systems in most Latin American countries are characterised by the coexistence of various sub-systems with different financing, membership, and benefit regimes, covering different socio-economic groups. This segmentation tends to enhance social exclusion in health because the subsystems are vertically integrated and offer coverage to specific population groups only. Universal coverage is difficult to achieve in segmented systems as long as no overall regulation and contractual obligations are in place.

Recently, a series of initiatives have started in Latin America to reduce social exclusion and improve social protection in health. The enforcement of social policy measures by international donors (HPIC-Initiative, MDGs) was a strong motivation for governments to create targeted insurance plans with a limited benefit package dedicated to maternal and infant health problems. Bolivia started to implement a mother-child health insurance scheme on the national level, while Peru initiated a pilot program that has continuously extended its geographic scope. The Paraguayan health ministry has also started a mother-child plan pilot scheme. On the other hand, specific social security systems have emerged to improve access and quality of care for professional groups.

This paper presents, analyses and compares four case studies performed in Latin American between 2001 and 2003 for GTZ's InfoSure project (see Appendix). Three of the studies deal with public microinsurance schemes in Bolivia, Peru and Paraguay, and the fourth case refers to the teacher welfare plan in El Salvador.

The Bolivian Basic Health Insurance (**Seguro Básico de Salud - SBS**) was created in 1999 as a social policy program. Financing is from national tax resources channelled via the municipalities according to a flat rate allocation mechanism. The SBS focussed on the poor population in rural and suburban areas. Enrolment was free of charge, and services were also free. Provider payment relied on the municipalities, and health care provision mainly on public facilities. The SBS offered a well-defined benefit package addressing the most important epidemiological needs of maternity and early childhood diseases. Meanwhile, the SBS has developed into the Universal Mother Child Insurance (SUMI) that offers additional benefits including coverage for chronic infectious diseases except HIV. Main observations concerning the SBS include low utilisation, a lack of incentives for users and providers, hierarchical structures and bureaucratic inefficiency. Providers complained about payment delays, and the performance was exposed to an obvious interference of political interests.

In 1999, the Peruvian Mother Child Insurance (**Seguro Materno Infantil - SMI**) started to grant its services in selected regions of the country. The Peruvian health ministry created the scheme mainly for political reasons, in order to reduce high maternal and infant mortality

rates. Thus, the scheme targets pregnant women and children between 0 and 4 years, focussing on the poor. About 95% of the SMI budget is tax-financed, the rest is from affiliation fees payable by the enrolees. No regular contribution has been implemented, and benefits are granted free of charge. Meanwhile, the SMI was combined with the former pupils' insurance plan to form the Integral Health Insurance (SIS) offering countrywide coverage for young women and children/adolescents under 18. The centralized structure and administration process, national and international political influence, negligence of ethnic and cultural differences and low consciousness about cross subsidies have the potential to develop problems in the future.

Inscription in the Integral Health Insurance (**Seguro Integral de Salud** - SI) in Caazapá, Paraguay, started in 2002. With support from WHO and other development organisations, the Paraguayan ministry of health started an insurance plan targeting women in fertile age and children under 5 years in order to improve infant and maternal mortality rates. Financing is mainly public and consists of a mix of national, departmental and local contributions. Subscription flat rate fees for enrolees were implemented only in 2004. The benefit package includes pregnancy-related preventive and outpatient care as well as diagnostics, vaccination, dental care for pregnant women, and perinatal in-patient treatment, including complicated delivery and caesarean section. The SI-scheme shows a series of regulatory, normative, administration and management weaknesses, low autonomy and independence from political interests, and difficulties in making the decentralised public institutions pay. Contribution collection needs to be improved, and the extension of the provider network is still in process.

The teacher welfare plan (**Bienestar Magisterial** - BM) in El Salvador was implemented by the ministry of education in the 1960s to improve the quality of health care for public school teachers and their dependents. Financing corresponds to social health insurance and relies on wage-related contributions shared between employer and employees. The BM offers a broad, benefit package delivered through a differentiated provider network. Primary health care is granted by hired medical staff, and second and third level treatment is accessible in various private and public facilities contracted by the BM. Several cost containment mechanisms are in place; the scheme shows a high flexibility in improving performance and efficiency. However, administrative and management tasks, claim processing and provider payment might be improved. The dependence from the ministry of education affects internal affairs, and low reimbursement tariffs and delay in provider payment have caused conflicts in the past. In certain areas of health care, moral hazard by users and providers is difficult to control. Client information and transparency is insufficient, but the beneficiaries' general perception seems to be positive.

An analysis of these four case studies provides some insights for future health insurance initiatives and sector reforms:

- Instead of insurance schemes, most evaluated plans can be considered as positive and effective social policy programs directed to the poorest population group. From the point of view of insurance theory, the public schemes practise **adverse selection**.
- Public health insurance schemes depend on hidden, cash and in-kind **cross-subsidies** from the public health care system. This relevant part of financing has to be taken in account during the further development of the insurance schemes to allow sustainability independent from political priorities or scarce public resources.

- State-run public health insurance plans have **improved access to and quality of health care** for the worst-off population shares, visible through the increase of institutional and professionally attended deliveries and other benefits.
- They have increased **concern about mother and early childhood health problems** among stakeholders, and also about the need to improve access to affordable health care.
- By raising demand for health care services, the schemes contribute to increasing the turnover of the national health care market and to **stabilise provider income**.
- The **attitude and behaviour of health professionals** towards the low class patients and the poor tends to improve as beneficiaries convert from “beggars” to clients. However, orientation towards cultural, ethnic and linguistic groups has to be intensified in all health plans in order to reach the most vulnerable groups like the indigenous population.
- The **lack of marketing and transparency** as well as **interfering political interests** raise false expectations among beneficiaries because predefined exclusions are often perceived as arbitrary and unfair. Moreover, the succession of different insurance plans generates confusion among the population.
- The Salvadorian teacher welfare scheme has experienced various strategies for **combining comprehensive coverage with cost containment**: Hiring family doctors, implementing a strict referral system and provider ceilings, negotiating bulk discounts and restricting eligibility of drugs are the most important measures.
- A **higher degree of customer orientation and participation** in the design of state-run and social insurance plans seems recommendable, and public insurance schemes ought to enhance decentralisation.
- Furthermore, insurance schemes **lack administrative efficiency**, and strict top-down structures have negative impact on performance.
- The **scope of the schemes has been limited** by the lack of incentives for affiliation, weak participation of the health care providers in decision-making, and the practically non-existent participation of NGOs.
- The public insurance plans give answers on how to **overcome traditional segmentation**. The tax-based SBS/SUMI as well as the mainly tax-financed SMI/SIS have overcome institutional barriers and cooperate not only with state-run, but also with social security and even private providers.
- With regard to the financing mechanisms, the SMI/SIS and the SI in Caazapá have implemented a **mix of tax-based and contribution financing**. From a systemic point of view, the experiences of shared financing of health care reflect the challenges of health sector reforms.
- **Stewardship and good governance** are key elements of successful performance of any type of public insurance plan; the best example therefore might be the recent evolution of the Salvadorian teacher welfare scheme.

# 1. Introduction

## 1.1 Exclusion from Social Protection in Health

Rapid progress characterises the development of health worldwide, where more advances have occurred in the past generation than in the previous 500 years. However, change is slow in one important area: the inclusion of the whole population in the development process. Health systems in developing countries, especially in Latin America, have to face a dual challenge: on the one hand, they must deal with a backlog of accumulated problems characteristic of underdeveloped societies; on the other hand, they are already facing a set of emerging problems that are typical for industrialised nations.

The division between the haves and the have-nots is particularly outstanding in Latin America. Although the economic and social situation has improved considerably in recent years, social and health indicators clearly lag behind increasing national incomes. Undoubtedly, this health gap is partly explicable by factors outside the health care systems, since Latin America is the region with the world's highest income disparities (Machinea et al. 2005, p. 8).<sup>1</sup> Social inequalities are deeply rooted in the prevailing social arrangements that extend beyond the health sector. However, the performance of health care systems is not to be ignored, especially the low coverage of social protection in most countries in the region.

Although the current laws in most of Latin American countries give all citizens the right to some type of health coverage, this is far from the case in practice. Approximately 220 million people in Latin America and the Caribbean lack protection against the risks of illness, while around 107 million have no access to the health services due to the geographical conditions (PAHO/ILO 2003, p. 2). Thus, the most important challenge for health systems in the region is to guarantee to all citizens an appropriate level of health care in terms of access, quality and opportunity regardless of their ability to pay. Social exclusion in health appears to be strongly linked to poverty, marginality, and racial discrimination, as well as to cultural patterns including language, employment circumstances, geographical isolation, lack of basic services such as electricity, drinkable water, and basic sanitation, as well as a low level of education or information on the part of service users (SIDA/PAHO 2004, p. XIV).

Exclusion from access to health services, the main indicator of social exclusion in health, has its origins in three dimensions: access, dignity in care and financing. Access refers not only to the supply of health goods, but also to protection against the economic and social risks of illness. Dignity in care is related to social groups who are ethnically, culturally and linguistically distinct from the majority population and it includes self-exclusion. This is particularly true for at least five countries in Latin America, including Bolivia, Paraguay and Peru (Acuña 2005, p. 3). Last but not least, financial exclusion is mainly related to the lack of affordable financing, particularly pre-payment mechanisms for preventing impoverishment and indigence caused by disease.

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<sup>1</sup> For instance, income of the 5<sup>th</sup> quintile is 12 times higher than income of the 1<sup>st</sup> quintile in Peru, 13 times higher in Bolivia, 17 times higher in El Salvador, and 32 times higher in Paraguay (OPS/PAHO 2003, p. 3).

During the last two decades, many Latin American countries have experienced considerable changes in the institutional framework of the health sector and in the provision and financing of health services. In particular, this health sector reform focuses on the provision of effective coverage to excluded groups, particularly those in the informal economy and those excluded for financial, cultural, geographical and/or other reasons. Thus, innovative health financing mechanisms are required to extend social coverage towards individuals and groups that do not participate in the formal economy and are unable to make the contributions required by traditional social security arrangements.

## 1.2 Social Conditions of Health in Latin America

Health care delivery is the most visible part of a complex assortment of institutions, regulations, and values that determine the performance of health care systems. However, delivery of health care is intensively connected with other functions. The organisation of the health systems is not neutral with respect to exclusion, but rather it is a determinant of it. Adequate health care financing remains an indispensable condition for good performance and especially for overcoming social exclusion in health.

Problems in access to adequate health care are particularly related to the lack of affordable, sustainable and fair financing mechanisms. No family should run the risk of impoverishment or indigence because of its payments for health services. Besides ethical considerations that sustain the concept of social financing, the need for it is based on the evidence that the cost of services poses an obstacle to access especially for the very poor, represents a high-opportunity cost for maintaining or increasing family well-being, and is highly regressive. Thus, the degree of prepayment and fairness of financing have significant influence on the operations of a health service delivery network.

Latin American and Caribbean countries vary a great deal in terms of health care indicators as well as in total and per capita health expenditures. Both types of variables are highly correlated to the GDP per capita of each nation, and relevant differences can be found with regard to the distribution of expenditure for health care. While the poorest countries do not spend more than 2% of their gross national product (GNP) on public health care, this proportion run up to more than 5% in the countries in transition. Total health expenditure, however, amounts to 6% to 8% of the GNP. That is because private health expenses play an important role in Latin America, and they are highest in poorer countries in the region where they represent higher shares of GDP than the public sphere.

These findings are especially true for the four countries that have started to implement the microinsurance schemes described in this paper. The following tables provide an overview of the general socio-economic situation and the share of health expenditures in Bolivia, El Salvador, Paraguay and Peru.

**Table 1.1 Per capita income, per capita national health expenditure (NHE) and population below the national poverty line. Latin America and the Caribbean**

Country	Per capita income in the poorest 20% 1980-1994	NHE per capita (dollars of 1995)	Population below national poverty line (as a %)		Population below national poverty line 1989-1994
			1989-1994	1997-2000*	
Bolivia	703	48	57	61	4,104,000
El Salvador	n/d	158	38	50	2,090,000
Paraguay	n/d	85	22	61	1,034,000
Peru	812	128	32		7,392,000

Sources: ILO/PAHO 1999, p. 47; \* OPS/PAHO 2003, p. 3.

**Table 1.2 Relative weight of private expenditure in the lowest and highest income quintiles 1995**

Country	Per capita private health expenditure/ per capita income in Quintile 1	Per capita private health expenditure/ per capita income in Quintile 5 (1980-1994)	Average per capita income in quintile 5/ average per capita income in Quintile 1
Bolivia	3.1	0.4	9
El Salvador	n/d	n/d	n/d
Paraguay	n/d	n/d	n/d
Peru	7.6	0.7	10

Source: ILO/PAHO 1999, p. 46

### 1.3 Segmentation and Exclusion

Segmentation, a characteristic of most Latin American health care systems including the four countries in consideration, is generally associated with a low-response capacity of health care systems. Segmentation refers to the coexistence of various sub-systems with different financing, membership, and benefit regimes for different socio-economic segments. Segmented models differentiate social groups into three, sometimes four segments: the ministry of health, the social security institute(s), the private sector, and in some countries non-for-profit private or public informal insurance schemes (Holst 2004c). Each of these is vertically integrated, so that it performs various health care functions, but only for a particular group. However, sometimes the combination of segmentation and fragmentation leads to double and triple coverage within the same family unit, with the consequent inefficiency in resource allocation (Londoño/Frenk 1997).

Segmentation is usually manifested in an under-utilised and poorly equipped the public sector oriented to the poor and indigent, and a client-oriented private sector with greater resources for the better-off. Between these two extremes are the social security systems for workers in the formal sector and their dependents. In countries with segmented systems, the public sector and the social security institutions are supposed to provide services for a broad segment of the population. However, the effective coverage is low, and private suppliers are increasing their share of the market, even in those social strata that are theoretically covered by the public systems. Furthermore, coordination between public and social security facilities is low, although both are financed by public funds. The segmented health sector generates and accentuates inequalities in access to health services and their financing.

**Table 1.3 Percentage of social security coverage, private insurance, and NGOs by country 1996<sup>2</sup>**

Country	Social Security in Health	Private Insurance	NGOs	Sum of A+B+C
Bolivia	19	< 5	5 to 10	< 34
El Salvador	14	< 5	5 to 10	< 29
Paraguay	19	< 5	5 to 10	< 34
Peru	30	< 5	10 to 20	< 55

Source: ILO/PAHO 1999, p. 44

**Table 1.4 Access to health care measured according to insurance affiliation, effective coverage and incidence of social exclusion in health**

	Uninsured population	Population lacking effective coverage	Incidence of social exclusion in health
Paraguay 2001	81.1	51.4	62.0
Perú 2001	73.0	31.0	40.0
El Salvador 2002	81.3	41.7	53.0
Bolivia 2002	72.7	55.0	77.0

Source: Acuña 2005, p. 4

In most of these countries, about one out of every three citizens has coverage of health risks. However, these are the data for the theoretically covered population—effective protection is limited to a far smaller group. Where prepayment schemes are lacking and social protection coverage is low, people have to pay for health care out of their pockets. Thus out-of-pocket payments represent the vast majority of private expenditure for health, and between a third and half of the overall health budgets. Table 1.5 summarises some essential indicators that are characteristic for the health care systems in the four Latin American study countries.

**Table 1.5 National health accounts for Bolivia, El Salvador, Paraguay and Peru for 1997: Health expenditure and its distribution over the various subsystems<sup>3</sup>**

Country	Percentage shares					
	THE/GDP	PHE/THE	PvHE/THE	PHE/GGE	SocSec/THE	OOPS/PvHE
Bolivia	4.7	63.9	36.1	9.1	65.3	85.7
El Salvador	8.1	38.7	61.3	22.6	43.3	97.1
Paraguay	7.5	33.1	66.9	13.6	47.8	69.2
Peru	3.5	57.3	42.7	11.8	61.1	86.4
Country	Direct payments		Per capita expenditures in dollars			
	OOPS/PvHE	OOPS/THE	THE	PHE	OOPS	
Bolivia	85.7	30.94	104	66	32	
El Salvador	97.1	59.52	328	127	195	
Paraguay	69.2	46.29	338	112	156	
Peru	86.4	36.89	160	91	59	

Source: Botschwei/Tait 2002, pp. 25-35

<sup>2</sup> Despite the low coverage of the institutional social protection, health care expenditure for the formal sector workers is high compared to the poorer population groups. As a share of total health expenditure, social security represents 65.3% in Bolivia, 22.6 in El Salvador, 47.8% in Paraguay, and 61.1% in Peru (Botchwey/Tait 2002).

<sup>3</sup> THE=Total Health Expenditure, GDP=Gross Domestic Product, PHE=Public Health Expenditure, PvHE=Private Health Expenditure, GGE=General Government Expenditure, SocSec=Social Security, GenRev=General Revenue (Tax Funded), OOPS=Out of Pocket Spending.

Three of the four health insurance plans analysed in this paper have prioritised maternal and infant health. Thus, the focus of the Basic Health Insurance in Bolivia (SBS), the Mother-Child Insurance in Peru (SMI), and the Integral Insurance in Paraguay lies on maternal and child health indicators. Table 1.6 gives an overview of the health system performance in the four countries with regard to these two epidemiological challenges, and compares them to the overall data of the Region.

**Table 1.6 Percentage of births unattended by trained staff and estimated population excluded based on these births**

Country	Births not attended by trained staff (%)		Estimated population excluded based on births unattended by trained staff
	1996*	recent**	
Bolivia	72	34.9 <sup>a</sup>	5 466 240
		Urban: 77 <sup>b</sup> Rural: 31 <sup>b</sup>	
El Salvador	38	9.6 <sup>c</sup>	2 199 060
Paraguay	64	39.2 <sup>d</sup>	3 173 120
Peru	44	40.7 <sup>e</sup>	10 536 680
		Urban: 69 <sup>f</sup> Rural: 20 <sup>f</sup>	

Sources: \* ILO/PAHO 1999, p. 54; \*\* WHO 2005a, p. 3f; \*\*\* PAHO 2004b, p. 4 (Data about urban and rural deliveries).

<sup>a</sup> Data for 2002; <sup>b</sup> Data for 1998, PAHO 2004b; <sup>c</sup> Data for 1998, including informal midwives; <sup>d</sup> Data for 1998, excluding informal midwives; <sup>e</sup> Data for 2000, excluding informal midwives; <sup>f</sup> Data for 1998, PAHO 2004b.

**Table 1.7 Percentage of immunisation coverage for children under 1 year 1997**

Country	Immunisation coverage in children under 1 year (%)			
	DPT3	OPV 3	BCG	Measles
Bolivia	82	82	98	98
Peru	98	97	98	95
Paraguay	82	82	87	61
El Salvador	98	96	100	96

Source: ILO/PAHO 1999, p. 55

**Table 1.8 Population without social security coverage in health**

Country	Coverage		Access			
	Classification according to social security coverage in health and level of integration in delivery of services	Population without theoretical social security coverage	Population below poverty line	Population without geographical access to health services	Rural population	Indigenous population
			<b>1989-1994</b>	<b>1995</b>	<b>1998</b>	<b>1992</b>
Bolivia	4	6005	4104	2447	2936	4900
Peru	4	16472	7392	13178	6944	9300
Paraguay	4	3911	1034	1786	2374	100
El Salvador	4	4875	2090	3401	3271	400
<b>Total Latin America</b>		<b>217855</b>		<b>107013</b>	<b>125480</b>	<b>39932</b>

Country	Structure		Process		
	Population affected due to lack of supply of medical services	Population affected due to lack of supply of hospital beds	Estimated population excluded based on births not attended by trained staff	Estimated population excluded based on gap between BCG and measles coverage	Estimated population excluded based on gap between BCG vaccine and vaccine with lowest coverage
	1997	1996	1996	1998	1998
Bolivia	4267	5062	5466	0	1244
Peru		16809	10537	746	746
Paraguay	1997	3626	3173	1319	1319
El Salvador	952	3873	2199	477	477
<b>Total Latin America</b>	<b>23643</b>	<b>267537</b>	<b>83558</b>	<b>36881</b>	<b>82023</b>

Source: ILO/PAHO 1999, p. 59

## 1.4 Role of the State

During the 1980s and 1990s, powerful international trends in neoclassical economic reforms swept through Latin America. This strategy has been reinforced by the practice of making market-oriented, social-sector reforms a condition of loans and aid from international donors. Searching for a renewal of growth, most Latin American countries started to narrow the role of the state, enhance private investments, deregulate the labour market, and reduce public social expenditure as a share of GDP.

