SOCIAL PROTECTION AND LABOR

SOUTH SOUTH 2014

LEARNING FORUM

Using Delivery Systems to Link Safety Nets and Health Insurance

20 March 2014

Contents:

Using Delivery Systems to Link Safety Nets and Health Insurance
Session Brief

Session Lead: Uwe Gehlen, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)

Speakers:

Vikas Sheel, Secretary, Department of Food, Civil Supplies and Consumer Protection, Government of Chhattisgarh, India

Lawrence Ofori-Addo, Deputy Director (LEAP Coordinator), Department of Social Welfare, Ghana

Vincent Leyson, Director, National Household Targeting Office, Department of Social Welfare and Development, Philippines

Background

There are now dozens of countries administering, or in the process of implementing, programs to expand health coverage, particularly to the poor in the context of the global push for universal health coverage (UHC). Recently, the World Bank's UNICO project documented 24 of these experiences in low- and middle-income countries (see these reports at www.worldbank.org/universalhealthcoverage). Among other things, these case studies document how the target population for the coverage expansion was determined and, in most cases, describe the various implementation processes involved in delivering health coverage ranging from enrolment to information systems. The linkages between social assistance programs and these efforts vary across countries and in countries where there are linkages between systems, the collaboration was often difficult. These experiences lead to a number of questions: How can delivery systems for anti-poverty programs be coordinated or leveraged to expand health insurance in the most cost-effective manner? What changes to existing processes and platforms would better exploit potential synergies between social assistance programs and bottom-up health coverage? What is the most efficient way to ensure unique and robust identification for beneficiaries of social protection and health programs?

Country Cases

The session will highlight the efforts of three countries to better integrate the processes associated with their targeted health insurance programs with their major social assistance programs. Each presenter will describe the implementation of their programs focusing on

practical issues such as institutional coordination, cost and outreach. They will describe the challenges that were faced and lessons from their experiences that may be relevant for other countries.

India

The Rashtriya Swasthya Bima Yojna (National Health Insurance Program or RSBY) was started in 2008 and now covers more than 36 million families, for hospitalization up to certain limits. The program uses the proxy-means test-based targeting approach that had been in place for decades and which is used to determine eligibility for other programs such as subsidized food and social pensions. Recently, the integration of processes has been extended to identification and transactions through the use of a multi-program biometric smart card on a pilot basis.

Ghana

In 2010, Ghana initiated an effort to provide health insurance to the poor and to extend its National Health Insurance program. Another anti-poverty program, Livelihood Empowerment against Poverty or LEAP, was expanding from its pilot phase at about the same time. For various reasons, the targeting approach for health insurance evolved separately. In the last two years, however, there has been a concerted effort to move to a single eligibility determination process and better coordinate the two programs.

Philippines

The Philippines has established one of the world's largest conditional cash transfer programs known as the Pantawid Pamilyang Pilipino Program. Piloted in 2007, the program now covers more than one million poor households. In 1995, PhilHealth, a new health insurance program, was launched. PhilHealth aims for universal health insurance coverage and includes a program that cross-subsidizes the premium for the poor. Having developed separately, the two programs are increasingly coordinating both in terms of their eligibility determination, and their transaction processes.

Using Delivery Systems to Link Safety Nets and Health Insurance
Session Summary

Much of the discussion following the presentations from Ghana, India and the Philippines revolved around the fact that ensuring quality of services in a system that is free at point of use, as well as the exclusion of many services from fee exemption has been a challenge for all the presenting countries. Performance-based contracts for health suppliers, supply side assessments as well as robust grievance systems were identified as a possible solution to the first challenge.