However, within this general tendency, different national policies persisted; and no direct correlation between the power of the state and the degree of market-oriented reform can be stated. On the contrary, the historic role of the state in a given country proved to be one determinant of the feasibility of reforms. Even more, in obvious contradiction to the neo-liberal ideology, the role of the state remained of utmost importance, even after having implemented market-driven elements in social policy.<sup>4</sup>

In most Latin American countries, the state has a triple role combining regulating, financing and providing of health care. This is not only true for countries with a national health service, but also for those with a segmented system where the state is financing and running its own health care facilities. In the public sector, state-organisms manage health financing – mostly in a way that lacks transparency due to indirect payments and hidden cross subsidies – and exercise an extensive control of the providers. Public supervision is less intensive in the social security system that is – at least in theory – an autonomous public entity and, thus, independent in terms of accountability, allocation of resources and other insurance tasks.

In most countries, however, there is limited regulation of the private health care market, especially regarding financing and service provision. Usually, public institutions and the ministry of health control market-access and supervise the performance of medical providers according to the existing legislation and regulation. However, private health insurance schemes escape from supervision by the ministry of health. They fall under the control of the

<sup>4</sup> The best example for this is Chile that started first and in the most radical way to reform the economy and the social sector, but where the role of the state has turned out to be essential not only to cushion the unwanted effects of privatisation, but also for economic and social development.

ministry of finance or a specific supervising board for the insurance sector. While these public agencies deal with accountability, market behaviour and fiscal affairs, they do not supervise the health-related aspects of insurance companies.

Within the ongoing process of decentralization, new functions of the state must be envisaged, and a redefinition of the relations between the state and civil society are required. Often, the traditional segmentation, ideological contradictions that have been enforced during the market-orientation of national policies, and some conceptual constraints hinder a closer cooperation between the various sub-sectors. For instance, the term “public” is usually used as synonym of “state-run”, although in many countries, autonomous public institutions exist completely independently from the state.

There is also the need to eliminate the mistrust between the state and non-governmental organisations, and to create a regulatory framework to allow for the legal existence of NGOs. This is especially true in areas where neither state-run, nor social security providers are in place and people are excluded from social protection. State-run microinsurance plans are potentially open towards NGO health care facilities, but in the practice cooperation is difficult and needs a more intensive preparation.

In most countries, the relationship with private for-profit enterprises is even more complicated. With regard to health care financing, private insurance companies show very little interest in offering packages and plans that are affordable to the poor. According to the very logic of enterprises, for-profit insurers are obliged to apply risk selection and cream skimming to guarantee returns to shareholders. Where private health insurance is in place, the state is responsible for the “bad risks” and acts as the insurer of last resort.

However, the state could be more active toward private health care provision. Most governments as well as social security institutions have the authority to contract private providers. Even in cases where legal constraints have been implemented to defend the providers in the own subsystem, flexible solutions might be introduced.<sup>5</sup> Furthermore, as state-run systems and social security schemes deal with a large number of services, their market position tends to be strong. Thus, they ought to use the relative power in favour of the beneficiaries, for instance by negotiating lower tariffs or special fares.

Due to their historical, cultural and societal conditions, most Latin American countries face the problems and challenges described in this chapter. However, political strategies vary from one state to another; some countries, like Chile, have chosen market-solutions, while in Brazil, public financing and service delivery are increasingly prevailing. Mainly the poorer societies have opted for less ambitious reforms, introducing focalised programs for the poor and the most vulnerable groups. The four examples from Bolivia, Peru, Paraguay and El Salvador discussed in this document present country-specific approaches to overcome the existing problems and provide some insights in how these challenges might be faced.

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<sup>5</sup> For instance, during the health sector struggle in 2003 in El Salvador, the social security (ISSS) was obliged to stop outsourcing of specialised services that were unavailable within their own provider network. However, this politically motivated decision could not be imposed in practice because enrolees would have been deprived from benefits they were entitled to.

## 2. Seguro Básico de Salud, Bolivia

In 1996, the National Maternal and Child Insurance (Seguro Nacional de Maternidad and Niñez- SNMN) was launched as Bolivia's first public health insurance scheme. Its target population was pregnant women and children under 5 years, and coverage included 32 interventions corresponding to the first and second levels of care. Basic Health Insurance (*Seguro Básico de Salud*- SBS) replaced the SNMN in 1998, complementing the same target population with the general population for some specific interventions at the first and second levels of care. The SBS had a greater budget so it could expand the benefits for the target population. Furthermore, it offered universal coverage for a series of preventive and curative services concerning sexually transmissible diseases, malaria and tuberculosis.

**Table 2.1 Bolivia Statistics**

Total population: 8,808,000
GDP per capita (Intl \$, 2002): 2,568
Life expectancy at birth m/f (years): 63.0/67.0
Healthy life expectancy at birth m/f (years, 2002): 53.6/55.2
Child mortality m/f (per 1000): 68/64
Adult mortality m/f (per 1000): 247/180
Total health expenditure per capita (Intl \$, 2002): 179
Total health expenditure as % of GDP (2002): 7.0
Source: The world health report 2005; figures for 2003 unless indicated.

The SBS is in the focus of this chapter, based on an InfoSure evaluation in 2001. However, the SBS was replaced in 2003 by the Universal Maternal and Infant Insurance (*Seguro Universal Materno Infantil* - SUMI), under which children under 5 years and pregnant women remained the target group, but coverage for the latter was extended until 6 months after childbirth. Amplifying the SBS-package, the SUMI is universal in terms of health coverage including complex and dental care for its target population (Rousseau 2003, p. 22).

As the SUMI succeeds the SBS, assessment and analysis of the Basic Health Insurance is not strictly limited to the scheme itself. To allow for a series of conclusions concerning the SBS, the following observations and considerations are partly based on the further development of the SBS in the new and amplified concept of the SUMI.

### 2.1 Setting up the Scheme

The SBS started to operate in May 1999, following the pre-existing Mother-Child Insurance (*Seguro de Maternidad and Niñez*) that had finished in September 1997. When the SBS was introduced, it was one of the most important pillars of the Strategic Health Plan (*Plan Estratégico de Salud*) within the official Operative Action Plan (*Plan Operativo de Acción*) 1997-2002 for development and poverty reduction. Relevant pressure came from donors after the implementation of the HIPC-initiative of the G7 countries. As debt relief for the poorest

countries of the world was conditioned to various social factors including health indicators, the bad performance of Bolivia's health care system led the government to place more importance on improving access to health care services for the poor.

Maternal and child mortality rates were the second highest in Latin America. Thus, the SBS scheme was an attempt to reduce maternal and child mortality focussing not only on economic factors, but also on geographic, cultural, political and other barriers.

The Bolivian government took the initial steps to set up of the insurance plan. Personnel from the health ministry, the social security and other related areas participated from the beginning; however, the central team did not involve health care providers, NGOs and other civil society organisations in the definition and application of the scheme. The decision-making processes in the initial phase were strictly limited to the reform-group in the ministry of health.

In the beginning, the SBS plan was supported by international donors and organisations, mainly the World Bank, and also by UNICEF, PAHO, IDB and DFID. The Social Security Institute contributed 5% of its budget for a countrywide immunisation program. Before starting the SBS, cost studies were performed by the Health Reform Unit; however, the strategy was based on existing information like the UNDP Human Development Index, the National Health Information System, Demographic Health Surveys, and the evaluation of the precursor scheme "Mother-Child Health Insurance".

## 2.2 Membership

Theoretically, the SBS is universal, though it was designed essentially to provide health care to those without access. However, the design of the benefit package reduced the scope of the core target population: pregnant women, children under 5 years and people affected by communicable diseases (tuberculosis, malaria, cholera and STDs except HIV). As the SBS contracted only public, social security and some NGO health care providers, it was mainly attractive to the lower socio-economic groups. The unwillingness of the higher socio-economic classes to use public facilities was an implicit positive selection of the poor.

The counterparts of the central SBS-structure at the local level are municipalities, which initially had the choice of registering into the insurance system. Since the implementation of the SUMI, participation of the municipalities has become obligatory, and Local Health Directories (Directorios Locales de Salud) were built to administer the funds on the local level and to organise the health care provision.

Once local governments had agreed to cooperate, they were responsible for registering enrollees, either by their own administrative staff or an authorized institution. An active process is necessary for the insured to be affiliated and to receive the membership card. Clients living in another community have immediate access in any place if the home municipality has signed the agreement. The municipal government is in charge of organising affiliations and providing membership cards to the citizens of the community.

However, in practice members are recruited mainly in the health care centres when they require treatment for any disease covered by the SBS. Thus, from an insurance theory point

of view, the affiliation method makes the SBS defenceless against the consequences of adverse selection, but this effect is intended and reflects the goal to provide services to the most needy. This tendency is even strengthened by the municipalities' policy to pass the responsibility for the inscription process to the health care centres. As affiliation means additional work, there are poor incentives for the municipal governments, but also for the health centres to promote the SBS. On the other hand, the insurance plan does not apply other active recruitment strategies or complementary marketing activities to promote the SBS.

Membership is formalised by an insurance card delivered by the local authority, and no further contract needs to be signed nor inscription fee paid. In good faith, the beneficiary has to declare that she or he resides in the community. Each family member – women in reproductive age and children until 4 years – has to be affiliated individually. Though they have the right to do so, health services do not regularly control the entitlement by demanding the membership card of persons who require SBS benefits, and no other type of identification has to be presented in the health care centres. It is sufficient to present any of the pathologies covered by the insurance scheme to be attended within the SBS-network of providers. On some occasions, the health centre staff tend to favour a patient who appears with a serious problem by registering him in the SBS and then “adapting” the disease to the SBS-covered package to allow the centre to present a claim.

Even though a slight majority of Bolivians live in urban areas, SBS affiliation is higher in rural areas. The relative majority of enrollees outside the cities is certainly related to the fact that the public sector is the only health care provider in most rural communities. Another factor is probably the higher poverty rate in rural areas, even though cultural barriers to use are greater in these areas.

Reliable data about the number of affiliated beneficiaries is extremely difficult to find. One of the reasons is that the whole population is entitled to receive the benefit package in case of need, and, thus, documentation about realised enrolments lack relevance and are incomplete. The only available data about active inscription refers to the first year of full activity of the SUMI-plan.

## 2.3 Financing

The SBS is designed as a tax-based health insurance plan, and resources are transferred from the General Treasury to the municipalities who are responsible for provider payment. The Bolivian tax co-participation system (*Coparticipación Tributaria*) commits the Central Bank to transfer 20% of the total income to the municipalities, according to a capitation system and based on the results of the most recent census. In 2000, the General Treasury transferred \$295 million to the municipal governments. The amount was independent from the number of affiliates inscribed in the SBS-plan. As far as the local governments were concerned, they had to dedicate 6% of that income to organise and finance the SBS.<sup>6</sup>

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<sup>6</sup> The preceding Mother Child Health scheme received 3.5% of the local co-participation funds, and for implementing the succeeding SUMI plan, municipalities increased the respective expenditure to currently 10% of their income from the national treasury (see below).

The universal coverage approach of SBS's tax-based financing system does not require any contribution from participants. Furthermore, enrollees do not have to pay any co-payment for SBS benefits, although co-payments might be required for services that are not covered by SBS.

The SBS receives donations from the general treasury to carry out a tuberculosis treatment and vaccination program. The most relevant indirect cross subsidy comes from the municipalities who carry the costs for the infrastructure and maintenance. Currently there is a debate about the coverage of the costs for water, electricity and telephone because municipalities want to transfer these costs to the health centres. The departmental government also gives an important indirect subsidy to the SBS by remunerating the work force involved in the delivery of the SBS benefits. In the same way, the Social Security (Caja Nacional de Salud) supports SBS with human resources, by offering the services for a tariff that is not reflective of real costs; however, they are unable to determine their exact operating costs of most of the services provided under the SBS-scheme.

On the other hand, the SBS subsidizes Social Security in most rural areas where it does not have its own infrastructure. And the scheme introduces a kind of subsidy to the urban middle class population that used to pay out of their pockets for health care. Since the creation of the SBS, they are entitled to use and are all beneficiaries of the SBS package free of charge.

For investments in infrastructure, the insurance plan obtained the most significant loans from the World Bank, conditional on local co-financing from municipal governments and other institutions. These loans build the central part of the "Resource Allocation Mechanism" (MAR) that has to be complemented by additional funds from local counterparts. The \$10 million World Bank loan to the Social Inversion Fund (*Fondo de Inversión Social*) has to be used for investments in the SBS scheme and its facilities.

The implementation of the SUMI has diversified the financial resources. The General Treasury continued paying the staff of the public health care system, while the involved social security and other providers cover the costs of their own work force. Additionally, an increasing proportion of the municipal tax income (*Coparticipación Tributaria*) (7% in 2003, 8% in 2004, and 10% since 2005) is dedicated for financing SUMI-benefits. And, when resources are insufficient, international donations collected in the National Solidarity Funds (NSF) are applied to co-finance the demand (PAHO 2004b, p. 61).<sup>7</sup> Resources are transferred to the Local Health Directories who are responsible for budgetary planning and provider payment. Enrollees do not have to pay any contribution or co-payment for health care.

## 2.4 Benefits

The benefit package is designed according to the country's health needs. The benefits depend on the financial situation of the treasury, obey economic and epidemiologic reasons, and follow the logic of a strict cost-benefit-relationship. The 76 services included in the SBS-package cover 56% of the necessities to deal with the most relevant epidemiological problems, giving priority to maternity and early childhood disorders.

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<sup>7</sup> The municipalities take over about three quarters of benefit financing, while the NSF is responsible for the remaining quarter (data for 2003 according to PAHO 2004b, p. 61).

As the SBS was initially designed to promote mother and child health, its benefit package is limited to maternity and childhood problems and some epidemic infectious diseases. The SBS-scheme does not grant any non-obstetric or orthopaedic surgery, no treatment of chronic or acute diseases except for the selected infections, and no specialised treatment. The benefit package does not offer any option of choice for providers and enrolees. The SBS does not cover the care of outpatients by specialists; though a specialist may treat a patient within the SBS, without it being considered as a SBS-benefit.

Theoretically, every citizen who wants to receive SBS services is supposed to have the right to get them. It is not even necessary for SBS-users to be registered with the providers. Nevertheless, in isolated areas some benefits are denied due to a lack of infrastructural conditions, which means there is a regional disparity despite the basic values of the SBS.

Benefits are provided within a so-called 'active capitation' mechanism: From the point of view of the SBS, the insurance funds are prepaid, not by the members but by the transfer of the resources destined to cover the benefits. The providers receive the reimbursement for the benefits granted from the municipalities according to a fee-for-service-mechanism.

Insured persons access services mainly the public provider network, but in case of referral also from Social Security facilities. Though public primary health care providers are open to the whole population, the SBS-scheme gives strong priority to the poor. Thus, providers and clients consider the SBS as a service for the lower classes. The quality of public services used to be poor, but after the implementation of SBS, the quality improved mainly due to donations by international agencies. The poor quality is not only a consequence of a limited range of services due to the low budget, but also of lacking quality of human relations and inadequate recognition of cultural values and differences.

In practice, promotional activities are limited to family planning. The quality of these activities varies according to the provider's capacity and equipment, and on the ability and effectiveness of the health promoters. Data about the impact of promotional activities and the effect on the health outcomes is lacking. The fertility rate has decreased during recent years, but no information is available on the role of the SBS family planning program.

Prevention appears mainly in form of vaccinations, including a triple antiviral (MMR), OPV, BCG and DPT extended to Hepatitis B and Haemophilus-influenzae B. Immunisation indicators are relatively high in most parts of the country (coverage rates between 87.0 and 94.8%; total vaccine coverage: 80.9% of the children until 1 year).

The relationship between the scheme and its beneficiaries does not include any financial transfer. The beneficiary does not make any payments so that she/he does not have to face contributions or reimbursement. A fee-for-service system is applied for the payment of SBS benefits, and the respective means flow from the municipalities to the health care providers. The reimbursement-method foresees a ceiling according to the package costs (fee-schedule) and the budget of the municipality. Thus, problems may rise if the guaranteed benefits remain unavailable due to insufficient infrastructural, financial constraints or other factors.

All citizens have access to the SBS package all over the country, not exclusively in their own municipality. The charge mechanism includes the possibility of sending a claim to each of the municipalities where treated patients in the last month came from. However, problems concerning these inter-municipal payments will have an increasing impact on the way the SBS membership and coverage grows and the population's mobility increases. The delay in updating the census database aggravates various problems of the countrywide scheme. These are summarized below:

1. Municipalities have to accept that their people might access health providers elsewhere, and that they have to pay bills presented by providers in other areas. Sometimes this procedure is not accepted, causing payment delays.
2. Municipalities cannot verify if one of their citizens has really used a particular health provider outside its own area.
3. A similar difficulty exists for the municipalities in assessing that a user really lives in the municipality of origin.
4. For the health care providers, it is also impossible to prove if a patient without a membership card really comes from the municipality he claims to come from.
5. Especially in isolated areas, the low amount billed often does not justify the costs of filling out the claims and the transport to the receiving community; thus, in those cases, health care providers often prefer not to charge other municipalities.

Family planning services, gynaecological cancer and sexually transmitted diseases detection and treatment had been included in the SBS for the whole population who did not have a private or social security insurance. With the creation of the SUMI in 2003, however, these services were excluded. As a result of the new population focus of the SUMI, pregnant women and new mothers can receive all these care services while the rest of the female—and male—population does not have access to public insurance coverage for these reproductive health components (Rousseau 2004, p. 24). Altogether, the Universal Mother-Child Insurance (SUMI) extended the coverage package from initially 76 to 424 basic and specialised health care benefits (Cuba 2004, p. 156).<sup>8</sup>

The SUMI scheme is currently covering the following benefits:

- Children under 5 years
- Comprehensive child vaccination
- Treatment of the most deadly diseases including diarrhoeas and respiratory infections
- Periodical prenatal control, delivery and post-delivery care
- Family Planning and treatment of endemics
- Diagnose and treatment of tuberculosis
- Diagnose and treatment of malaria
- Health care and nutrition
- Nutritional promotion and feeding
- Diagnose and treatment of STDs, except AIDS
- Prevention and treatment of pregnancy complications
- Information, education and family planning
- Health care of women in fertile age
- Diagnose and treatment of cholera

<sup>8</sup> 153 benefits for pregnant women until six month after delivery; 234 paediatric services - 93 for newborn and 141 for children under 5, plus 37 dentist care benefits.

**Table 2.2 Use of SBS/SUMI-covered Benefits (1996-2004)**

<b>Bolivia</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
New prenatal consultations	234 702	273 055	288 220	331 036	348 022	335 134	338 787	347 562	346 408
Repeated prenatal consultations	229 764	307 257	321 507	372 343	425 968	450 413	512 023	557 386	586 674
Prenatal controls before the 5 <sup>th</sup> month	95 716	110 320	119 500	137 656	151 987	155 738	165 423	176 730	185 206
Prenatal controls after the 5 <sup>th</sup> month	138 986	162 735	168 720	193 380	196 035	179 396	173 364	170 832	161 202
4 <sup>th</sup> prenatal control	61 148	76 299	85 004	97 474	115 719	117 931	116 608	127 597	133 171
High obstetrical risk pregnancies	37 255	43 354	47 208	49 432	54 254	58 566	63 721	44 912	s/d
Attended deliveries	102 728	119 462	131 669	146 679	158 211	146 800	166 510	167 515	164 821
Institutional deliveries	90 500	109 861	120 328	136 195	148 161	138 042	158 555	160 882	158 589
Domestic deliveries	21 878	18 131	21 668	20 635	20 573	21 138	22 056	21 555	20 412
Caesarean sections	13 657	16 722	19 962	23 448	25 103	21 470	29 946	31 614	32 357
First post-delivery control	66 512	69 792	76 465	88 520	103 265	94 329	104 001	115 750	122 759

Source: Ministry of Health and Sports 2005, accessed July 10<sup>th</sup> 2005.

## 2.5 Risk Management

The SBS allows open enrolment and does not impose any regulations concerning the risk mix. The SBS cannot reject applicants, nor does it apply an active strategy to influence the risk mix. The main target groups are underprivileged people with limited access to health care. As mortality and morbidity are higher for this group, SBS concentrates on the bad risks. However, the choice of contracted health care providers also induces an implicit adverse risk selection. The exclusive cooperation with public and social security providers makes the SBS scheme unattractive for the middle and upper socio-economic classes.

There is no mechanism in place to exclude people who are covered by another insurance plan or who can afford their health care costs by themselves. In fact, a group insured with Social Security changed to SBS to have access to health care in areas where the Social Security offers insufficient coverage. The financial risk is controlled by the strict exclusion of the coverage not included in the package. The benefit package was designed according to the disposable budget; services that do not provide good value are excluded. Thus, some expensive health problems like AIDS, premature birth and cancer are excluded.

There is no explicit reinsurance mechanism in the SBS-system. If the budget is insufficient, the central government is expected to transfer additional funds. In the end, however, the financial risk is on the providers contracted by the scheme. Ultimately, the health care providers can transfer their risk to the beneficiaries by charging for health care services.

## 2.6 Services

A publicity campaign carried out by TV, radio and brochures accompanied the introduction of the SBS. The central health reform project and public health providers organised meetings to inform the public. On the district level, SBS staff held workshops and lectures promoting the scheme. Nonetheless, the impact of this campaign seems to be relatively low. According to information from the La Paz municipality in early 2000, only between 5% and 8% of the interviewed persons had sufficient knowledge about the SBS.

## 2.7 Legal Issues

The SBS is ruled formally by legal dispositions of the health ministry and the Bolivian government that institutionalise and regulate the insurance scheme. On the other hand, the SBS-legislation is planned in a way that allows for transforming it into national law. According to general regulation, decisions concerning the SBS rely on the staff of the SBS who are led by the general director, who is in turn responsible to the health minister.

The SBS forms an essential part of the public health system. Consequently, the autonomy of the scheme is generally low as it depends on the national health policy and the support of the Minister of Health. This arrangement allows political officials to influence the direction and adaptations of the basic insurance system. The control of applicable regulations relies on the municipal governments who intervene in various tasks. And, as the salary payer, the departmental governments have some influence on the labour force.

## 2.8 Administration

In principle, **member registration and inscription** is a task of the municipal governments. Often, however, they delegate this to the health care providers. When residents go to their health care centre, they are inscribed in the registration book and receive a membership card.

Though the procedure is cost-free and easy, the registration rate is relatively low. One of the reasons might be the lack of incentive for the providers, as well as for the beneficiaries, to register or be registered. For the health centre, the process of registration is unpaid extra work that is not compensated by any kind of additional payment for the staff. In practice, it does not make a difference for the users of the public health services whether they are registered or not because they receive the necessary treatment even when they cannot present a membership card or live in another municipality.

As the SBS is financed by a legally defined percentage of the national households, no specific **contribution collection** process has been implemented. A certain percentage of the yearly tax- and toll-income of the Bolivian State is transferred to the SBS municipal accounts by an automatic debit transaction from the Central Bank to local municipal funds.

The **claim processing** is run by reimbursement from these municipal funds to the health provider network for the granted services. Once a month, the health care providers have to present aggregated lists in a standardised format to the municipalities to be paid for the services provided. The claims contain the 76 benefits included in the SBS-plan, their price,

the number of services granted per month and the amount for the total number of benefits, the number and the amount for each benefit included in the insurance-package. All participating providers received manuals and guidelines concerning the technical framework of claim processing (Technical Guides, Administrative Guides).

However, some municipality authorities experience problems with the claims they receive from the health care providers: wrong numbers, arithmetic mistakes and other errors. In rural areas, the dispatch of the claim-forms is difficult and raises technical problems.

The National Management Unit in the ministry of health sets the general framework for the **financial management and planning**. The SBS itself is not in charge of its own resources, and it does not run an accounting and budget control system. These tasks are delegated to the district health authorities, municipalities and health care centres throughout the country. Thus, financial management tends to be decentralised and heterogeneous.

To always have a stock of assets needed for the SBS benefits, the providers are obliged to use the money they receive from the insurance plan to buy drugs and other supplies. Only when this condition is fulfilled, are they allowed to spend it for other purposes like maintenance, investments and other necessities of the health care centre.

The **verification** is carried out by the district and the local governments. Health care authorities at the district level are responsible for certifying the health care providers. The municipalities are entitled to follow-up and verify the use of funds they deliver to the health care providers. However, no standardized instruments or systemic processes are in place for the control and follow-up of SBS procedures and results.

Concerning the **bookkeeping** process, the SBS relies on registration lists and several standardised forms for various administrative tasks. The **statistics** are monitored at the central level through the National Health Information System. However, only 33% of the SBS services are effectively monitored. Thus, the database is incomplete and does not fulfil the essential criteria of comparability and reliability.

As for **human resources**, SBS relies mainly on the staff employed in public health centres. In the case of the core and regional SBS staff, the central or departmental governments pay salaries. All public sector employees receive their salaries from treasury funds, and the social security system is responsible for the salaries of their staff. Resources generated by the SBS are not used to pay the workforce involved in providing its health services. Thus, the providers are unable to hire more staff to satisfy the growing demand generated by the SBS.

## 2.9 Healthcare Provision

As the SBS is an insurance scheme operating all over Bolivia, the performance of the insurance tasks and healthcare provision have to tackle the country's general physical and infrastructural conditions with a wide range of geographic, climatic, cultural and living circumstances. Seasonal conditions affect public transport, the delivery of administrative forms, and health interventions like vaccinations.

The SBS does not run its own health centres. The infrastructure available for SBS includes 2230 health providers. The majority (2029) belonged to the health ministry.<sup>9</sup> Public health facilities were included in the SBS-scheme by law and thus no specific contract was required. The remaining 201 health care providers were part of the social security system.<sup>10</sup> The SBS was open for contracting NGO providers on a voluntary basis.

Public and social security providers have no choice about their participation since they cannot negotiate, nor determine the fees they receive for each service. For many providers, that reduces the attraction to participate in the SBS, since the tariffs paid by the scheme often do not cover the costs. The provision of all required SUMI health services remained mandatory for all state-run and social security providers in the country (Cuba 2004, p. 156).

## 2.10 Provider Payment

All health care centres cooperating with the SBS scheme have to prove the services they have granted to beneficiaries to receive reimbursement. For primary and hospital care, provider payment relies on the municipal governments and is based on the CAPO's according to a fee-for-package. Once a month, the health care providers send a standardised form to the municipalities on which they list the type and the number of services provided under the SBS-package in the past month. The payment is based exclusively on these form-lists. The invoices to hospitals are transferred by cheque, and transfer of invoices to health posts and centres is usually made by messenger once a month.

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<sup>9</sup> 1304 health posts all over the country, 596 health centres, 97 basic hospitals, 23 specialised institutes, and 9 general hospitals.

<sup>10</sup> 119 health centres, 28 basic and 25 general hospitals, 23 health posts and 6 institutes.

### 3. Mother-Child Insurance, Peru

In Peru, the first public health insurance was the Free School Health Insurance (*Seguro Escolar Gratuito* - SEG) created in 1997. Originally designed as a pilot project, President Fujimori ordered nationwide implementation because he wanted to be remembered for his contribution to education. Targeting public school children from age three to seventeen, the insurance covered healthcare services related to an accident or a disease with a few exceptions, and provided the services at public health facilities (Guzmán 2003).

The creation of a new insurance plan, the Maternal-Infant Health Insurance (*Seguro Materno-Infantil* - SMI) in 1998, sought to respond to the greater public health priority of providing health care to infants (0 to 4 year old), pregnant women and new mothers. It covered prenatal, natal and post-natal care for women, as well as general care of newborns, vaccinations and common childhood diseases. The SMI was designed to provide coverage to women belonging to poorer or at greater risk sectors.

**Table 3.1 Peru Statistics**

Total population:	27,167,000
GDP per capita (Intl \$, 2002):	5,101
Life expectancy at birth m/f (years):	68.0/73.0
Healthy life expectancy at birth m/f (years, 2002):	59.6/62.4
Child mortality m/f (per 1000):	36/32
Adult mortality m/f (per 1000):	193/133
Total health expenditure per capita (Intl \$, 2002):	226
Total health expenditure as % of GDP (2002):	4.4

Source: The world health report 2005; figures for 2003 unless indicated.

In 2001, the Toledo government implemented a new Integral Health Insurance Plan (*Seguro Integral de Salud* - SIS), after rejecting the Public Health Insurance (*Seguro Público de Salud* - SPS) designed under the transition government of Valentin Paniagua (2000-2001). The SIS, which also targeted the poorest sectors, created new categories of beneficiaries besides infants, pregnant women and new mothers, such as “adults in situation of emergency”, “targeted adult population”, and children from 5 to 17 years. Thus, the SIS can be considered a synthesis of the pre-existing Mother-Child and the Free School Health Insurance, including other vulnerable groups of the society and an amplified benefit package. However, not every group has access to the full range of services, because each category benefits from a different list of covered care components (Rousseau 2003, p. 22f).

#### 3.1 Setting up the Scheme

In July 1998, Fujimori announced the creation of a mother-child insurance scheme. Before running the SMI as such, a pilot project started in two regions (Tacna, San Martín). The Mother-Child Insurance (SMI) started to grant services in selected areas in October 1999 (including the two pilot regions). By the end of 2001, the number of districts increased to 22.

The SMI emerged mainly as a political strategy to fight the most important health problems of Peru. Epidemiological surveys revealed a high maternal and newborn mortality and morbidity in Peru, especially in rural areas. For this reason, the ministry of health decided to improve the accessibility of health care for pregnant women and young children. The World Bank-led HPIC initiative was an additional incentive to improve social indicators.

The ministry of health led the implementation process and made available most of the financial infrastructure and technical support. The government, which relied mainly on the ministry's staff plus a couple of contracted experts, was the only relevant stakeholder of the scheme and it served as a last resort for potential financial and reinsurance problems.

The Inter American Development Bank (IDB) financed the pilot phase in two regions, but did not give any technical or administrative support. No specific feasibility study was performed before the implementation of the SMI; the ministry relied on regular household surveys and general statistical data concerning the socio-economic situation of the target group. Additionally, the concerned expert group performed some cost calculations according to existing data and the estimation of expected costs of potential benefits packages.

### 3.2 Membership

The SMI program emerged as an attempt to reduce the high incidence of pathologies associated with pregnancy, birth and early childhood. Thus, it offers benefits to pregnant women, newborns and children until the age of 4 years. This target group was limited to certain health districts (División Regional de Salud = DISA), starting in two and increasing the coverage to 22 DISAs at the end of 2001. As long as the insurance scheme did not work in the whole country, some health providers were confronted with unexpected demand from the neighbour districts where SMI had not been established yet.

**Table 3.2 Target population of the SMI (22 DISAS)**

Newborn	Children	Women 15-49 years	Pregnant women	Total
182 920	1 055 054	1 835 070	231 165	<b>7 131 105</b>

The affiliation is strictly limited to the target group.<sup>11</sup> The SMI does not foresee any exclusion; nor does it apply any active selection strategy to avoid the affiliation of high-risk or low-income groups. By the definition of covered services, the SMI excludes persons who do not present pathologies associated to pregnancy, birth and early childhood. Due to the type of contracted health providers, it is more attractive for lower class and poor people than for the better off, who tend to avoid using health centres and posts frequented by the poor; however, no control mechanism exists for preventing the affiliation of the better-off.

The SMI-scheme focuses on citizens not covered by any social protection in health. As long-term employees in the formal economy are covered by the national social security system EsSalud, the SMI is only targeting the informal sector, especially the poorest citizens. Almost

<sup>11</sup> According to the official population estimation of 2001, the target group in all participating health districts comprises 878,927 children between 0 and 4 years; 1,835,070 women in fertile age; 182,920 newborn, and 231,165 pregnant women.

all enrollees have none, very low or low incomes; and the majority are women and mothers with young children. In the suburban slums, most of the SMI beneficiaries live off independent, precarious, short-term and poorly paid activities. In rural areas, most SMI beneficiaries live in remote areas working on a small piece of land in a classic subsistence economy that operates without money.

SMI beneficiaries are spread over the districts where the insurance plan was implemented. As they belong to the lowest social class in Peru, this group shows the worst indicators in terms of mortality, morbidity and life expectancy. Beneficiaries in rural areas are mostly indigenous. Hardly anyone in the SMI target group has a bank account, and many of them are unable to pay even a little sum of money at one time.

Inscription relies mainly on the health care providers who apply a passive and an active affiliation strategy. Health workers encourage pregnant women and young children to enrol in the scheme. Enrolment is voluntary and individual; the SMI does not affiliate households or family members. Membership can be constituted immediately by filling out an affiliation form, and paying a fee of 5 Soles (\$1.50) for pregnant women and 10 Soles (\$3) for newborns and children. The affiliation form assigns an individual reference number to all beneficiaries, for administrative purposes. The form remains in the provider facility as a part of the personal medical documentation, and serves in identifying the enrollees whenever they require SMI health care services.

SMI coverage is restricted to the services granted in the health centre or post where the beneficiary is inscribed. In case a beneficiary requires health care in another facility, he has to affiliate once again. If he or she needs referral to a higher-level provider, the referring centre has to prove the membership and specify the reason.

The succeeding health insurance plan, SIS, extended the SMI coverage in geographical and population terms. From 2003, all Peruvians had access to the public insurance benefits, which is approximately a doubling of the SMI target group. By integrating the old SMI with the Free School Health Insurance, all children under 18 years were covered, and additionally the new scheme included some highly vulnerable groups. All together, the target population experienced a significant increase from the SMI to the SIS (ref. Table 3.3 and Table 3.4). However, considering the affiliation of the “traditional” SMI beneficiaries – children under 5 and women between 15 and 49 years – the number of SIS enrollees has shown an increase that clearly surpasses the doubling of the specific target group.

**Table 3.3 Beneficiaries of the Mother Child Insurance**

	1999		2000		2001	
	Contributing beneficiaries	Total	Contributing beneficiaries	Total	Contributing beneficiaries	Total
<b>Total</b>		<b>44 176</b>		<b>315 758</b>		<b>358 187</b>
<b>0-4</b>	9 467	34 055	60 863	212 592	61 121	204 566
<b>5-14</b>	0	0	0	0	0	0
<b>15-44</b>	2 821	10 121	49 777	103 166	67 665	153 621
<b>45-59</b>	0	0	0	0	0	0
<b>60-74</b>	0	0	0	0	0	0
<b>&gt;74</b>	0	0	0	0	0	0

**Table 3.4 Beneficiaries of the Integral Health Insurance**

	2002 (Feb-Dec)		2003	
	Females	Males	Females	Males
<b>Total</b>	<b>2 713 038</b>	<b>2 262 654</b>	<b>4 155 551</b>	<b>3 415 751</b>
<b>0-1</b>	392 546	412 983	709 368	745 191
<b>0-4</b>	760 968	796 287	1 221 041	1 276 896
<b>5-14</b>	1 200 927	1 250 612	1 785 856	1 852 207
<b>15-24</b>	439 861	200 058	648 868	269 269
<b>25-44</b>	285 810	10 330	448 799	11 131
<b>45-59</b>	18 757	3 525	35 817	3 931
<b>60-74</b>	5 611	1 450	12 500	1 774
<b>&gt;74</b>	1 104	392	2 670	543
	2004		Until May 2005	
	Females	Males	Females	Males
<b>Total</b>	<b>4 906 716</b>	<b>4 282 111</b>	<b>4 525 089</b>	<b>4 152 969</b>
<b>0-1</b>	921 334	967 754	872 669	908 455
<b>0-4</b>	1 497 651	1 571 673	1 529 585	1 589 183
<b>5-14</b>	2 299 483	2 394 942	2 228 819	2 321 081
<b>15-24</b>	638 504	297 283	424 457	224 358
<b>25-44</b>	418 371	11 620	288 637	11 698
<b>45-59</b>	36 819	4 174	37 162	4 213
<b>60-74</b>	13 072	1 858	13 499	1 872
<b>&gt;74</b>	2 816	561	2 930	564

### 3.3 Financing

About 95% of the SMI budget comes from the national treasury. The ministry of health earmarks a certain amount to cover the budget and to finance the benefits. The remaining 5% comes from the affiliation fees. The SMI contributes 1 Sol from each fee to the inscribing health provider to create an incentive for affiliation. The SMI's budget is shown in Table 3.5.

Insurance contributions are due as single capitation fees. Even in rural areas with a non-monetary economy, enrollees have to pay in cash. However, most users profit from exemptions from contribution payment: almost three out of every four children and more than half of the pregnant women do not pay any fee. A clear definition of exemption criteria is lacking; the insured are exempted based on subjective decisions by the health personnel. No data are available on the relative impact of fees on the household income of enrollees.

The SMI does not require co-payments or user-charges for health care. Enrolees have the right to access all covered benefits free of charge. Any co-payment for diagnostic procedures, drugs and transportation in case of referral is unofficial and illegal. However, beneficiaries from various DISAs declare having been charged extra for covered benefits.

In the pilot phase, the IDB financed several activities to support the SMI implementation. Afterwards, the bank made 70 million dollars available for improving the Peruvian health sector. The accumulated interest contributed to the SMI budget for training, support, supervision, evaluation services and follow-up.

**Table 3.5 Development of budget and expenses of the SIS**

	2002 (Jan.-Dec.)	2003	2004	2005*
Administration costs	9 745 336	12 184 415	15 418 209	17 969 259
Children 0-4 years	51 870 887	78 032 213	103 762 081	90 643 732
Children 5-17 years	61 657 847	51 219 656	67 540 624	54 717 608
Pregnant women	46 673 674	66 398 922	100 054 899	97 276 583
Emergency care adults	0	7 071 215	4 807 255	3 281 736
Focalised Adults	8 538 278	4 645 021	2 558 281	833 113
<b>Total</b>	<b>178 486 025</b>	<b>219 551 445</b>	<b>294 141 351</b>	<b>264 722 031</b>

Source: Planning and Development Office, Peruvian Ministry of health; \* Ordinary household planning

### 3.4 Benefits

The SMI benefit package was designed according to the epidemiological challenges and the economic possibilities in Peru. SMI benefits are clearly described and listed on a form used for claim processing. After registration, the beneficiaries have the right to access all services without any delay or waiting period.

In the practice, however, deficiencies of the pharmacy stock or other inputs might limit the availability of benefits. The pharmacy shortages are more likely to depend on supply problems than on financial limitations. Different degrees of access also occur due to geographical reasons; reference transportation is more often denied in remote areas because the real costs exceed the reimbursement.

The insurance plan covers services related to the most important maternal and infant pathologies. Some treatments are expressly excluded.<sup>12</sup> The package includes mainly primary health care benefits in the field of prevention, promotion and therapy of maternity and childhood pathologies. Preventive and promotional services include regular pregnancy controls (4 pre- and 2 post-delivery ultrasound controls), vaccinations for children, and infant growth and development controls (maximum 5 development and growth controls in year 1, 4 in the second year, and 1 in the two following years). The SMI scheme also covers in-patient treatment of complicated births, caesarean operations and severe diseases of young children.