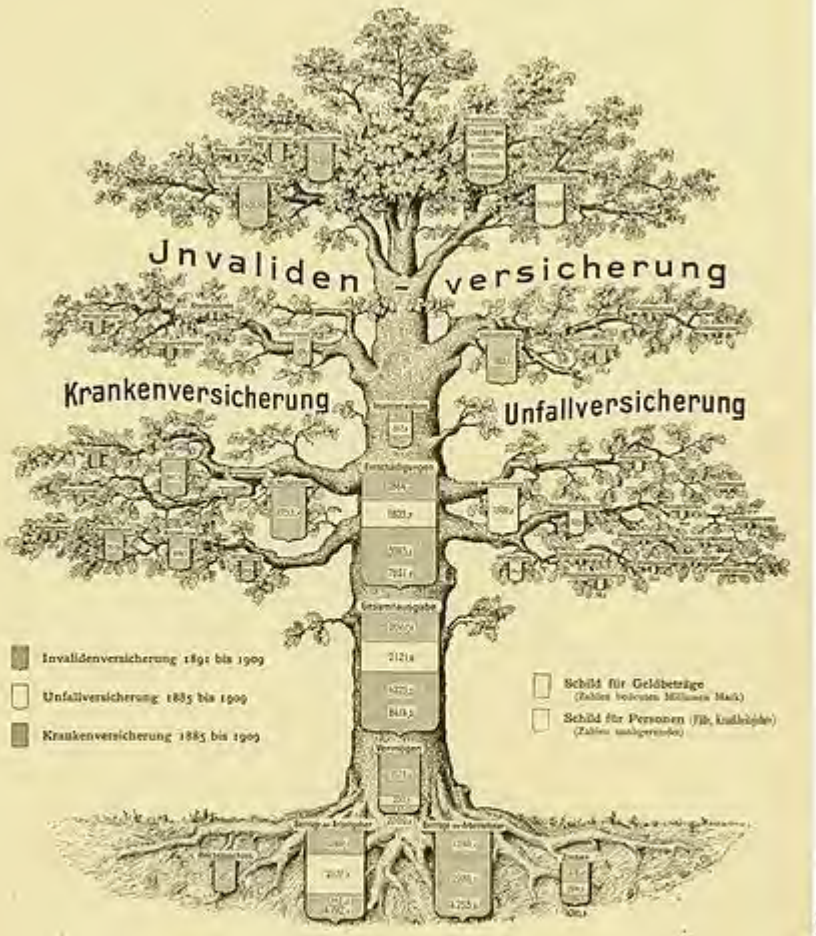
In the case of India, the discussion focused on how a fully automated system can help ensure the absence of fraud and monitoring in all transactions. Also, the conversation touched upon how access to services in remote places is a challenge in India, but a pick up and drop off service put in place by the government for pregnant women and small children has been found effective in mitigating the access problem.

For the Philippines, the discussion centered on how, despite challenges in quality of care, improvements in health outcomes among beneficiaries were significant. Also, participants expressed interest in the Government's method of financing the health package through the "sin law," as an interesting example of finding resources for healthcare for the poor.

As for Ghana, participants were interested in its experience with inter-ministerial coordination, and determination of who would host the unified registry. The presenter shared that by having a solid mandate for protecting the extreme poor with only one Ministry (Gender, Children and Social Protection) the decision on the registry host designation was easier.

Using Delivery Systems to Link Saftey Nets and Health Insurance

South-South Learning Forum 2014



Versicherte Personen:
Krankenversicherung 13,4, Unfallversicherung 24,1, Invalidenversicherung 15,4 Millionen.
Gesamtbevölkerung 63,9 Millionen.

Einnahmen, Ausgaben und Leistungen der Arbeiterversicherung des Deutschen Reichs 1885 bis 1909.

Rabbit to Lion Problem – solutions?

- Start a capacity building program to –
  - Train rabbits to become lions or
  - Evasive maneuvers
- Insurance for rabbits
- Conditional Cash Transfers –
  - For LIONS – benefits to lions only if
    - They don't harm rabbits
    - The cubs join the rabbit protection force.

Linking Food Security with Health Insurance

CHHATTISGARH - INDIA

Vikas Sheel
Secretary
Department of Food & Civil Supplies
Government of Chhattisgarh

Chhattisgarh - profile

- 9th largest State in the country (135,191 sq km)
- A young State – formation on Nov 1st, 2000.
- > 50% area under forest.
- Population – 27 million.
  - 70% rural. 32 % indigenous
  - 76% small & marginal farmers.
  - 7.714 million households.

Chhattisgarh - profile

- 48.7 % population below poverty line (BPL)
  - monthly income < 400 $
- 58% population – socially & economically backward.
- Second best gender ratio – 991
- Literacy – 71.04%. Female literacy – 60.59%

Chhattisgarh - profile

- Malnutrition > 50%.
- Per capita average daily calorie intake – 2050 kcal
- Per capita daily protein intake – 50 gm
- IMR – 48
- MMR – 269
- TFR – 2.7

Chhattisgarh - profile

- No. of doctors per 10000 population – 1.2
- No. of hospital beds per 1000 – 0.2
- Life expectancy at birth – 66
- Per capita annual public health expenditure - $ 120
  - High out-of-pocket expense.
- 40% of area affected with Left Wing Extremism

Health insurance in Chhattisgarh

- National Health Insurance Scheme (RSBY) covers the BPL families (48%) - 2009
- Universalization in 2012 – Chief Minister's Health Insurance (MSBY) covers the rest.
- Annual insurance cover of Rs 30000 ($ 500) – up to 5 members of the family.
- Predefined package rates excluding OPD.