Basic laboratory services plus a HIV-test are implicitly included for pregnancy. However, the availability of laboratory tests depends on the local infrastructure. To make the plan more attractive, pregnant women are entitled to primary dental care for services such as fillings and extractions. The insurance scheme strongly recommends the use of generic drugs, but the SMI does not regulate drug supply and reimburses all prescribed drugs.

In case of referral, the SMI covers specialised obstetrician or paediatric outpatient services. Transport is covered only for emergencies and according to three tariffs depending on the

<sup>12</sup> Children: All other congenital defects or diseases than hydrocephalus and leporine labia, - Malignant tumours, aesthetic surgery, dialysis, lesions caused by thirds, physical medicine and rehabilitation, artificial limbs and articulations, AIDS-therapy, health care abroad. Pregnant women: Congenital defects or diseases acquired before affiliation, malignant tumours, mental diseases, aesthetic surgery except in necessary cases, e.g. after an accident, dialysis, self-induced lesions and lesions caused by thirds, physical medicine and rehabilitation, artificial limbs and articulations, AIDS-therapy and health care abroad.

distance and the geographical conditions. Although emergency transport is free of charge, providers sometimes ask for advance payment for gasoline.

### 3.5 Risk Management

Although the SMI focuses on the poorest sectors of the Peruvian society, its design does not foresee any active selection mechanism for regulating the membership. All applicants who fulfil the biological preconditions have the right to enrol. However, the SMI has the possibility to reject people who are covered by another health insurance scheme or have apparently enough money to pay on their own. Coverage can also be reduced for general financial reasons when the SMI imposes affiliation ceilings (for instance in Cusco).

Implemented to reduce certain morbidity and mortality rates, the SMI is especially attractive for pregnant women of low income and high risk. Thus, in terms of insurance theory, the SMI is exposed to an adverse selection risk, affiliating carriers of the insured risks and the poorest social groups who are run the highest morbidity risk.

Risk management relies to a large extent on the exclusion of a wide range of treatments and of most pre-existing pathologies, except two congenital malformations in children. The financial risk of the SMI falls on the state, which finances the insurance plan and the granted services, and acts as a last resort.

### 3.6 Services

Although TV spots, newspaper announcements and some other publicity accompanied the launch of the SMI, publicity was weak and did not provide adequate information for potential users. The low impact of the SMI propaganda is partly responsible for the false expectations the health care providers are often confronted with when beneficiaries demand uncovered services. Usually, the SMI members receive most information about the scheme from their health centre. Especially in rural areas, the crucial part of information provision for enrollees relies on the local health staff. During the implementation, the administrative and central staff organised training sessions for health workers in the field.

### 3.7 Legal Issues

As an institution of the ministry of health, the SMI is a public organism run by the Peruvian state. Implementation was based on several ministerial resolutions, mainly No. 448-99-SA/DM from 1999. Peruvian laws do not have any legal prescription or specific registration requirements for this type of public insurance program. No special regulations for health insurance are in place. The SMI is integrated in the Peruvian public health provider system, but there is no relationship with other insurers or reinsurers.

The ministry of health supervises the SMI. With regard to financial and administrative aspects, this task is shared with the ministry of finance. The ministry of health strongly backs the insurance-program with regard to the institutional and legal framework. Decision-making is hierarchic and depends mainly on the national and regional governments. Usually, the vice-minister of health appoints the SMI management. The director's position is highly political

and depends directly on the political leadership. During the first two years, the director changed several times (average length of stay 7.6 months). After the initial struggles, the stability of management has increased considerably.

### 3.8 Administration

The enrolment procedure relies mainly on primary health care providers. SMI-users have to pay the affiliation fee and fill out a registration form, and the provider sends it as hardcopy to the regional SMI-office. The DISA staff is responsible for digitalising the basic data and transferring it to the SMI office in Lima.

No special contract is required for health care providers, most of which belong to the public sector. However, due to the weak formal relationship between the scheme and providers, the SMI has not implemented quality controls and assurance measures. The providers have to register all delivered services on special forms to present their monthly claims. The regional SMI staff performs a first verification of the data. Incomplete or wrong forms are returned to the provider, while the accepted ones are submitted to the central office. Once the forms, the procedures and the services are approved, the reimbursement of all accepted items starts.

The financial management of the insurance scheme relies partly on the SMI and its regional representatives, and partly on the health care providers. The SMI is responsible for the reimbursement of the provider's share of the inscription fee and of the claims for delivered benefits. Providers have to spend about 50% of the SMI resources for drugs, inputs, and other running costs. The remaining funds are used according to the health centre's priorities.

Claim processing relies on the monthly reports. The SMI health care providers have to present data the 3rd of every month. The form sheet with the specified benefit packages and their single price serves as standardised billing list. The providers have to fill in the number of benefits granted to SMI-beneficiaries during the last 30 days, and to calculate the accumulated price for each service package as well as the total sum for the whole month. No manuals or technical support via internet are available, so that intended as well as unintended errors are common. Moreover, feedback, monitoring and a systematic follow-up of administrative tasks is lacking. Controls of claims and bills are not institutionalised and occasional; and the irregular visits cannot avoid fraud that can only be detected with a closer look to the provider's documentation. Moreover, no punishment is foreseen in case of false documentation; providers do not even have to pay back the corresponding reimbursement.

The SMI statistics are based on the provider information contained in the monthly claim reports that are digitalised on the district level. The SMI-software is unable to detect errors at the moment of data entry, thus it does not facilitate the control or help to avoid mistakes. No specific manual is available, and the SMI has not established data collection guidelines. For instance, provider driven fraud, e.g., the intentional increase of the number of claimed services, tends to influence the epidemiologic statistics. On the other hand, the serious troubles that health workers face if delivering women die might induce them to hide these cases. Thus, potential errors and the consequences of incentive or sanction measures enter directly into the nationwide database and might influence SMI-related decisions.

The SMI was implemented with a small staff, averaging 5 to 7 well-trained professionals of adequate qualification, many of them with university degree. Most SMI employees are working without a stable working contract or access to social security and other guarantees. In the first two years, staff turnover was high, especially at the director's level.

### **3.9 Health Care Provision**

The regional distribution of participating health providers is relatively broad because it uses all the public providers in the different DISAs. In the 20 health districts that were participating in July 2001, 82 hospitals, 608 health centres and 3699 health posts were available for the SMI enrolees. The SMI usually does not reimburse claims presented by external (not public) providers. Only where no public provider is operating, the insurance plan hires non-profit providers and reimburses their bills.

The availability of services depends on the provider's level. Primary care providers are located in (peri-)urban and in rural areas, and apparently the remotest facilities offer the worst services. Second-level providers are in urban areas, and the two third-level institutes are in Lima. Most health posts are poorly equipped and in general they offer only outpatient treatment including primary care, vaccinations, general care and pharmacy. Some posts have simple laboratory facilities, but none can provide imaging services or specialised care.

The health centres used to offer outpatient service in PHC including some laboratory exams, pharmacy and obstetrics; some have a dentist whose services including extractions and fillings. In several health centres, inpatient obstetric service is available for at least one, sometimes up to four beds, and some of them even offer ultrasounds.

The public hospitals run by the ministry of health are relatively old, with deteriorated infrastructure. They offer in- and out-patient care and most major specialties (internal medicine, surgery, gynaecology-obstetrics and paediatrics). Sub-specialisations might exist in some level 2 providers, e.g., cardiology, gastroenterology, oncology and orthopaedics.

The third level providers in Lima that are included in the SMI program present a high degree of specialisation including several sub-specialisations (neonatology, neurosurgery and others). The Institutes are relatively well equipped, and they offer all common services for diagnosis and care, such as complex laboratory, x-ray, ultrasound, scanner, intensive care units and operation theatres.

### **3.10 Provider Payment**

The SMI insurance scheme reimburses claims according to the monthly supply by the health care providers. The beneficiaries do not have to advance any payments. Reimbursement relies on a fee schedule and does not involve financial ceilings; however, the frequency of use is limited. The fees do not rely on strict cost calculation and are supplemented by various cross subsidies. Second and third level providers are especially dissatisfied with the reimbursement tariffs for more complex services, though their own cost calculation is still insufficient. Many providers also complain that the delay of reimbursement is between 2 and 6 months.

## 4. Integral Insurance, Paraguay

The *Seguro Integral* (SI) scheme in a rural area of Paraguay is a relatively young public insurance scheme. Many findings during the evaluation process evolved into planning issues, and even induced a series of concrete strategies for the SI-plan. The following description of the Integral Insurance does not rely exclusively on the finding of the InfoSure-evaluation, but it presents all relevant information and refinements implemented in the scheme.

**Table 4.1 Paraguay Statistics**

Total population:	5,878,000
GDP per capita (Intl \$, 2002):	4,061
Life expectancy at birth m/f (years):	69.0/75.0
Healthy life expectancy at birth m/f (years, 2002):	59.6/64.2
Child mortality m/f (per 1000):	33/26
Adult mortality m/f (per 1000):	171/119
Total health expenditure per capita (US-\$ 2002):	343
Total health expenditure as % of GDP (2002):	8

Source: The world health report 2005; figures for 2003 unless indicated.

### 4.1 Setting up the Scheme

The initiative to create a local insurance scheme in the department of Caazapá began in 2001. The project started officially in June 2002 when enrolment became possible for the first beneficiaries. The primary motivation for implementing a public health insurance plan in Caazapá was because of the high maternal and newborn morbidity and mortality rates in Paraguay. These epidemiological problems were attributable to a low rate of institutional deliveries and a high prevalence of preventable paediatric diseases. Furthermore, access to health care was lacking for a relevant share of Paraguayans, and about four out of every five citizens were living without social protection in health.

After a long period of a paternalistic dictatorship by Alfredo Stroessner, governance was highly ineffective, stewardship was lacking and the public sector was deteriorated. Thus, the state-run health care system was inefficient, chronically under-financed and under-equipped. Geographical, institutional and economic barriers were too high for most Paraguayans, especially in rural areas. In theory, public providers had to charge for health services; however, they had to exempt a large part of the users who were unable to pay for care.

The health system in Paraguay is segmented and fragmented. The minority of Paraguayans who have social protection in health are in different sub-systems like the Social Welfare Institute, (*Instituto de Previsión Social*), several for-profit health insurance companies called “Prepaid health” (*Salud Prepaga*), and a wide range of local, cooperative social protection schemes (Holst 2004b; Holst 2004a, pp. 29ff). Overall, the health system is far from achieving universal coverage, and it lacks equity, solidarity and sustainability.

**Table 4.2 Exclusion from social protection in health in the Department of Caazapá**

Criteria	Indicators of exclusion			
	Paraguay	Caazapá	Urban Caazapá	Rural Caazapá
Official coverage	100%	100%	100%	100%
Population share that does not consult for disease or accident	51.4%	70.1%	44.7%	74.4%
Population without health insurance	81.1%	95.6%	83.1%	98.7%
Poverty rate	33.9%	56.6%		
Household out-of-pocket expenditure (Gs.)	1,174,980	498,150	1,040,396	340,898
Population share speaking mainly Guaraní	50.6%	80.6%	64.7%	84.9%
Indigenous Population share	85,674	2,544		
Total unemployment rate	15.3%	15.0%	21.9%	13.2%
Physicians per 10,000 inhabitants	3.9	2.2		
Non-institutional births	27.3%	50.5%	13.9%	59.6%
Population without access to drinking water	45.5%	80.6%	21.7%	96.4%

Source: Güemes et al. 2005, p. 46, relying on data from DGEEC-EIH 2000/01.

As a political attempt to improve health care and to broaden coverage, the National Ministry of Public Health and Social Welfare (MSPBS) initiated a health insurance plan called Integral Security (*Seguridad Integral* – SI) for the underdeveloped, mainly rural pilot area of Caazapá in the Eastern part of the country. From the very beginning, the ministry received strong technical and some financial support from PAHO; additional funding came from the Government of Taiwan, while GTZ and others provided technical support. The main sources of finance during the implementation phase have been the ministry of health, its regional representation and the municipal governments.

Prior to setting up the scheme, the PAHO-team carried out a survey about the socio-economic situation in the target region, including an estimation of household's ability to pay. Furthermore, the group studied the most relevant health problems, the epidemiological challenges and the physical needs to satisfy the expected demand. Experience from other countries was also taken into account.

## 4.2 Membership

According to its technical design, the SI will offer universal coverage in Caazapá, and potentially in other regions. However, during the pilot phase, the target group is limited to women of childbearing age and children under five residing within the district. Residents from other departments, even those who live close to a Caazapá provider, are in principle excluded from coverage. In practice the scheme has not denied affiliation to anybody who applied with the main provider, the regional hospital (see Table 4.3).

The majority of the target group lives in households that earn their livelihood from small-scale farming and stockbreeding, often on a subsistence basis. About 50% of the population work partly on their own land, about 30% on the land of others, and the rest are day labourers. The beneficiaries have some common characteristics concerning the cultural, educational, religious and ethnic background; in spite of a relevant share of indigenous people in some communities, affiliation of this group has remained low.

**Table 4.3 Demographic structure of the population in the Department of Caazapá**

Age group	Number
Infants < 1 year	4,547
Children 1 – 4 years	17,883
Children 5 – 14 years	40,475
Adolescents 15-19 years	15,457
Adults 20 - 59 years	58,123
People > 60 years	8,545
<b>Total</b>	<b>145,033</b>
Women in fertile age (15-49)	30,686

Source: Güemes et al., p. 52.

The implementation of the SI started with a radio campaign, supported by information in health care providers, churches, and other social institutions. However, word of mouth propaganda seems to be the most important source of information. Most enrollees affiliate when they apply to the public regional hospital in Caazapá where the SI office is based.

To become a member, no formal contract is required. The applicant has to fill out an inscription form and give the necessary information for the affiliation survey. During the pilot phase, affiliation was free to attract members, and the enrollee could receive all covered benefits immediately after affiliation. Shortly after affiliation, insured households receive a card that they have to present to identify themselves as beneficiaries.

In time, entitlement to benefits no longer depended only on affiliation. Since monthly contributions have been introduced (see below), active membership implies regular payment of the contribution. If an enrollee stops contributing, he/she remains eligible for two months, but if payment is delayed for three or more months, the enrollee loses benefits.

The affiliation unit is the family group defined as the household of persons who live together “below one roof” or “eat out of the same pot”. According to the living conditions in rural Paraguay, all dependents – children, grand parents and other relatives who do not have their own income – are considered beneficiaries. However, during the implementation phase, the whole range of SI benefits was available only for pregnant women and small children until their fifth birthday. Additionally, women of childbearing age were entitled to receive family planning services and the PAP-test for detecting early cancer of the womb.

### 4.3 Financing

During the first three and a half years, the ministry of health paid for the running costs. In general, funding is based on a concept of shared per-capita financing and aims to reach a minimum amount of \$300,000 per year in the department of Caazapá. The ministry of health finances about 70% of the budget, paying salaries, fixed and running costs. The district government ought to contribute \$1 per citizen and year or \$145,000, but in 2002 it did not transfer more than \$17,000. And, the municipal government that was supposed to pay \$1 per inhabitant, but instead of the expected \$27,000, it contributed less than \$200 in 2000. Loans were not available when setting up the scheme, but initially SI received donations from the PAHO (\$5,000) for office equipment and running costs, from the Government of Taiwan

(\$10,000) for inputs and drugs, and from GTZ (\$1,500) for technical assets plus ca. \$10,000 for advisory services. The SI's budget and balance sheet are shown in Table 4.4.

**Table 4.4: Budget and financial balance in 2003<sup>13</sup>**

Source of income	Amount in Gs.
Initial contribution - Local Health Council (10.12.03)	26,271,236
Initial contribution – agreement with PAHO/WHO (10.12.03)	49,414,000
Initial contribution – municipality (30.12.03)	2,600,000
Initial contribution - municipality (16.09.04)	3,000,000
Initial contribution – district government (04.06.04)	10,000,000
Contribution from district government for equipment (09.06.05)	1,600,000
Contribution from beneficiaries	69,970,000
Cooperative interests	5,033,882
District government advance payment for contribution of enrolees	4,515,000
Recovered funds	12,641,837
Pharmacy sales	68,545,640
<b>Total income</b>	<b>253,591,595</b>
<b>Expenditure</b>	
Drug purchase for pharmacy	61,122,653
Commissions paid to promoters	125,000
Expenses by PAHO-donations	49,376,680
Expenses for delivered benefits	68,753,129
<b>Total expenditure</b>	<b>179,377,462</b>
<b>Balance</b>	<b>74,214,133</b>

Source: Direct information from the SI administration

In the beginning, the district and local authorities tended to interpret the agreed modality to mean that they only had to contribute for citizens who had enrolled in the insurance scheme. In time, the disposition of both the departmental and the local governments to co-finance the insurance plan has increased and they are contributing the foreseen amounts of money.

The SI receives financing from various sources; however, a clear allocation is not possible due to a series of non-cash transfers and hidden cross-subsidies.

- Ministry of health: co-finances the scheme by paying the salaries of the staff involved in administration and health care delivery, running costs for administration and maintenance, and all nationalized health program like immunisation, family planning, etc.; altogether equivalent to approximately 70% of the SI budget.
- Departmental government: about \$145,000 per year
- Municipality: about \$27,000 per year
- Member contributions (30.000 Gs. or \$5) since March 2004.<sup>14</sup>

The insurance scheme has not considered or designed flexible mechanisms of contribution payments that might be more suitable with regard to the irregular and frequently unstable income situation of enrolees. The initial financing plans rested on regular, monthly contributions from the affiliates. However, to ensure that households contribute according to

<sup>13</sup> All fees and tariffs are in national currency: €1 = 7302.95 Gs; \$1 = 6035 Guaraníes (Gs.) (1 July 2005).

<sup>14</sup> Compare also Güemes et al. 2005, p. 76.

their ability to pay, the insurance plan intended to differentiate contribution fees. Therefore, the survey performed during inscription should allow a rough estimation of the enrollee's socio-economic situation and his/her classification in group A, B or C.

The introduction of contribution payment by the enrollees was postponed several times so that the scheme was initially running with public funds only. Finally, the collection of enrolment fees started in March 2004. The monthly flat-rate contribution of 30.000 Gs. is paid per household and is identical for all enrollees. In the end, the insurance plan renounced the idea to offer different rates according to the enrollee's economic situation—the possibility of paying a lower contribution rate seduced many applicants to appear as poor as possible in the socio-economic survey associated with the inscription process.

To allow for flexibility according to the affiliated households' income situation, the SI has implemented certain time limits for contribution payment. If enrollees cannot afford the contribution, they do not lose entitlement immediately. Access to insurance coverage expires only if beneficiaries fail to contribute for more than two months. In the middle of 2005, only 235 of the 813 enrolled families (or 28.9%) had paid their contribution payment on time, while 578 families (71.1%) had discontinued payment more than two months before. To improve the payment behaviour and to facilitate regular subscriptions, the SI is testing home visits to collect fees; however, the provision of 5,000 Gs. (\$0.80) for each monthly subscription fee seems to be too low to be a real incentive for the collecting personnel.

In principle, the SI does not require any co-payments. However, sometimes beneficiaries have to pay small sums to buy needles or drugs when the hospital runs out of inputs. The impact of this unofficial cost sharing tends to be perceived far more drastic by the users than the real cost might suggest. Furthermore, the fact that SI-users have to pay for drugs induces a kind of indirect co-payment for health care. Although SI beneficiaries have the right to use the social pharmacy, pharmaceutical treatment might become a relevant part of health care costs that individuals have to pay for even if they have enrolled in the insurance scheme.

#### 4.4 Benefits

The SI benefit package is designed to fight the most prevalent pregnancy and childhood health problems. It follows the political priority of the Paraguayan ministry of health to reduce the alarming mortality and morbidity indicators. Maternal mortality was estimated close to 600/100,000 newborn, and delivery injuries were also higher than in other countries of the region. Infant morbidity showed a high prevalence and incidence of preventable problems like pneumonia, diarrhoea, measles, and other infectious diseases.

Currently, the SI offers a well-defined and reduced service package restricting coverage to women between 15 and 49 years and children under the age of five. Female enrollees have access to gynaecology and dental care; infants can apply for benefits in neonatology, paediatrics, orthopaedics, pneumology, cardiology, urology and preventive dental care. During the initial phase, the SI insurance package comprises of 23 benefits for the treatment of maternal and infant health that belong to the following health care groups:

- Outpatient consultations for normal and high risk pregnancy, family planning, PAP-test, pregnancy-associated diseases, curettage, and puerperal period.

- Vaccinations: complete tetanus immunisation for women of reproductive age, children's vaccination according to the National immunisation program (under 5); however, German measles is not included in the preventive package for young women.
- Dental out-patient care: during pregnancy and for special reasons; extractions, and fillings
- Laboratory tests during pregnancy and puerperal period: Syphilis, blood group, blood sugar and uric acid, in high risk patients also blood coagulation.
- Ultrasound
- X-rays in case of disease
- PAP- controls during pregnancy
- In-patient treatment: high risk pregnancy, normal and complicated delivery, caesarean section, and other associated problems
- Foetal controls, paediatric surgery of children under five years.

A certain conceptual confusion and the lack of clear guidelines drive medical providers to grant uncovered benefits to the covered sub-population. This attitude creates unjustified expectations on the beneficiary side and, thus, the risk of disappointment. On the other hand, due to insufficient personnel and supply gaps, not all covered services were always available. This might be pardonable as long as the insurance plan does not collect premiums from the enrollees, but if the SI cannot fulfil the promised entitlements, the disposition to contribute regularly will disappear very soon.

Together with the ministry of health, the insurance scheme has developed standardised protocols about the delivery of health care benefits. The SI has ceilings for outpatient controls during pregnancy (up to six in normal and up to 12 in complicated cases), but laboratory tests are covered without limitation whenever a medical prescription indicates their necessity.

None of the SI-packages includes drug treatment. Even in case of hospitalisation, the beneficiaries have to acquire medication on their own. However, all enrollees have the right to access social pharmacies where drugs are offered at prices 30% to 50% cheaper than in commercial drugstores. In Paraguay, medical drugs are a highly political issue and play an important role in election campaigns of potential parliamentarians. The candidates use drugs – and other medical treatments - as campaign goodies. Thus, organising fair access to adequate drugs would interfere directly with an important political propaganda strategy.

## 4.5 Risk Management

The SI is not mandatory and, thus, affiliation is voluntary. Its office is based in the most important health care provider of the scheme. These factors make the insurance plan susceptible to adverse selection, i.e. attracting mainly those citizens who are looking for treatment in the Regional Hospital. Furthermore, as affiliation is by household, each contributing enrollee increases the number of dependents and, thus, the expected expenditure. However, as long as the Department and the Municipality were contributing only according to the number of beneficiaries, the automatic affiliation of family members leads to a higher income from public sources.

While inscription is voluntary for users, the insurance organisation is denied to refuse any applicant who meets the target group criteria and resides in the department. The SI does not

even exclude those enrolees who are formally insured by another scheme, be it a social security or a private organisation.

In terms of insurance theory, the SI is managing the financial risks only through the biological definition of the target group – women in reproductive age and young children – and by limiting the benefit package. Therefore, the SI does not cover any complex or catastrophic disease that needs referral to a specialised hospital outside the district.

With future expansions of both the target group and the benefit package, the financial risk will increase. One risk management mechanism implemented recently, together with contribution collection, is waiting periods for non-emergency benefits before the new beneficiaries are entitled to receive the insured benefits: 15 days for diagnostic procedures and 30 days for hospital treatment.

Although no reinsurance system is in place for the SI, the public sector carries the financial risk for the insurance plan. Namely, the ministry of health acts as a last resort because it is responsible for ensuring the delivery of health care benefits. However, in case of insolvency, the beneficiaries will be kept from receiving the benefits they are entitled to.

#### **4.6 Additional Services**

The SI does not offer additional services beyond the well-defined package of health benefits. Publicity and consumer information is relatively weak. A series of radio transmissions accompanied the implementation of the scheme, pamphlets were distributed in the town of Caazapá and some of the surrounding villages, and a communication specialist worked for a couple of months in the Regional Hospital. However, a propaganda strategy has been lacking and information about the insurance plan relies mainly on personal contacts of the health care staff with the potential users and on direct “mouth-to-mouth-propaganda”.

#### **4.7 Legal Issues**

The implementation of the *Seguro Integral de Caazapá* rests basically on the Law 1032/96 about the construction of a national health system and national health insurance, and other pre-existing legal dispositions. The SI is a public, formally established and non-for-profit insurance organisation run by the state and its decentralised organs. As any health insurance organisation in Paraguay, the scheme underlies the national dispositions of the Health Codex and the other laws that are in force to regulate the health care system. There are no specific statutes or decrees in place prescribing the functions and obligations of the SI; however, the SI has developed its own regulations and guidelines for co-ordinating financing, benefit delivery and internal control.

The ministry of health supervises and directly appoints the SI co-ordinator. The administrative council, composed of the regional representative of the ministry, the Governor’s health secretary and a representative of the municipality, monitor the performance. The SI is legally registered in the municipal administration according to the agreement between the ministry of health, the Governor and the Mayor of Caazapá, and certified by PAHO and the local health council. It is not a juristic entity (otherwise it would

lose the right receive financing by the ministry). Being a public non-profit institution, the insurance scheme is exempted from all direct taxes; however, it is submitted to the normal value-added tax for drugs and other inputs.

Although the Law 1032/96 expresses another spirit, one conceptual limitation for all insurance plans in the country derives from the exclusivity of Social Welfare Institute (IPS) concerning social protection: All formally employed citizens have to contribute to the IPS for health and pension insurance.<sup>15</sup> That inhibits alternative social protection schemes to affiliate the members of this group even in areas where no IPS provider is available.

## 4.8 Administration

Member registration is carried out in the SI office in the Regional Hospital of Caazapá. During the inscription process, the insurance staff registers the personal data of applicants and dependents. Additionally, a mandatory inquiry is performed to achieve a socio-economic classification of the enrolees; the digitalisation in an Access-file allows for analysis. After a few days, the new enrolee receives one insurance card for the whole family.

In the beginning, the infrastructure for contribution collection was lacking. Health posts were not participating in the SI network. However, nobody could expect enrolees living outside the town to travel to Caazapá, just to pay their contributions. When contribution collection started, affiliation was no longer limited to the Regional Hospital. Then, all nine health posts began collecting contributions. As no banking system is in place, the health centre personnel carry the fees to the insurance office twice a month. To create an incentive for inscription, the centres receive a provision of Gs. 5,000 per new affiliation.

The required administrative procedures are in place only on the provider level. Thus, data interchange from the various health centres to the insurance office is not automatic, and the control of entitlement is limited to the post where the household is affiliated. If beneficiaries require attention in a centre other than where they are affiliated, they have to show the insurance card. But the local staff is unable to assess the contribution payment status. To avoid abuse, health workers have started to ask for the latest contribution receipts. However, if patients cannot present the receipt, they are not prevented from receiving the required care.

The hospital staff do not make a distinction between beneficiaries and non-affiliates, and they do not even register the insurance status of their patients. This attitude was attributable to the fact that provider payment started only four years after the first members affiliated to the insurance scheme. However, the General Hospital benefited from SI-resources during the initial phase because a clear separation of inputs for different purposes was impossible to realise. Thus, the additional assets granted by the ministry of health to deliver the SI benefits were used for the daily hospital activities and ran out prematurely.

The SI counts on the necessary hardware to use computer programs, including Access for databanks, and WinSIG to manage bookkeeping, accountancy and administration procedures.

<sup>15</sup> Until now, only the most developed social security system in Paraguay, the Sozialversicherung Chaco (SVCh) of the Mennonite colonies in the Chaco-Region have achieved a complete independence from the obligation to contribute to the IPS (Holst 2004b, p. 33ff).

According to the extension of effective coverage, participating providers will be equipped with technology to process relevant data in a digitalised format. However, the software and the personnel for an effective administration and accountability are lacking. Despite support from PAHO, better technical equipment and specific training of employees appeared to be crucial aspects for improving the performance of the SI. The insurance scheme started to work without having defined the core tasks. Three persons were working full-time and one on a voluntary basis in the SI office, sharing 3 computers, 2 printers, only one unstable telephone line, and a walkie-talkie for contacting the health centres in remote areas.

#### **4.9 Health Care Provision**

For a long time, the only provider where enrolees could receive benefits was the Regional Hospital, a state-run second level clinic offering internal medicine, surgery, gynaecology and paediatrics. Financing of the SI-covered health care benefits rests on the historical budgets of public providers, and depends mainly on the salaries paid to the personnel by the health ministry. The hospital is easy to reach for people living in and around the town, and public transport to the hospital is available at least once a day from all villages in the department.

With the implementation of a decentralised system, the SI provider network was extended to the nine health centres in the department. Since 2004, the beneficiaries are entitled to receive all covered benefits in the primary health care facilities in their village of residence; a referral-system is being implemented for patients who need specialist or hospital care.

The delivery of SI benefits depends almost completely on public sector health care facilities. However, the cooperation with the local IPS-provider seems reasonable, mainly for those services the public network cannot resolve. In this case, claim processing and reimbursement mechanisms will have to be implemented.

#### **4.10 Provider Payment**

The insurance plan started without any direct payment to the provider(s). However, since the implementation of the SI, the Regional Hospital received extra supplies of clinical material, drugs and vaccinations to provide the covered benefits. Facing continuous constraints of inputs, the hospital used the goods without any distinction between affiliated and non-affiliated patients. The social pharmacy in the hospital receives direct payments from the enrolees who have to buy the prescribed drugs supplied by the ministry of health.

Since the expansion of the provider network, the insurance plan reimbursed the Regional hospital as well as the local health centres according to their monthly claims. Provider payment obeys a fee-for-service or fee-for-package mechanism. Therefore, the hospital and the health centres have to present a list of delivered services until the 30<sup>th</sup> of every month. The form is the same for all providers and contains the whole list of insured benefits. Until March of 2005, the hospital in Caazapá received reimbursement in cash. However, due to a series of bureaucratic obstacles, provider payment currently relies on assets and inputs acquired by the insurance scheme according to the demand of the provider and the monthly reimbursement amount. Insurance tariffs are lower than the usual public sector fees because they do not include the cost of human resources.

## 5. Bienestar Magisterial, El Salvador

The Teacher Welfare Insurance in the smallest Central American country is the oldest health insurance scheme analysed in this sample. Furthermore, it is the only insurance plan directly linked to formal employment, mandatory for a specific professional group. Undoubtedly, the Bienestar Magisterial (BM) fulfils the relevant criteria of a “traditional” social health insurance, like obligatory contracts, mandatory enrolment, wage-related and bipartite contributions and linkage to pension insurance. Thus, it might be considered a formal sector health insurance scheme. However, some specific characteristics can justify an analysis of this scheme within a microinsurance context. One important reason is that the BM co-exists with a comprehensive and countrywide social health insurance for formal sector employees (Instituto Salvadoreño de Seguridad Social – ISSS). The relatively small target group of the BM, in connection with the scope of coverage and a series of recent changes differentiates it from usual formal sector health insurance.

**Table 5.1 El Salvador Statistics**

Total population: 6,515,000
GDP per capita (Intl \$, 2002): 5,641
Life expectancy at birth m/f (years): 67.0/73.0
Healthy life expectancy at birth m/f (years, 2002): 57.2/62.3
Child mortality m/f (per 1000): 9/3
Adult mortality m/f (per 1000): 248/138
Total health expenditure per capita (Intl \$, 2002): 372
Total health expenditure as % of GDP (2002): 8.0
Source: The world health report 2005; figures for 2003 unless indicated.

### 5.1 Setting up the Scheme

The Bienestar Magisterial (BM) was created by the ministry of education to provide health insurance for teachers. When the scheme came into being in March 1969, the primary motivation for implementing a nationwide insurance plan was because of the teachers’ dissatisfaction with the scope and quality of social protection provided by the ISSS. The teachers’ trade unions demanded better social security and access to appropriate medical care. To calm the movement, the government created the BM to improve medical and hospital care for teachers and their families.

No information is available about the steps taken before starting the BM, and the time between initial decision-making and creation is also unknown. Setting up the scheme relied mainly on the ministry of education, which financed the implementation of the scheme, gave administrative support, and organised technical assistance and training for personnel. The teachers’ trade unions gave logistic support; the ministry of finance participated actively in the financing design; and the providers contracted in the initial phase – mainly the hospital of the public telecommunication enterprise – helped to define the benefit package, claim processing and other insurance tasks.

## 5.2 Affiliation

The core target group are all teachers in public sector schools and colleges as well as in the Salvadorian Rehabilitation Institute for Disabled Persons. For all personnel contracted by the ministry of education for educational services, affiliation is exclusive, mandatory and automatic. However, affiliation is restricted to teachers who work a minimum of 4 hours per day, and ends when a teacher retires and has to change to the ISSS. The BM is not for the staff working in the ministry or for any other subsection of the population.

The unit of subscription comprises all dependent relatives, i.e., the spouse and all children under 21 years who do not have their own income or other source of maintenance. However, affiliation is restricted to the biological children of the affiliated teacher and does not cover the children of the marriage partner even though they are living in the same household.

Approximately 36,000 are affiliated in the statutory health insurance for teachers; two out of three contributing enrolees are females. In late 2003, the total number of beneficiaries was 75,871; and 33,769 of the dependents are younger than 19 years. The socio-economic situation of BM-members is relatively homogeneous because they are all employed and receive salaries between \$286 and \$800 per month, in six different salary grades. Thus, the insurance covers a formally employed middle-class population group.

One-quarter of the beneficiaries live in the capital San Salvador and 11% in the second city San Miguel. Due to the distribution of educational centres, most reside in urban areas; only a minority live in rural areas. Thus, access to health services might vary according to the infrastructure conditions, though each enrolee is entitled to the same benefits.

Although affiliation is mandatory and automatically performed by the ministry of health, the enrolees have to inscribe in the central BM-office in San Salvador or a regional branch (either in Santa Ana and in San Miguel). Therefore, a clearly defined series of documents are required to prove the entitlement of the contributing member and of his/her dependents.<sup>16</sup> Furthermore, to be entitled to the whole range of benefits, the members have to subscribe to the BM family doctors plan (see below). However, only 70% of the registered teachers have inscribed in this program and are, thus, using the insurance benefits. The reason for the difference between entitled affiliates and users is unknown.

To access BM health insurance services, beneficiaries have to show their personal insurance card containing the name, the affiliation number, a photo and – in case of dependents - the date of birth. The insurance card is valid for 5 years. In practice, the controls are not very strict. Many members claim for benefits after retirement or, in the case of dependent children, after the 21<sup>st</sup> birthday, as long as the insurance card remains valid.

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<sup>16</sup> The application form involves by the following documents: 1) for contributing enrolees, a copy of the employment deed, of the appointment record, of the ID card, and the salary classification, plus an earnings record and two passport photos; 2) for spouses, the marriage certificate, the original and a copy of the ID card, 2 photos and an affidavit for not being covered by another health insurance; 3) for inscribing newborn, the birth certificate; children between 6 months and 18 years need the birth certification and two photos, and dependents between 18 and 21 years have to present the ID card number and one photo.

### 5.3 Financing

The *Bienestar Magisterial* finances all health insurance benefits through the contributions paid by the enrolees. Applying the traditional financing mechanisms of social health insurance, financing is based on wage-related and bipartite contributions shared between the employer and the employee. The ministry of education pays 7.5%, and the enrolled teacher 3% of his/her salary, plus a general contribution of \$1 per month per enrolee. Including the extra dollar, the average contribution rate is close to 11% of the taxable income, or between \$31 and \$85 per affiliated household per month.

The premium base is the monthly gross salary, and the bookkeeping department of the ministry transfers the payroll deductions automatically to the BM account administered by the ministry of finance. As the deduction is effective automatically and before the employee receives his monthly pay, contributions can be considered as “implicit taxes”. Thus, control mechanisms for avoiding contribution evasion and elusion are unnecessary.

The BM offers neither differentiated contribution rates nor different benefit packages for special sub-groups, and all services are available without any co-payment. In general, there are no exemptions from contribution payment except for enrolees who receive, temporarily or permanently, the disability subsidy offered by the BM. They remain entitled to benefits even though they are exempt from contribution payment.

The BM receives direct and indirect subsidies from the ministry of education. Although the subsidy in case of temporary or permanent disability is a BM benefit, the ministry pays this support directly to guarantee the maintenance of disabled teachers. In addition, the ministry pays the salaries of the BM staff, and the fixed and running costs of the insurance scheme.

### 5.4 Benefits

The benefits of the scheme are regulated by the Law of Medical and Hospital Services and published in the monthly reports of contracted providers. The benefit package includes primary health care, specialised outpatient care including dentistry, diagnostic procedures according to medical prescription, and inpatient care that has to be pre-approved by the BM staff. The directorial board influences the coverage of some benefits by selecting the least expensive provider or postponing an elective treatment in case of economic constraints.

To become entitled to benefits, members have to register at their local family doctor. Following the experience of social security in the 1970s, the BM has contracted more than 100 physicians to provide preventive, promotional and primary health care services all over the country. To participate, family doctors have to attend in a special training program organised by the National University. The focus of family doctors is on the active health promotion and prevention benefits, including home visits to the enrolled teachers and special disease management programs for the chronically ill.

Except for emergency care, coverage is only applicable upon referral by the family doctor. Thus, the medical professional is not only responsible for health care provision, but also for guiding the beneficiary through the system. Inpatient treatment requires referral by an outpatient specialist as well as the prior approval by the BM staff. Only in case of emergency

care is the patient entitled to receive hospital treatment without pre-approval. All providers who attend beneficiaries referred by the lower level are obliged to counter-refer the patient to the referring centre or health professional and to send a copy to the family doctor if the latter has not been involved in the referral process.

Although the BM health insurance plan has defined a small number of excluded services, namely vaccinations, family planning and any type of prosthesis, it is an integral health insurance providing the complete range of preventive, curative and reconstructive health care. The health care covered by the BM includes the following benefits:

- **Primary health care:** Health promotion, preventive care (except vaccinations due to historical decisions), medical consultations, treatment of wounds and uncomplicated diseases, emergencies, domicile visits, and referrals.
- **Specialised outpatient care:** Wide range of specialist services (including sub-specialities) that are available in the country, with a limit of 4 treatments per year, except for psychological treatment, where 5 visits per trimester are covered.
- **Dental health care:** Prevention, gums treatment and fillings.
- **Hospital care:** According to the necessity and medical indication, all treatments are covered by the BM as long as they are required by medical prescription or referral with no exclusions or limitations with regard to the complexity; for inpatient emergency care, no referral is required.
- **Laboratory/pathology:** Without exclusions according to availability
- **Pharmacy:** Two drugs are included in all out- and inpatient treatments; if more medications are needed, additional prescriptions including the specific indications are required for to be covered by the BM. The physician has to fill out one receipt per substance. The pharmacy and the insurance have limited the options to three generic drugs per substance.
- **Maternity:** Pre-, peri- and postnatal controls and care, including ultrasound and delivery.
- **Transport:** Covered after previous authorisation by a medical professional.

## 5.5 Risk Management

According to the affiliation rules, the BM represents a relatively large risk pool composed of all public sector teachers. The BM is not permitted to refuse applicants, or their dependents, who want to enrol. However, by binding membership to a professional activity and excluding retired teachers, the scheme applies effective risk selection because health care costs rise in the elderly, while the income level decreases with retirement. The exclusion of part-time teachers (with lower salaries) also contributes to the cream skimming applied by the BM.

In terms of administrative risk management, the most relevant strategy applied by the BM is the definition of the target group and potential enrolees. As affiliation is limited to teachers who belong to the middle class of the society, the insurance plan avoids the higher financial burden of the poor population.