Health insurance in Chhattisgarh

- Cashless services through empanelled Public and Private hospitals.
- Fully computerized paperless scheme.
- Each beneficiary household has a biometric smart card.

RSBY\MSBY delivery process

- Preparation and validation of base data.
- Issue of biometric smart card.
- Beneficiary presents the smart card at empanelled hospital.
- Bio-metric authentication of beneficiary at the hospital
- Electronic claims generation, claims settlement and payment to the hospital.

RSBY\MSBY - Status

- 3.797 million smart cards issued (55% coverage).
- 483 hospitals empanelled. (243 public)
- 285,932 claims settled during FY 2012-13.
- Total claim amount – $ 30.32 million
- Claims ratio – 159 %

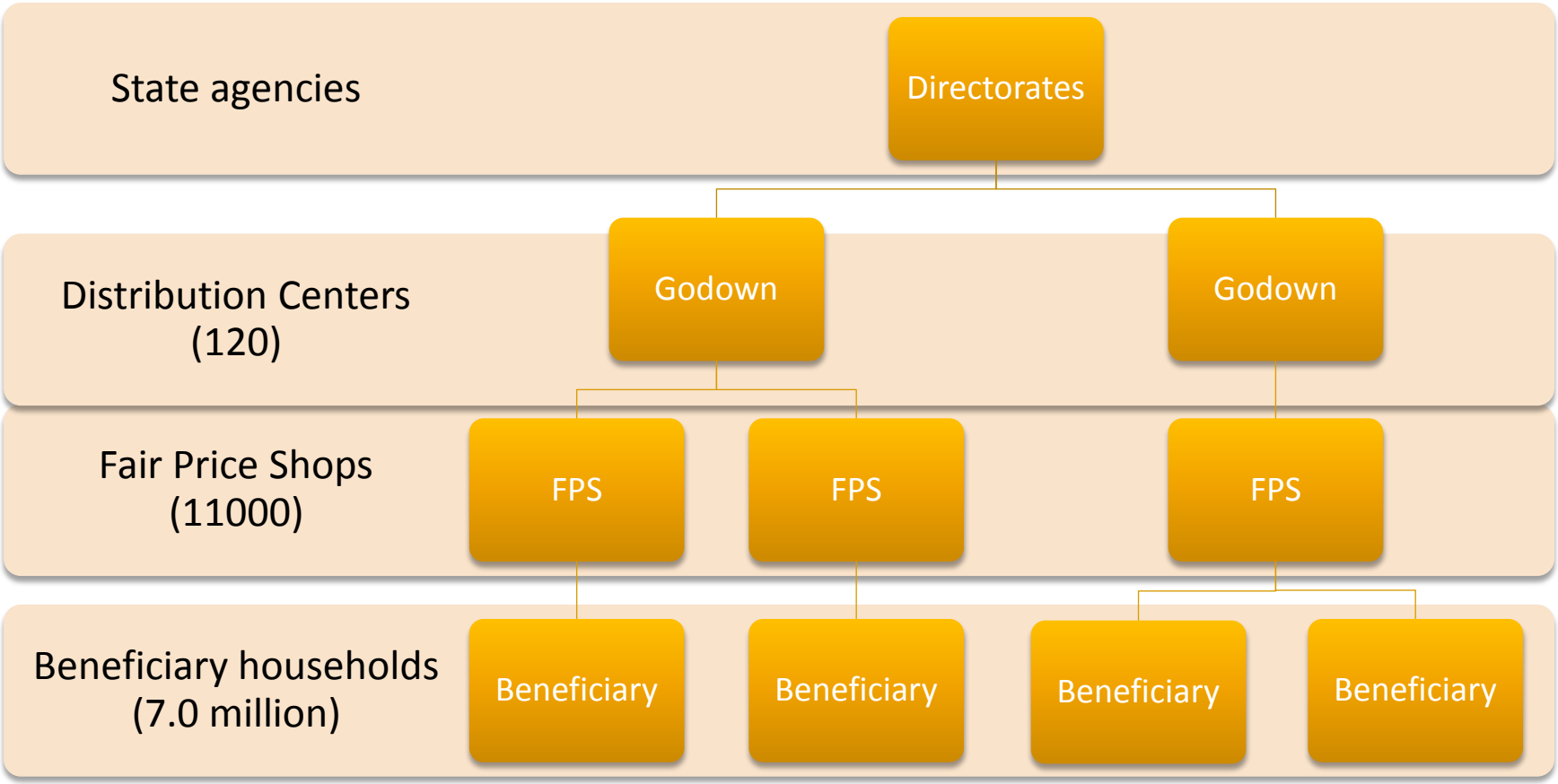
Food Security - evolution

- Expansion of Public Distribution System (PDS) in 2007 – coverage increased to 67% from 33%.
- A series of legal, structural and financial reforms – Proclamation of guarantee & restoration of credibility of service delivery
- NO HUNGER DEATHS or FARMER SUICIDES in last 7 years.

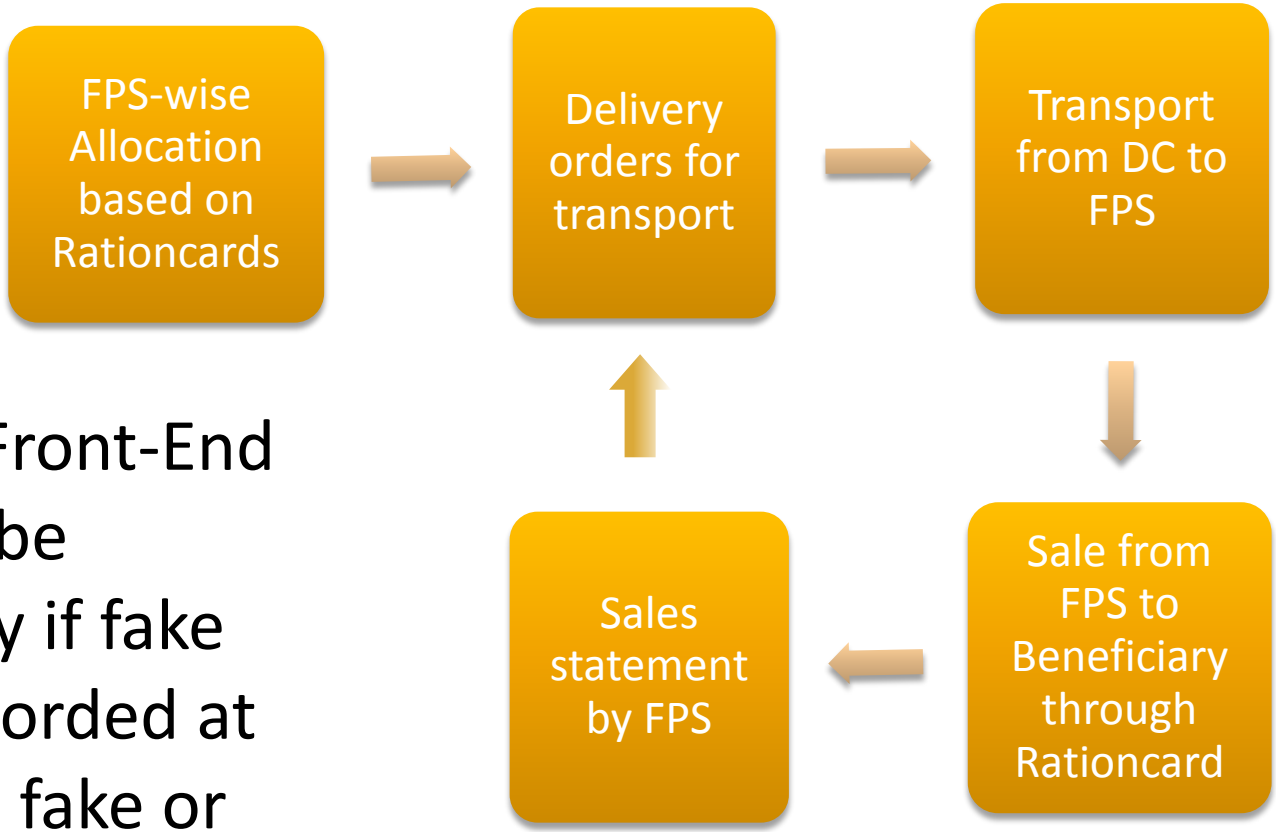
Chhattisgarh Food & Nutirtion Security Act, 2012 - provisions