As for financial risk management, the scheme applies two strategies: 1) definition of ceilings for health care services, and 2) budgeting. Furthermore, in the negotiations with providers the

BM achieves bulk discounts to reduce expenditures. There is no explicit reinsurance in place, but the ministry of education carries the financial risk of the social insurance plan.

## 5.6 Additional Services

Beyond the health care benefits, the BM grants a temporary or permanent subsidy in case of labour disability. Therefore, the physician in charge has to fill out a disability certificate with the name of the enrollees, the type of handicap, the associated risk and other medical specifications. The subsidy amounts to approximately \$90 per month and is payable as long as the disability persists, but stops when the enrollees retire.

The BM produces a regular television program, organises round-tables and workshops, and uses other channels to inform members about the services and innovations in the insurance plan. Recently, the BM launched a public relations campaign to explain the improvements implemented during the few last years. However, enrollees refer mainly to direct talks with colleagues and, to a smaller extent, with family doctors when they are asked where they get information about the scheme.

## 5.7 Legal Issues

Bienestar Magisterial is a state-run institution registered by the ministry of education according to the Legal Decree N° 588 (1968) and its amendments. A series of additional regulations and orders regulate the operation and performance of the scheme as well as the delivery of health care services. Regarding the financial tasks, the BM is subjected to the fiscal legislation and the accountability norms of the ministry of finance. As a public organisation, the BM is exempt from taxation. However, reimbursement transfers include the general value-added tax rate.

In El Salvador, there is no systematic verification and supervision of health insurance plans. The ministry of education reviews the financial transactions of the scheme, but it does not intervene in allocation decisions or in internal affairs except human resources. The administrative and organisational structure is hierarchical. The minister of education appoints the director. The enrollees do not have their own representation and cannot participate in the decision-making processes.

The regulation of the health care sector relies on the Ministry of Health and Social Assistance (MSPAS) that authorises market access for health providers and performs a series of sanitary controls with regard to the quality and adequacy of care. But the MSPAS does not interfere in the tasks of the BM. However, the BM leaders are intensifying the contact with the health authorities in order to ensure the adequate embedding of the specific social security plan for teachers in the national health policy and the ongoing sector reforms. In 2001, the MSPAS started a technical support and consultancy program for the BM.

## 5.8 Administration

The registration of members takes place in the ministry of education where all contracted teachers are registered. The ministry is also responsible for transferring the contributions for

all employed teachers to the BM-account in the ministry of finance. Thus, administration of contributions relies mainly on the ministry of education's finance department, which also develops the scheme's budget. Autonomy of the insurance plan is low in terms of general policy and overall budget; however, the BM is vastly independent regarding resource allocation and other insurance functions.

The BM staff are responsible for claim processing, control and oversight. Standardised forms and administrative guidelines are available for claim processing. Until 2003, all documentation was in paper format and administrative procedures relied on hardcopies filled out by hand, which were sometimes illegible. Now a computerized procedure has been implemented for claims payment, which requires a series of well-defined documents according to the type of provider. Provider control and monitoring relies on irregular audits by specialised BM staff who compare the claims forms with the medical histories and other provider documentation. Due to the lack of adequate information technology, the BM has not performed a systematic collection and statistical processing of data. Consequently, the monitoring of demographic, epidemiological and affiliation information has been difficult to perform and decisions are often made based on rough estimations.

The BM is running three offices with approximately 40 employees (26 in the headquarters), including administrative and specialised medical personnel. The scheme does not have any means of transport at its disposal and the auditing staff relies on their own vehicles. Space is scarce and several employees share offices and a few telephone lines. The physical conditions in the BM-office tend to affect the working conditions of the personnel.

## 5.9 Provision of Health Services

In May 2003, the BM provider network consisted of 103 family doctors, 180 specialists, 7 psychologists, 65 dentists, 44 clinical, 3 pathological and 5 radiological laboratories, 21 public hospitals, 8 private hospitals, 49 private and 18 Cefafa pharmacies.<sup>17</sup> Density is more available in urban areas than in rural regions. The second and third level health care facilities are especially concentrated in towns and in the capital. Family doctors are more homogeneously distributed over the country.

The Bienestar Magisterial and the ministry of health do not operate their own health care facilities. However, the more than 100 physicians covering primary health care of BM-beneficiaries are contracted and remunerated by the insurance plan. In most cases, the salary paid by the BM is their only source of income. Primary health care provider-choice is restricted because affiliates have to be subscribed by the family doctor according to domicile.

Free provider-choice is in principle assured for specialised out- and for inpatient care, provided enrolees are referred by their family doctors. However, ceilings imposed by the scheme to contracted providers might limit the options for beneficiaries. This problem usually appears at the end of a month when providers have exhausted their quotas. However, providers can dodge this restriction by treating a patient as an emergency case; beneficiaries who prefer certain facilities can prompt the provider to hospitalise them for an emergency.

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<sup>17</sup> Cefafa = *Centro Farmacéutico de la Fuerza Armada*, a countrywide operating chain of drugstores run by the Salvadorian Army

The BM has contracted a range of specialists and hospitals to reduce access barriers and provide real options and competition between different providers. The insurance staff is continuously revising provider contracts and conditions of health care delivery. The BM has contractual relations with public and private facilities in various areas of the country and infrastructure and quality of care vary significantly. As most specialists and clinics are interested in renewing their contracts with the BM, the insurance plan can exert pressure for improving health care. The negotiation of tariffs for health services gives the scheme a possibility of contributing to health sector cost containment.

### 5.10 Provider Payment

Regarding hospital payment, the BM combines different mechanisms: fee per diem, fee for service, fee per case or diagnosis related groups<sup>18</sup> (mainly in surgery) according to the type of service and the respective contracts. Fee schedules are negotiated with each provider and may vary between public and private hospitals, as well as between private clinics. Provider payment is always subjected to monthly or annual budgeting that limits to the health care production within a time period (except for emergency). Hospital providers receive the monthly payment for claims by cheque.

Outpatient specialist, laboratories and pharmacies are also paid once a month by cheque according to a fee-for-service mechanism combined with general budgeting. When a provider reaches the monthly service ceiling, he/she needs special authorisation from the BM to provide additional services that month. This allows the scheme to limit the effects of supplier-induced increase in demand and to contain the overall expenditures. In case of drugs, the BM reimburses the price of one medication per prescription; the pharmacist can choose from three licensed generic products per substance. Control of pharmacy claims is difficult to perform since it is hard to detect fraud when provider accepts one of the prescribed options.

The family doctors are contracted as self-employed physicians and receive a fixed monthly salary that is completely independent from the health services delivered. Once a month, doctors have to pick up their cheques at the BM-office to deposit it into their bank account. This means of remuneration avoids incentives for self-induced demand. However, there is little incentive to increase preventive and primary health care delivered.

Although regular supervision and systematic control is lacking, the BM-staff caught several attempts of fraud at different levels of health care provision. Some clinics presented surprisingly high invoices, and one hospital claimed exactly the same amount of money every month. Unofficial information reveals that some specialised outpatient and hospital providers have claimed for benefits granted to non-beneficiaries. Furthermore, they tend to exaggerate the number of delivered benefits. A series of concrete attempts at fraud were detected in pharmacies that tend to hand out the cheaper drugs and claim for the more expensive ones.

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<sup>18</sup> However, unlike the concept of diagnose-related payment, the provider does not really carry the financial risk. If medical or other reasons delay the average treatment time, the hospital can claim the package tariff plus the additional days. If treatment is shorter than average, the provider does not have to repay the difference.

## 6. Synthesis of Results

**Table 6.1 Institutional Comparison Summary**

Issues	Seguro Básico de Salud	Seguro Materno-Infantil
Legal structure	Government-run national health insurance plan	Government-run national health insurance scheme
Start of microinsurance operations (year)	1999	1999 (Pilot phase: 1998)
Target market	Theoretically all children under 5 years and all women in fertile age plus carriers of selected chronic infectious diseases	Theoretically all children under 5 years and all women in fertile age that are not covered by another health insurance scheme
Delivery model	Tax-financed, capitation based, theoretically universal health financing mechanism Affiliation voluntary, but entitlement does not depend on inscription Policy-driven initiative, offered mainly through public health care providers, directed to the poor population share	Mainly tax-based health financing model open for the excluded population share Affiliation voluntary, but inscription is required for entitlement Policy initiative, offered mainly through public, health care providers, oriented to the worse-off
Reinsurance provider, type	Implicit reinsurance through the ministry of health	Implicit reinsurance through the ministry of health
Product offerings	Restriction of coverage to a limited benefit package oriented towards the most relevant challenges concerning maternal and infant health as well as chronic diseases, including immunisation and prevention. Benefits are not eligible for enrolees and providers, all uncovered services are strictly excluded from reimbursement. Standardised tariffs are applied for provider payment in cash.	Coverage limited to a limited package of preventive and curative benefits, designed in order to face the most relevant challenges concerning maternal and infant health, except vaccinations. Benefits are not eligible, neither for providers nor for beneficiaries; all services that are not explicitly insured remain strictly excluded from reimbursement. Provider payment partly in kind, according to homogeneous fee lists.
Main benefits/coverage	Maternal, newborn and infant health care including pregnancy, delivery and postpartum; dental care; vaccinations; paediatrics; treatment of chronic infectious diseases	Maternal, newborn and infant health care including pregnancy, delivery and postpartum; dental care; paediatrics; Vaccinations excluded
Outreach (number of policyholders, persons covered by the policies)	3,427,396 (1999)	358,187 (2001)
Contribution income	49,164,311 Bs. (1999)	399,830 (2001)
Claims expenses	38,284,164 Bs. (1999)	44,000,000 Soles (2001)
Claims/contributions (%)	77.87 (1999)	0.01 (2001)*

Issues	Seguro Integral de Salud	Bienestar Magisterial
Legal structure	Government-run regional health insurance scheme	Social health insurance scheme
Start of microinsurance operations (year)	2002	1969
Target market	Population share uncovered by other health insurance schemes	Public school teachers and their families
Delivery model	Public provider model with mixed financing Affiliation voluntary, but affiliation is indispensable for entitlement Policy initiative, offered mainly through public, health care providers, oriented to the worse-off	Health insurance fund Affiliation mandatory for target group Stated as response to a trade-union initiative of a specific professional group
Reinsurance provider, type	Implicit reinsurance through the ministry of health	Implicit reinsurance through the ministry of education
Product offerings	Coverage strictly restricted to a limited benefit package oriented towards the most relevant challenges concerning maternal and infant health as well as immunisation. Benefit package not eligible for enrollees and providers Provider reimbursement according to preferential fee list in kind	Practically integral coverage with a broad package including promotional and preventive services as well as primary, secondary and tertiary care. Benefit package not eligible for providers and clients, but for a series of elective treatments the welfare scheme gives a certain margin of decision to the insurance staff Provider payment by reimbursement according to the monthly benefit production and differentiated fees, cost containment by provider-specific ceilings
Main benefits/coverage	Maternal, newborn and infant health care including pregnancy, delivery and postpartum; dental care; vaccinations; paediatrics;	Integral coverage with regard to preventive, primary, secondary and tertiary care
Outreach (number of policyholders, persons covered by the policies)	15,600 (2002)**	75,871
Contribution income 2003	69,970,000 (Jan.-Jun 2004)	22,000,000
Claims expenses 2003	53,231,000 (Jan.-Jun 2004)	20,161,509
Claims/contributions (%)	76.98	91.64

\* Percentage of subscription fees only; if overall income is considered, the relationship is close to 1.

\*\* One year after the implementation contribution collection, in the June 2005 the number of insured households was 813, but only 28.9% (235 families) had paid their subscription fee in time.

## 7. Analysis of Issues

### 7.1 Institutional Structure

#### *Main differences between the structures and delivery systems of the schemes*

Although these health insurance plans share characteristics, there are some essential differences, especially between the teachers' welfare scheme in El Salvador and the three public insurance models. The Bolivian SBS/SUMI, the Peruvian SMI/SIS, and the Paraguayan SI were implemented by the national ministries of health<sup>19</sup> with support from international donors (World Bank, IDB, PAHO and others). The main goal for these public schemes was to improve the most worrying epidemiological and health indicators in the respective countries. The international development strategies—initially the HIPC-initiative, and more recently the Millennium Development Goals (MDG)—were relevant incentives for national governments to face the challenges of social exclusion in health.

However, the strategies differed across the countries. The SBS was implemented as a nationwide scheme from the beginning. The Peruvian experiment started as a pilot program in two districts and was then expanded to about half the territory; after two years of experience and the integration with another public insurance plan, the SMI/SIS covered the whole country. In Paraguay, stakeholders implemented the public scheme in one pilot district and to observe the experiences before extending coverage elsewhere.

Unlike the other insurance plans, the BM in El Salvador covers a specific share of the formal sector. Thus, the target group belongs to neither the informal economy or to the poor. Furthermore, the BM is mandatory for the target group. The BM is the only scheme that fulfils the criteria of social health insurance based on wage-related and shared contributions and offers relatively broad benefits. It was the ministry of education that was responsible for its creation, and not the ministry of health as in the other cases. And the motivation to implement the teacher insurance arose from the claims and demand of professional organisations; external factors did not play a role.

#### *Differences between the initial target group and the members who joined in reality*

Due to the organisational framework in place, membership has always been identical to the target group in the case of the Salvadorian teachers insurance; however, this is valid for “passive” enrolment only, because approximately one out of three entitled beneficiaries do not rely on the BM-services.

For the other organisations, the experience is more diverse although the SBS, the SMI and the SI managed to cover at least a relevant share of their target group. However, two phenomena have to be stated:

<sup>19</sup> The official name of the ministries varies between the four countries: Ministry of Health and Sports in Bolivia (MSD), Ministry of Health in Peru (MINSAs), Ministry of Public Health and Social Welfare in Paraguay (MSPBS), and Ministry of Public Health and Social Assistance in El Salvador (MSPAS). However, as health is the common denominator, this paper uses the generic term “ministry of health” for all four countries.

1. The schemes could enrol only a portion of the target group.

In Bolivia, about three out of every four potential enrollees are geographical excluded from SBS/SUMI since health care provision is lacking in remote areas.<sup>20</sup> In Peru, coverage of the SMI did not exceed 16.5% of the target group for infants, 8.4% for women of reproductive age, and 5.0% with regard to the total target population.<sup>21</sup> The SI-scheme in Caazapá never achieved to cover a relevant part of the target group.

Thus, the state-run insurance plans are obviously unable to reach the whole target population in a given area. This is explained by the fact that affiliation is voluntary, and limited to a specific demographic and epidemiologic group. Although public per capita financing is related to the total number of inhabitants of a country or region, the benefit packages are closely related to childhood and maternity what makes the schemes attractive only for infants and for women during pregnancy. The additional services like dental care, specific diagnostics and treatments are unable to attract a broader range of potential affiliates.

Furthermore, marketing tends to be insufficient to reach all potential members. In many cases, the individual advantages of enrolment are invisible or unknown, and political, cultural, ethnic, and financial barriers prevent a relevant share of the target group from enrolling. One common reason seems to be the affiliation method: since enrolment is intimately linked to health care providers, the insurance plans attract mainly those who are in need of care - enhancing adverse selection.

2. The insurance bodies were unable to avoid the affiliation of undesired population groups.

Except for the BM, these microinsurance systems cannot completely avoid the inscription of persons outside the target population. In Bolivia, some persons who had access to affordable health care joined the SBS to reduce their out-of-pocket payments. In Peru, during the restricted implementation of the SMI, the scheme could not avoid affiliating persons who did not live in the participating district, but had access to its provider system. The Paraguayan experience also shows a tendency towards free riding and the inscription of people covered by other plans or who are not poor.

### *Impact of enrolment on financial performance*

The differences between the original target population and the affiliated enrollees do not have much effect on the financial situation of the schemes in Bolivia, Peru and Paraguay. In the two Andean countries, the overall budget was calculated based on the expected enrolment and benefit package, and it is widely independent from the actual number of beneficiaries. In the same way, departmental and municipal contribution is – at least theoretically – independent from the number of beneficiaries. Furthermore, “undesired” beneficiaries have to contribute so that the difference in affiliated people does not have an effect on the financial performance. The differences between the intended and affiliated population is not supposed to have any influence on the frequent problem of false or inadequate expectations.

<sup>20</sup> 56% of the SUMI services are delivered in La Paz and Santa Cruz (PAHO 2004b, p. 53f).

<sup>21</sup> See Tables 3.3 and 3.4: Beneficiaries of the SMI and SIS.

*Improving accessibility and affordability of health care*

Undoubtedly, the four health insurance plans have improved the accessibility and affordability of health care for the target populations. For the SBS/SUMI and the SMI/SIS, this is a result of the very nature of these social policies. They enable beneficiaries to access health services they usually cannot afford.<sup>22</sup> The same observation is valid for the Paraguayan scheme, though the small number of beneficiaries and the regional limitations are unlikely to produce measurable changes on the national level.

Due to the complex and multi-causal nature of epidemiological indicators, it is impossible to assess extent to which the schemes have decreased unattended birth rates. However, along with the campaign to combat infant and maternal mortality, the insurance benefits have undoubtedly influenced the epidemiological situation. As international donors and public health policy makers focus strongly on these indicators, it raises concern about them. Thus, information strategies, propaganda and increasing awareness will play an important role for improving access to health care for pregnant women and small children.

One systemic consequence of focal health insurance schemes like SBS, SMI and SI derives from the effect they have on the uncovered population and on uncovered benefits. As these plans serve only children under 5 and pregnant women, a significant population remains excluded. Although the severity of pathologies tends to be less menacing for older children, the fact that a 6 or 8 years old child is not covered by the state-run scheme tends to reduce accessibility to health care, and is difficult to understand and to accept. At the same time, as childhood and maternal health are prioritised, the availability of other diagnoses or treatment procedures is likely to decrease. Furthermore, access to free care in some cases or for some individuals may reduce the disposition of uncovered groups to pay out of their pockets.

In El Salvador, the BM has improved the accessibility of high quality health care for the target group. However, as reimbursement is often delayed for patients covered by other plans, providers tend to prefer BM-enrolees, because their treatment results in relatively prompt and high payment. The reallocation of human resources and materials towards the BM affiliates might have negative impact on the non-beneficiaries.

## 7.2 Premium Collection Process

*Clients' options to generate the premium amount*

In two of the four insurance organisations, members do not make contribution payments. The SBS/SUMI and SMI/SIS are completely tax-financed except for insignificant affiliate fees. In contrast, the monthly contribution in the SI-scheme is payable in cash, and beneficiaries have to pay from their household budgets. As income tends to be low and irregular in rural areas, the scheme extends coverage for two months after the last contribution payment. However, if enrolees are delayed for three months or more, they lose their entitlements. The BM-plan relies on payroll deductions for the enrolee's and the employer's contributions. Thus, payment is transferred directly from the budget of the ministry of education to the scheme's bank account, and it does not depend on an active procedure by the beneficiary.

<sup>22</sup> See Table 1.6: Percentage of births unattended by trained staff.

*Collection processes for the low-income market*

Contribution collection of the Salvadorian teacher welfare corresponds to the typical methods applied by social insurance schemes. The application of the mechanism to informal and low-income market is difficult because it is not possible to use payroll deductions to mobilize payments from the poor persons who lack regular income and banking facilities.

The decision-makers of the Paraguayan scheme are making efforts to adapt contribution payment to the economic situation of poor households and the lack of information technology or bank accounts in remote rural areas. However, even though payment is possible at various health care providers, barriers remain relatively high and new mechanisms of contribution collection are being tested.

The Paraguayan approach to induce contributions from various sources is especially interesting. On one hand, the SI combines national public resources with departmental and local funding to decentralize decision-making as well as financing. On the other hand, enrollees' subscriptions ensure users participate in financing of health care instead of receiving "mercy" care. In poor socio-economic settings, the individual or household contributions are unlikely to cover the expenses for health care and have to be complemented by public, tax-funded resources to guarantee a minimum of quality care. However, the active subscription enhances participation of enrollees and raises the available resources. In the middle or long run, the household contribution might increase and allow the social policy to transform into a real insurance plan. Therefore, in introducing the concept of fair financing in health, income-related fees are preferable to per capita fees and risk-adapted contributions.