- Shift to a rights based approach.
- Legal entitlements to 90% households. Core idea for targeting - EXCLUSION
- Monthly entitlements per household –
  - 35 kg foodgrains @ Rs. 1 per kg (0.02 $ per kg)
  - 2 kg iodized salt free of charge
  - 2 kg lentils @ Rs 5/10 per kg (0.10/0.20 $ per kg)
- Food subsidy bill – ($ 1.193 Billion)
  - Procurement of grains – Rs 24 Billion ($ 387 Million)
  - Distribution – Rs 50 Billion ($ 806 Million)

Public Distribution System



Delivery process



Problem at Front-End

Rations can be diverted only if fake sales are recorded at the FPS – on fake or genuine ration cards

Problems at FPS (PDS Front-end)

- Diversion in PDS at the FPS -
  - Fake/ghost cards.
  - Fake issue on cards.
  - Nexus between the FPS and staff.

- Monopoly of FPS over beneficiary –
  - Overcharging
  - Under-weighing
  - Multiple trips
  - Behavior of shop salesman

Centralized Online Real-time Electronic PDS - COREPDS

COREPDS - Inspiration

"A person produces the same commodities in the same way and ends up with same income and buys the same goods, she may still have very good reason to prefer the scenario of free choice over that of submission to order"

--- Amartya Sen

- From 'Development as Freedom', p 27

Intervention - COREPDS

- Ration shop converted to a virtual food ATM
  - Point Of Sale (POS) device with GPRS connectivity at the FPS.
- A Smart Ration Card (SRC) (non-biometric) to the beneficiary.
- Authentication of beneficiary by SRC at the shop.

Intervention - COREPDS

- Portability –
  - empowerment of beneficiary by giving her choice to buy rations from the shop of her choice.
  - Making the shop accountable to beneficiary.
  - Incentive for shop to deliver better services to capture more market share
- Portability instruments –
  - Smart card – RSBY
  - Mobile phone – OTP
  - AADHAR – Biometric unique identifier

COREPDS – status & outcome

- Implemented in 500 FPS' in 7 cities. 40 shops in rural areas.
- Risk mitigation strategies –
  - Mobile vans
  - Offline issues
- 500,000 beneficiary households.
- 15% - 18 % portability –
  - Improved beneficiary satisfaction.
  - Reduction in trips – from 5 to 1.6.