The financing of health care by the SBS/SUMI and the SMI/SIS rely on tax-funded public resources. Undoubtedly, the corresponding transfers respond the conditions in both countries where the purchasing power of households is low. However, a lack of transparency and corruption is relatively common. Despite the decentralized cost sharing, the financing mechanisms are closer to state-run health systems than health insurance. The applied financing mechanisms do not create incentives for enhancing affiliation and controlling the access of those who were not enrolled in the scheme. Moreover, consumer position and consciousness for entitlement are not enforced by the SBS/SUMI and SMI/SIS schemes.

*Problems and ongoing changes made to the collection processes*

In former times, the Salvadorian teacher insurance adapted the percentage of wage-related contributions to the demand, but the payment mechanism remained unchanged. The extension of the Peruvian Mother Child scheme has not been accompanied by any change of the payment mechanism in place and the majority of resources are tax-based, channelled through the ministry of health. Only a small proportion comes from affiliation fees. The Bolivian SBS increased the participation of municipal funds in the financing of a scheme that was initiated with national funds. The Paraguayan Integral Insurance has started financing health care services by subscription fees payable by the enrollees. It was initially financed only through public resources shared between the national, departmental and local levels.

The Paraguayan plan has the most experimental financing mechanisms, so it is not surprising that it is facing the most problems. The decentralised public stakeholders – department and municipal governments – had refused until recently to pay their financial contribution

according to the agreements signed with the SI. In addition, a majority of enrollees fail to pay their fees on time and run the risk of losing coverage. Furthermore, to be eligible for the lowest contribution rate, beneficiaries tried to appear poorer than they are. These problems seriously affected the performance and sustainability of the scheme.

#### *Main differences and implications concerning contribution collection*

The comparison of the financing methods in the four Latin American insurance schemes allows for some general conclusions:

1. Mandatory schemes with automatic payroll deduction perform best, but they are difficult to introduce in the informal economy and in poor and remote settings.
2. Public tax-based financing is relatively easy to implement and to carry out as long as the political support of the schemes is guaranteed.
3. Shared financing between central and local public organisms decentralises responsibilities; but performance depends on good governance and stewardship.
4. The introduction of subscription fees is relatively difficult after having initiated service delivery without collection.
5. Fees payable by enrollees in an informal and poor setting are complicated to implement accordingly; adequate rules and administration have to be in place, and the barriers for payment must be low to avoid discontinuity of affiliation.
6. The fees have to be adapted to the customers' purchasing power; fair financing mechanisms are desirable, but control mechanisms are required to avoid moral hazard.

### **7.3 Premiums, Coverage and Subsidies**

#### *Determination of contributions and benefits*

The SBS, the SMI and the SI defined their initial benefit packages to face the most relevant epidemiological problems of maternal and early childhood health. In all cases, the core team responsible for the implementation of the schemes took the decision to define the coverage package. No specific research was performed in advance; the decision relied primarily on general statistical data. On the other hand, the design of the benefit packages always conformed to the fiscal situation of the country. The definition of the succeeding SUMI and SIS benefit packages followed the same logic, extending coverage to a higher number of health care benefits for the initial target group, and including additional population groups.

#### *Attitude towards subsidies, other sources and financial sustainability*

The public schemes in Bolivia, Peru and Paraguay received specific loans and subsidies during their pilot or implementation phase. Although the schemes do not depend on loans for covering running costs and benefits, the SBS, SMI and SI rely on hidden subsidies from the public health system, which provides human resources, infrastructure and a series of inputs. The decision-makers of the state-run health insurance schemes do not seem to be aware of the extent of cross subsidies; this will become increasingly relevant as the social policies develop towards real insurance schemes. Diversification of income has been implemented in various ways to decentralise responsibility and financial burden, getting furthest in the SI-scheme.

Only the Salvadorian teacher welfare is covering its costs from contribution fees. For the others, tax-based public financing is responsible for the overwhelming part of insurance funds. The economic situation of the focal target group is unlikely to improve enough in the near future that will allow them to pay contributions to cover all covered benefits.

*Key lessons emerged from the organisations' different approaches*

A relevant proportion of income might come from public sources to facilitate the implementation of problem-oriented social policies in health care. The Latin American experiences show that the combination of tax-based financing and contribution payment is not only possible in a health system, but also in a health insurance model. However, if decision-makers intend to implement viable insurance plans, they have to be aware of both explicit and implicit subsidies. Though these transactions and cross-subsidies often exceed the scope of direct financing from public sources, their relevance tends to be underestimated.

The introduction of household subscription fees in the context of a partly free public health care is a major challenge. The public will be less willing to pay fees if a scheme starts without collecting any contribution. In an informal setting, more flexible and suitable collection mechanisms are required to facilitate fee collection and to lower existing barriers for insurance entitlement.

## 7.4 Controlling Insurance Risks

*Policies and procedures for controlling adverse selection, moral hazard, client fraud, cost escalation and over usage*

None of the pro-poor health insurance schemes has implemented effective mechanisms for avoiding adverse selection. On the contrary, they are practising an adverse selection policy because they focus on the most vulnerable population groups. This type of selection is even enforced by the affiliation procedures organised by health care providers, which attracts mainly people who need health care.

Representing social policy strategies focused on the most underprivileged groups, none of the public health schemes apply effective measures to avoid moral hazard, neither on the user nor on the provider side. Payment is made mainly in a fee-for-service or fee-for-package modality and, thus, creates incentives for increasing service delivery. This is also true for the teacher welfare system in El Salvador, but only for secondary and tertiary care. The fact that primary health care relies on contracted family doctors, whose remuneration is independent from service production, reduces moral hazard. However, except for drugs, the scheme does not have effective tools to avoid or reduce over usage.

Being (almost) cost-free for enrolees, both schemes do not offer specific incentives for abuse and client fraud. This phenomenon appears only when people are excluded for more or less arbitrary reasons; for instance if they reside in an uncovered district or fail to have free access for biological reasons. In some cases, applicants hide membership in another health insurance plan to be affiliated by the public scheme.

In the case of the SI in Paraguay, the expectation to be covered for a lower subscription fee seduced a relevant share of enrollees to make themselves appear poorer than they actually were. In the case of the BM, some beneficiaries do not return their cards when affiliation expires, extending coverage beyond the prescribed age limits.

Since the three public health insurance schemes aim to extend health care services to their target groups, they do not apply strategies for controlling or reducing service delivery. Cost containment relies mainly on the definition of covered benefits and the control of applicable tariffs and fees. The BM is the only scheme that applies active strategies to control cost escalation by negotiating bulk discount packages and special fees for a series of services.

The SBS/SUMI and the SMI/SIS have reduced client abuse by expanding coverage rather than by tightening controls. While the Bolivian plan has multiplied the number of covered benefits, decision-makers in Peru opted for expanding coverage to the whole territory to avoid the main incentive for client fraud. The SI has not yet implemented any effective mechanism for cost containment.

To reduce moral hazard and health care expenses, the BM has implemented a series of procedures in order: Contracting family doctors for primary care, implementing provider-specific ceilings for health service production, and limiting the options of choice for drugs were the most relevant responses. Cost containment for secondary and tertiary health care are currently discussed, but have not been implemented yet.

#### *Staff fraud problems*

As provider payment relies mainly on fee-for-service or fee-for-package methods, a typical fraud problem results from the artificial increase of delivered benefits in the claims for provider payment. This attitude is often “justified” because the tariffs are perceived as insufficient to cover the costs of the benefits. Thus, the health provider exaggerates the number of benefits claimed to generate an “adequate” payment from the insurance plan.

In other cases, the provider staff claims benefits granted to uncovered patients; or they falsify the services to receive reimbursement for benefits that are not covered by the schemes. Mainly in Bolivia, the local staff has limited capacity to detect fraud. Undoubtedly, the advantage for individual staff members is negligible, and the main reason for this type of fraud seems to be altruistic, as it allows access to health care for those who would otherwise remain excluded.

To reduce provider fraud, close monitoring of the claim lists is performed before provider payment is authorised. Announced and spontaneous, sporadic and/or regular visits of the insurance staff to health care providers are used to detect inconsistencies between medical histories, provider documentation and claims.

#### *Major differences in the organisations’ approaches to controlling risks*

The three public schemes do not apply any explicit risk management methods to influence the risk structure of enrollees. On the contrary, due to their purpose and design, they complement the adverse selection by negative risk selection and bottom skimming. They mainly enrol the most vulnerable groups and the worst-off, combining low purchasing power with a high

average health risk. These insurance plans do not use health questionnaires to determine the individual risk of the enrolees. However, the Paraguayan scheme has recently implemented waiting periods for elective treatments to reduce moral hazard effects.

In contrast, the BM applies positive risk selection by limiting coverage to active teachers and getting rid of beneficiaries after retirement, before they tend to cause higher health care costs. Furthermore, by exclusively enrolling teachers, the scheme limits its risks because all beneficiaries belong to a relatively well-off stratum of Salvadorian society.

## 7.5 Claims Payments Process

### *Documents required for claims submission*

**SBS:** Provider payment relies on the municipal governments and is based on the Aggregated Certificates for Benefits Granted (CAPO) according to a fee-for-package. Health care providers present standardised claim forms monthly to the municipalities with the number and amount for each service covered by the insurance-package. In a first column, the price of each of the services is specified, and the health provider has to fill the number of services granted in the month in the second column, and the sum for each of these services in the third column. The total amount of the bill is calculated by adding the sums. No data form or automatic information format is available at the national level. However, each municipal government keeps records of the SBS payments. Manuals and guidelines were distributed to all participating providers (Technical Guides, Administrative Guides).

**SMI:** Claim processing relies on the monthly reports of the health providers. By the 3<sup>rd</sup> of the month, they have to present a billing list with all benefits granted to SMI-beneficiaries during the last 30 days on a form where the covered SMI-benefits are listed with their prices. The provider fills in the total number of each service delivered to SMI-members, and calculates the accumulated price per service as well as the total sum for the month. These claim forms are standardized, but no manuals are available and there is no electronic support for providers. The provider staffs used to be informed about billing and claim processing, but they seem to commit a number of errors including services that are not covered by the SMI.

**SI:** Claim processing relies mainly on a “List of delivered benefits” that contains all services covered by the insurance plan, but not the single tariff per benefit. In the case of the Regional Hospital, this list is filled according to the hospital documentation and the monthly report is edited on the computerised information system. The health centres deliver a handwritten hardcopy form that contains the total number of delivered benefits.

**BM:** The requirements for claim processing vary according to the type of provider. For example:

- Family doctor: Monthly report of family doctors activities (Sheet 1 and 2), local family plan, work and help guide (2 sheets) for the family doctor, activity form
- Specialised outpatient care: Service order sheets A and C, referral and counter-referral sheets, weekly report sheet about patient attention, daily activity census, monthly report of specialised medical activities

Similar lists of claims forms exist for dentists, pharmacies, laboratories, radiology, pathology, and public and private hospitals.

*Parties involved in claims settlement*

None of these schemes requires user charges or payment in advance by patients. In all cases, claims are presented directly by providers to the insurance staff to be reimbursed. Thus, no claim payment to beneficiaries is in place.

- In Bolivia, health care providers present their claims to the local municipalities or health directories, who approve claims and authorize reimbursement. After approval, provider payment also relies on the local or district health authorities.
- In Peru, claims are first presented to the district representatives of the SMI/SIS. After a first plausibility check, the data are digitised and transferred to the insurance headquarters in Lima for a second check. All claims approved by the central staff are reimbursed; in other cases, the providers can explain the claims that have not been approved by the headquarters.
- In Paraguay, the providers present their claims once a month to the insurance office whose staff is responsible for controlling and approving the claim list and for authorising reimbursement for granted benefits.
- In El Salvador, primary care benefits are financed through regular salaries paid to family doctors and does not rely on production-related fees and invoices; thus, no claim processing and controlling is needed. The insurance plan reimburses specialised outpatient and hospital care according to the claims presented by the health care providers. The BM staff performs a series of claim control processes, including the validation of delivered benefits and the revision of submitted paper forms, to approve or reject the claims.

In all these schemes, claims are supposed to be submitted within one month after the insured benefit is delivered. Usually, all services granted during one month ought to be claimed for by a specific day in the following month, and then reviewed within a specified period. However, in Bolivia as well as in Peru, many providers fail to present their claims within the prescribed period so that all succeeding processes are delayed.

In the SBS, health providers complained about the delay of reimbursement for benefit claims. In some cases, the payment process took up to one year; the average time was approximately 2-3 months. However, reimbursement delay was often due to technical problems caused by the providers. For instance, some claims were incomplete or wrong, so that the documentation review took longer, and they had to be returned to the providers. Even in the fastest procedure, it took at least one month until the provider was paid. Altogether, the reimbursement seems to be an unnecessarily bureaucratic and complicated process.

No valid data are available about the proportion of rejected claims. The main reason for claims rejection are human errors including incorrect terms, incomplete data, lack of plausibility, and obvious contradictions. Claims rejected for uncovered benefits also seem to be relatively frequent. Detection of fraud by providers is another reason for refusing reimbursement. All schemes have tried to train the provider personnel involved in the claim processing. However, efforts to reduce the rejection rate are occasional and lack measurable effects. No relevant changes in claims processing were observed in recent years.

*Challenges with regard to claims processing*

Effective claims processing requires a series of conditions that are sometimes difficult to obtain in developing countries. First, clear and understandable guidelines are key elements for avoiding the most typical mistakes that tend to cause the most frequent problems. Second, staff involved in claims processing for the insurers and the providers ought to participate in regular trainings to deepen knowledge about processes, introduce innovations and allow for an exchange between stakeholders. This ought to include regular feedback rounds with regards to the most frequent errors. Third, claims forms should be clearly designed and self-explanatory. As handwriting is a severe reason for mistakes, information technology might improve the quality of bureaucratic procedures.

**7.6 Prevention Services***Promotion of preventative health care*

All four schemes apply strategies to promote the use of preventive services for their target populations. The childhood and maternity oriented schemes cover early cancer detection as well as regular prenatal examinations to reduce maternal and female mortality. Dental care includes some preventive measures, and family planning is also a preventive service.

Interestingly, the vaccination strategies differ between the SBS/SUMI and SI, on one hand, and the SMI/SIS on the other hand. The Bolivian and the Paraguayan schemes include an active policy for promoting the national immunisation program, including the most common vaccinations expressively in the benefit package. In contrast, the Peruvian scheme excludes all types of vaccination from the covered health services because the national immunisation program covers them.

In recent years, the BM has enforced preventive elements of health care. A major step was the implementation of family doctors in the field who are not only responsible for primary health care, but also for primary and secondary prevention. Therefore, general physicians are supposed to make home visits to the inscribed families and offer promotional and preventive services for chronically-ill enrollees.

Except in the case of family doctors in El Salvador who receive a regular salary independent from the monthly delivery of health care services, all insurance schemes have included preventive care in the benefit package. Thus, providers who grant these services have the right to process the corresponding claims and to be reimbursed for the preventive benefits.

Except the general decrease of maternal mortality in Bolivia, Peru and Paraguay, no empirical data are available to prove the impact of the scheme's promotion and prevention services. Some early observations might show an improvement of ambulatory care for the chronically-ill enrolled in the BM in El Salvador; however hard epidemiological results are unlikely to surface.

*Main lessons learned from the organisations' different approaches*

The tendency to include health promotion and preventive care in the benefit packages of publicly run insurance plans is obviously high. This is certainly due to the generally accepted

idea that promotion and prevention are milestones for achieving better health. Furthermore, this service group has the advantage of having low-cost interventions with high cost-effectiveness. Thus, promotional and preventive health care is compatible with the usual constraint budgets of publicly run schemes and promises positive effects on the overall expenditure of public health systems.

However, effective measures for enforcing the use of promotion and prevention services are needed to ensure their desired use. This might be applicable by conditioning access to other health care benefits to the demand of preventive services. However, such a policy might interfere with the strategy of state-run social health plans to lower access barriers to adequate health care. The comparison of the Latin American case studies suggests that promotion and prevention is easier to implement in mandatory schemes and needs more suitable methods to reach remote areas where enrolment is voluntary.

With special regard to family planning services, the attitude of publicly run insurance schemes shows a high degree of variability between and within countries. While the SBS in Bolivia as well as the SMI in Peru cover family planning, these services were clearly reduced in the respective succeeding plans, the SUMI and the SIS (Rousseau 2004, p. 24). Moreover, the BM plan in El Salvador expressly excludes any type of family planning from insurance coverage. Altogether, the inclusion of family planning services in the benefit package of a public health insurance plan seems to depend on the mix of political, ethical and religious positions in a given country.<sup>23</sup>

## 7.7 Marketing, Client Education and Retention

### *Primary marketing expenses, methods and strategies*

No data were available about marketing and publicity expenses, mainly because the public insurance plans rely on the support of various state organs, public media and others. None of the schemes has performed an evaluation of its marketing costs, perhaps because they are provided in-kind and do not put a strain on the insurance budget.

In Bolivia, a publicity campaign carried out by TV, radio and brochures accompanied the introduction of the SBS. The public sector, mainly the central health reform project and various public health providers, organised meetings to inform the population about the insurance. On the district level, the SBS held workshops to promote the scheme.

However, in practice the health care centres are primarily responsible for providing information to affiliates, because the impact of the marketing campaigns has been low. The target group has very little information about the SBS. The concept of this insurance system is especially not well understood in the lower socioeconomic groups and the people usually do not know what services are included. According to information of the La Paz municipality, at the beginning of 2000 only 5% to 8% of the interviewed persons were sufficiently familiar with the SBS.

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<sup>23</sup> This is clearly observed in Peru, where the Catholic church has a strong voice and a series of conservative political decisions. The fact that the SMI-scheme that preceded the current SIS had implemented family planning benefits for affiliated women became possible only through a strong political intervention by former President Alberto Fujimori.

TV spots, newspaper announcements and other publicity accompanied the implementation of the SMI in Peru. However, propaganda was weak and did not provide adequate information. Marketing relied largely on the regional staff, mainly the personnel involved in the recruitment and affiliation of insurance beneficiaries. For SMI-affiliates, the primary information source was from their health centre.

Also in Paraguay, marketing and publicity for the SI plan have been weak, and clients rely mainly on personal contacts with the providers for information. In the beginning, the insurance staff distributed pamphlets to inform the target population, supplemented by a couple of radio programs. Additionally, the SI organises approximately 200 information sessions in different municipalities of the district.

At the BM in El Salvador, client information depends first on the family doctors who are responsible for conducting the promotion and prevention programs. Secondly, the insurance staff seem to be a relevant source of information for beneficiaries as well as for providers. Furthermore, the BM organises a TV program, supplies information in teaching centres and universities, and has implemented an initiative to improve social communication. However, the BM marketing and publicity strategies do not seem to reach the target group very well and information relies largely on direct exchange of personal experiences and observations.

Except the teacher welfare plan in El Salvador, these schemes focus their services on the worst-off populations. This approach is visible in the design of the target group, the benefit package, and in the provider network that implicitly excludes the non-poor who are not attracted by public health facilities. The marketing and publicity strategies are oriented mainly to this socio-economic target population. However, recruiting enrollees relies mostly on the health care providers who offer to affiliate potential members who appear to belong to the target group. Thus, active marketing strategies for effectively enrolling the lower socio-economic population depend on the capability of the health care staff to select and to motivate the most appropriate beneficiaries of the public insurance plans.

#### *Marketing efforts and criteria*

These health insurance plans have made attempts to improve their marketing strategy. However, the initiatives that normally accompany the launch of new schemes lose intensity after short-time periods. None of the insurance plans has implemented sufficient changes to rejuvenate their marketing strategies.

The publicly run health insurance plans in Latin America have not defined any “sales targets”. The social policy programs in Bolivia, Peru and Paraguay have been reoriented to cover the highest possible share of the target groups whose care is affordable with the given amounts of money. Recruitment of beneficiaries is not linked to financial awards, and no overzealous sales practices have been used.

#### *Renewal and dropout rates*

The renewal and dropout rates are widely unknown in the three public insurance plans. This is mainly due to the definition of target groups and entitlements because affiliation ends automatically when children reach their fifth birthday, when women become 50, and after

pregnant women deliver. Renewal is only possible for young women if they are pregnant again. Enrolees of the teacher welfare plan in El Salvador drop out when they work less than the required minimum of lessons or retire; renewal can happen only when a part-time teacher increases his working hours. For these reasons, none of the insurance plans has studied the causes of dropouts or interviewed enrolees who discontinued affiliation.

#### *Client satisfaction and complaints*

The state-run health insurance plans in Bolivia, Peru and Paraguay do not apply mechanisms for the systematic monitoring or evaluating client satisfaction. The BM in El Salvador, however, has implemented an obligatory client satisfaction inquiry. Providers are responsible for filling in the questionnaires for each enrolee treated, and data collection is enforced because the BM requires the quality control forms for claim processing.

The most frequent complaints about the SBS, SMI and SI is the exclusion of population groups and benefits. Some people expect to be entitled, although they do not belong to the target groups. In other cases, beneficiaries do not know or understand the scope and limits of services covered. Thus, a major cause for dissatisfaction derives from deficits in marketing and publicity that exaggerate expectations and induce people to want uncovered services.

In the Caazapá scheme, the premature consumption of inputs needed for insurance benefits in the Regional Hospital obliged the provider to charge the patients temporarily for a minor proportion of treatment costs. Despite the low amounts people had to spend, the psychological impact was relatively high and caused complaints because enrolees perceived the insurance did not provide the promised benefits.

The BM enrolees feel relatively well covered and attended by their welfare scheme. Most complaints refer to the fact that beneficiaries feel insufficiently informed about the services they are entitled to. Except casual pamphlets about the coverage and scope of the BM, teachers only receive information about drugs covered; more detailed information is only available in the insurance offices. The limited working hours of some family doctors also lead to complaints. Health physician can often only attend to patients during the morning hours when teachers have to work due to their administrative tasks. Teachers living in patchwork families are unsatisfied because dependents living in the household of an enrolee who are not direct relatives are excluded from coverage.

#### *Main differences between the organisations and lessons learned*

None of the schemes has taken specific and concrete actions in response to the client complaints. However, the teacher welfare plan seems most concerned about beneficiary complaints and client satisfaction. In all cases, dissatisfaction has its origins in the provider network and the responsible health staff. As the Bolivian, Peruvian and Paraguayan schemes rely mainly or exclusively on public, state-run facilities, they can influence the quality of care and attention for enrolees through the respective ministries of health. Additionally, they can try to improve the conditions of care in health centres, but the power depends on the income share of insurance reimbursements in the total provider budget. The SMI/SIS allows the providers to use a certain proportion of reimbursements for improving the provider facility, for investments in infrastructure and inputs. However, the three public schemes do not apply financial or other sanctions that would make providers improve their quality of care.

The Salvadorian plan has focussed on health care quality by implementing an obligatory measurement of client satisfaction. This approach is interesting because it ensures that providers are aware of their behaviour towards beneficiaries, but it implies an additional bureaucratic burden for the health staff, which may have a negative impact on motivation.

#### *Management information systems and performance monitoring*

The statistics of the SBS were monitored at the central level through the National Health Information System (SNIS - *Sistema Nacional de Informacion en Salud*). This included various levels of data collection and aggregation of information from the local, departmental and national levels. However, only 33% of the SBS services were monitored and the database of the SNIS was relatively incomplete and did not fulfil essential criteria of comparability and reliability. Even though the organisations responsible for the SBS are clearly defined, no standardized instruments or processes are in place for controlling SBS procedures and results. The tri-cephalic organisation of the SBS - national government, departments and municipalities - makes it susceptible to political interests. No exclusive bookkeeping system for the SBS was in place; resources were processed through the bookkeeping systems of health care providers.

The SMI statistics are based on the provider information contained in the monthly claim reports. Except irregular and unsystematic controls by the regional staff, no effective revalidation method is in place to incorporate these data into the SMI system. In case of fraud, false data can directly enter the SMI database and, thus, influence all SMI-related decisions. On the other hand, the serious consequence that health workers could face if a pregnant or delivering woman dies might induce them to hide these cases or to present them as an unattended birth. Thus, incentives or sanctions may have a direct effect on the health statistics. Bookkeeping of all SMI-related functions is carried out by the Support Program for the Health Reform (PARSALUD), the executing unit of the ministry of health. This department is well equipped with computers, and the staff have high qualifications in terms of bookkeeping and controlling. They apply the general criteria and guidelines of the ministry of health.

In the beginning, statistics of the SI insurance plan in Paraguay relied on provider information, although the hospital did not even indicate the insurance status of patients. In time, provider documentation has been adapted to the needs of the insurance plan, but standardised norms and formats are still lacking. Additionally, the SI has implemented its own data collection system that contains relevant information about the beneficiaries and the use of health care benefits. However, the lack of adequate forms and the low quality of provider documentation remain relevant challenges. Specific manuals for insurance procedures are still lacking or incomplete. Recently, with the support of PAHO, an information system has been implemented for controlling the number of affiliations and the entitlement of enrolees. However, an overall bookkeeping system is still lacking, and the existing computers are not equipped with the necessary software to allow for computer-based bookkeeping and controls.

The BM scheme does not yet have a systematic data collection and monitoring mechanism for demographic, epidemiological, affiliation and other data that allows for estimations and

projections concerning relevant insurance information. With regard to the enrolees, the BM relies on the systems of the ministry of education, which is also responsible for the control of general expenses and provider financing. Bookkeeping is also performed in the financial unit of the ministry that is responsible for the general budget decisions, allocation of resources and fiscal control. No supervision of the technical performance and insurance-specific tasks is in place.

## 7.8 Reserves, Investments and Reinsurance

The four health insurance schemes are publicly run and non-for profit according to their design and purpose. If an insurance plan ends a fiscal year with a surplus, the remaining resources are destined for investments or even integrated in the normal budget for health care expenditure.

Investments are usually financed by the yearly surplus or by extra financing from the responsible ministries. None of the publicly run health insurance schemes has raised credits for financing investments or running costs. The public health insurance schemes decide about the destination of investments according to the most obvious needs in order to improve the performance of the schemes, to implement additional services or procedures, and to improve client satisfaction, mainly according to the most visible demands. Decision-making in these schemes relies on the directors of the insurance scheme and the health ministry.

The Salvadorian teacher welfare plan is working according to a pay-as-you-go system<sup>24</sup>; thus reserves are unlikely to be made. Decisions concerning the tasks and performance of the BM are the responsibility of the insurance staff; the ministry of health is not involved because it is an institution of the ministry of education.

The most visible results of investments made in recent years are improvements in administration procedures and organisational processes like affiliation of beneficiaries, control of entitlements, claim processing, provider payment, and statistical documentation. On the provider level, the state-run schemes have induced improvements with regard to equipment and performance. Additional and stable income for health care delivery to beneficiaries has allowed many contracted health centres and hospitals to invest in the restoration of the infrastructure and the acquisition of diagnostic and therapeutic equipment.

None of the schemes has felt the need to obtain reinsurance. On the one hand, this is applicable to the fact that the social policy schemes dispose of certain budget and could simply stop reimbursement of delivered benefits so that the providers are running the financial risk. On the other hand, the responsible ministries are expected to cushion potential financial risks of the schemes and, thus, act as implicit reinsurance.

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<sup>24</sup> The income per time period (mostly one year) has to cover the expenses, thus expenditure per period of time depends on (expected) contribution or other revenue.

## 7.9 Conclusions and Lessons Learned

### *Major breakthroughs*

Available empirical data indicate that the state-run public health insurance plans have improved access and quality of health care for the worst-off members of society. The increase in the number and share of institutional and professionally attended deliveries might be the most eloquent indicator for the effects of the social policy programs in Bolivia and Peru that were implemented to fight high maternal and infant mortality rates.<sup>25</sup>

Rather than insurance schemes as such, the SBS/SUMI as well as the SMI/SIS and – on a regional level – the Paraguayan *Seguro Integral* can be considered positive and effective social policy programs directed to the poorest population share. They put the priority on better access to health care according to the real needs of the people; and they benefit the large majority of the poor in Bolivia and Peru. From the point of view of insurance theory, both schemes practise adverse selection towards underprivileged groups, and apply an implicit discrimination against the middle and upper classes. The implementation of the SBS/SUMI and the SMI/SIS schemes has especially contributed to improving coverage of some epidemiologically important diseases.

Although these effects are not exclusively attributable to the public insurance plans, one of the most important achievements seems to be that health professionals and politicians have started to direct more attention on relevant epidemiological problems. The increasing concern about mother and early childhood health problems is certainly a consequence of the implementation of state-run health insurances plans.

Since these insurance plans raise demand for services of the health care providers, they contribute to the stabilisation of the providers' income and increase the turnover of the national health care system. This creates incentives for increasing the production of insured benefits in a context where access and adequate health care are lacking. Even though no direct incentive exists for the providers to inscribe members, the perspective of additional earnings might encourage affiliation. However, the Peruvian and Paraguayan experiences show that a direct financial incentive for enrolling beneficiaries is preferable.

Regarding the Salvadorian teacher welfare scheme, insurance staff, stakeholders and beneficiaries agree that the plan has recently improved coverage, service and client orientation. Undoubtedly, an important change was the implementation of family doctors for primary health care and prevention. Enrolees welcome the direct relationship with the generalists who guide them through the health care system. Special training programs, guidelines for contracted primary health providers, and the fact that entitlement to some benefits is attached to prior and regular use of certain benefits have enforced the use of promotional and preventive services. Furthermore, the co-ordinating role of family doctors has enhanced the co-ordination between the scheme and the contracted providers.

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<sup>25</sup> However, social and health indicators are always multi-factorial and depend on a series of different variables. The observation of indicators reveals that the mentioned trends had begun already before the implementation of the SB and SMI (compare INE 2005, last accessed on July 14<sup>th</sup> of 2005).

On the other hand, as the BM does not have its own secondary and tertiary providers, the welfare plan has introduced market mechanisms and bulk discounts in the negotiations with specialists and hospitals. In this sense, the teacher welfare scheme is a pioneer regarding innovative health market approaches.

More generally, in all analysed cases, the attitude and behaviour of health professionals towards the low class patients and the poorest health consumers seems to have improved. One of the main reasons for the changing attitude is because the providers are receiving payment for those patients that the providers used to serve for free (or not serve). As they are entitled to receive benefits, and payment is guaranteed, provider staff has started to consider beneficiaries as customers rather than as “beggars”.

### *Major challenges*

The low impact of marketing and propaganda strategies is partly responsible for the false expectations of beneficiaries who demand uncovered services. Furthermore, politicians try to profit from public insurance schemes by presenting the coverage and scope in a euphemistic way. Additionally, questions related to health and insurance are relatively complicated to understand, so that exclusions are often perceived as arbitrary and unfair. Frank and realistic information to potential customers and other stakeholders is crucial and represents a continuous challenge for health insurance plans.

One important step to improve the general understanding of what is covered seems to be a higher degree of customer orientation and participation in the design of social insurance plans. The involvement of beneficiary representatives could help overcome hierarchical problems within the schemes and foster democratic structures. Moreover, nationwide insurance plans ought to enhance decentralisation, vest regional and/or local organs with more responsibility and introduce subsidiarity for administrative financial tasks.<sup>26</sup>

In general, deficiencies with administrative tasks and consumer participation are shared by all the schemes, even though the extent and focus varies. Surely, problems derived from a central organisation of the insurance plans are less marked and easier to overcome in a local or regional scheme compared to nationwide insurance organisations. This becomes evident comparing the Paraguayan SI to the other health insurance schemes.

However, the consequences of centralism might differ according to the degree of effective decentralisation and the attitudes of the headquarters staff. For instance, the SBS was organised with a top-down structure, lacking any bottom-up mechanism. It allowed very little participation of the health sector institutions, and even less by the population. The strictly centralised structure gives the SBS little flexibility, which prevents it from recognizing

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<sup>26</sup> The European concept of subsidiarity is closely related to decentralisation of functions and decision-making. The principle of subsidiarity, which has been developed in the context of the Catholic social doctrine, is meant to protect against a preponderance of hierarchical levels that refer decisions as far as possible from local bodies. This implies that the State might withdraw from a series of tasks and only intervene if decentralised decision-making fails or is contradictory to legal, economic or other general preconditions. Thus, subsidiarity also means institutional protection against the preponderance of higher hierarchical levels. It is an effective tool to counteract the potentially negative effects of formal solidarity mechanisms. In practice, it strengthens responsibility, accountability, and self-reliance not only of lower, or decentralised, levels of public administration, but also of civil society organisations, communities, households and individuals.

specific local phenomena. Furthermore, it is also responsible for the low recognition and utilisation rates. However, the latter is also attributable to the lack of incentives for affiliation, the weak participation of the health care providers in decision-making, and the practically non-existent involvement of NGOs.

The Peruvian SMI implemented a higher degree of decentralised participation and decision-making. Although relevant decisions always relied on the ministry of health, the health district management had some authority concerning priority measures and resource allocation. Indeed, some activities and procedures differed between the various DISAS throughout the country.

In the teacher welfare scheme, decision-making is concentrated in a small core group of BM-staff. This arrangement produces and enhances structural administration failures concerning the resolution of claim processing problems and client complaints. The lack of decentralised decision competencies induces a high labour burden for the headquarters staff because they have to worry about minor inquiries and issues.

The publicly run schemes lack independence from political interference. Especially during implementation and early stages, they depend largely on national politics and are often influenced by short-term political or party interests. This was evident in Peru where the president appoints the SMI-director, who therefore changes frequently. However, the last SMI-director is still leading the succeeding SIS-plan and stability seems to be assured at least for the legislative period. The Paraguayan case shows the risk that political interests might interfere directly with the performance of state-run insurance organisations.

External influence is also strong, particularly on schemes that emerge due to international development strategies like the HPIC-initiative or the MDGs. As developing countries depend on financing from abroad, social policy strategies run the risk of meeting donors' demands rather than facing the epidemiological and health needs. This might induce governments to focus exclusively on some indicators to satisfy the expectations of the global community rather than fight country-specific problems.

Despite the intention to improve access for the poor, publicly run insurance schemes face problems in extending effective coverage to remotest areas. This is partly due to the lack of health care facilities, but also to the difficulties of reaching the poor. For instance, an active consideration of the demands and necessities of ethnic and linguistic groups is required to improve the poor's acceptance of publicly run health insurance schemes. Although indigenous people tend to be the most underprivileged social groups, the health insurance schemes have not adapted benefits and services to the ethnological and linguistic demand of this population share.<sup>27</sup>

To allow for evidence-based strategies, the insurance plans must improve statistical procedures to detect epidemiological challenges and prove the impact of the scheme on

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<sup>27</sup> To overcome the discrimination against the indigenous population and to improve their access to SUMI-benefits, the Bolivian ministry of health has recently equipped 59 health brigades to fight the maternal mortality rates in the less developed regions. Additionally, 1,400 local health workers recruited from personal of the armed forces are realising promotional and preventive activities in remote parts of the national territory (Ministry of Health and Sports 2003b, p. 3).

relevant health indicators. Furthermore, the schemes ought to invest in controlling and accountability to overcome the current deficiencies, to improve the performance, and to intensify indispensable insurance tasks. This is certainly one of the most relevant areas of interest for international technical cooperation.

The publicly run schemes depend on hidden, implicit and in-kind cross-subsidies from the public health care system. This condition might be of low relevance for the schemes as long as they are social policy strategies. However, if the schemes intend to develop into health insurance organisations, this financing has to be taken in account to allow better planning independent from political priorities or scarce public resources.

### *Key lessons learned*

The experiences in Bolivia and Peru show that the succession of different insurance plans runs the risk of generating confusion among the target population. In both countries, the intended beneficiaries never felt well informed about the scope of the insurance schemes and observed that the conditions kept changing every second or third year. Confusion also reigns among health care professionals and administrators who have to deal with changing benefits covered by the insurance plans, varying rules for reimbursement, and different incentives to recruit enrollees (comp. Rousseau 2004, p. 23).

Communication and social marketing strategies are of utmost importance for the acceptance and performance of public health insurance schemes. Relevant questions have to be raised about how to inform stakeholders, how to create conditions for successful approaches, and how to sell health sector reforms to the population. To implement successful public insurance schemes, decision-makers ought to seek community participation in setting the health policy agenda with all stakeholders, including community organisations representing vulnerable groups such as the indigenous population and women. Therefore, creativity in identification of alternative forms of communication is required. The costs for a comprehensive communication strategy should be included in the budget.

For improving participation and sustainability, the inclusion of beneficiaries on insurance boards can be effective. Client, provider and other stakeholder participation is generally preferable in public health financing schemes, especially in countries that have to deal with corruption, as the Paraguayan case study recommends. A governance organ independent of the state authorities, elected by and responsible to the members, might be an important step towards increasing trust in the insurance plan.

Governments are recommended to concentrate on regulating the design and implementation of health plans. They can also establish the legislative framework for the efficiency and transparency of operations, and are in the best position to guarantee the replication of experiences across areas, sectors or occupations. Stewardship and good governance are key elements for a successful public insurance plan; the best example therefore might be the recent evolution of the Salvadorian teacher welfare scheme.

### *Outstanding questions and conclusions*

When it comes to implementing a health insurance plan designed for the poor, one central question is whether a public health insurance scheme should be financed in the long run by

taxes or by contributions. Tax-financed schemes like the Bolivian SBS/SUMI offer the advantage of universal coverage, at least in theory. However, the denomination as “insurance” schemes in the public sector creates the expectation that the health plans are related to contributions and entitlements.

The case is somehow ambiguous for SMI/SIS and different for the Integral Insurance. The Peruvian initiative has introduced beneficiary contributions in the form of subscription fees, and the further extension of contribution payment might develop beneficiaries’ consciousness regarding entitlements and enforce the demand of adequate care in the moment of need. The Paraguayan scheme has recently introduced household contributions payable by all enrollees. However, the negative impact on enrolment illustrates the challenge of introducing subscription fees in health insurance plans that start without individual contributions.

The three public insurance schemes give various answers to the question on how to organise and improve segregated and segmented health care systems. The purely tax-based SBS/SUMI and the mainly tax-financed SMI/SIS have overcome institutional barriers to cooperate not only with state-run health facilities, but also with social security and even private providers. As for financing mechanisms, the SMI/SIS and the SI have implemented a mix of tax-based and contribution financing. Under different conditions, this is also true for the BM because the employer is a public institution financed from the national treasury; thus, a part of the subscription fee comes from the general tax revenue. From a systemic point of view, the experiences of shared financing of health care are important because they reflect the challenges of health sector reforms in developing countries and allow for conclusions for the whole sector.

State-run health insurance schemes that strive to improve access of the poor to health care depend largely on the public provider network. This dependence and the overall goal put clear limits to the option to act according to insurance theory, for example to negotiate bulk discounts, special fares or other advantaged conditions for the beneficiaries. Decision-makers should try to raise capacities and to implement a framework for provider negotiations that allow for achieving favourable conditions for the insured group. In the medium or long term, that might have positive effects on the performance of the health care system.

Public health insurance schemes usually lack transparent cost-calculation systems that allow for a time-close overview about income and expenses, and hinder adequate planning. All schemes in this paper have to improve bookkeeping procedures and develop actuarial approaches to improve financial transparency, analyse aggregated hidden subsidies, and determine the scope of coverage.

Another important issue is the effect of focalised health schemes on those who are not in the target group. Regarding overall fairness and equity, negative impacts on non-beneficiaries seem to be unavoidable; however, during the implementation of new schemes, these effects ought to be taken in account and reduced as far as possible.

## Appendix

GTZ Division 4320  
Health and Population



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**InfoSure**  
Health Insurance  
Evaluation Methodology  
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**Data Entry Tool**  
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