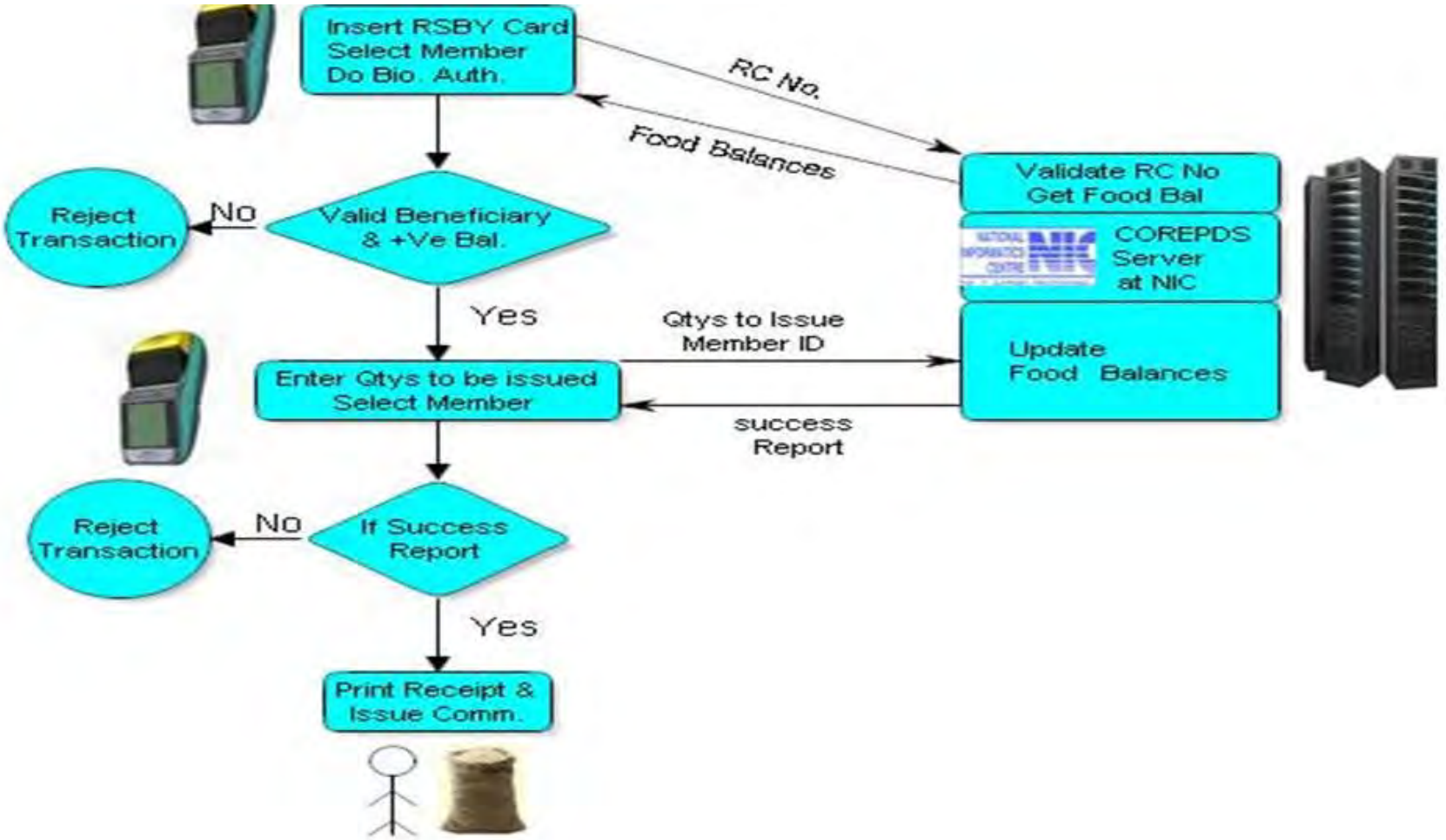
COREPDS – outcome

- 25% shops selling to > 100% beneficiaries
  - Incentivizes the FPS to improve service delivery, even marketing !!!! FMCG package , discounts etc.
- 20 shops have shut down due to non-performance
  - Nexus is no more effective
- 3% reduction in sales – saving of $ 1.2 million per annum. Cost of initiative – Fixed - $ 250,000, recurring - $ 40000 pa.

Linkage between COREPDS & RSBY

- Both the safety nets were universalized in 2012.
- Ration Card database used as base data for RSBY.
- RSBY smart card in place of smart ration cards
  - PDS partition in RSBY smart card chip. RC details in card at the time of enrolment.
- FPS in place of hospital
- Authentication process analogous in 2 schemes.

Authentication with RSBY smart card



Benefits of linkage

- Beneficiary –
  - Multiplier effect - Single instrument for two schemes.
  - Increase in value of instrument without any additional cost.
  - Bio-metric instrument – entitlements can't be availed by anyone else.
- RSBY –
  - Readymade base data – saving in time and cost.
  - Increase in value of instrument (and scheme) without any additional cost.

Benefits of linkage

- PDS –
  - Issue of separate smart cards not required – savings in cost. (almost 50%)
  - RSBY smart card is bio metric – immense saving in time and cost.
  - Biometric authentication possible – helps in reducing leakages through fake sales.
  - Convenience for the beneficiary – transparency.

References and links

- CG profile –
  - WHO report 2011
  - District Level Health Survey reports – 2012
  - Census – 2011
- Chhattisgarh RSBY\MSBY –
  - http://cg.nic.in/healthrsby/
- COREPDS –
  - http://khadya.cg.nic.in/pdsonline/corepds/EnglishVersion/frmNavigationPageEnglish.aspx
- Contact –
  - iamvikassheel@yahoo.com

Thank you

iamvikassheel@yahoo.com

COREPDS MODEL - Every FPS has a POS device

Freedom to chose

- Currently 18% of beneficiaries are using portability. Remaining beneficiaries are taking at their own FPS, but now with their choice not by compulsion.

Mobile FPS

- CGSCSC operates mobile FPS


PDS

LINKING LIVELIHOOD EMPOWERMENT AGAINST POVERTY TO THE NHIS

South-South Learning Forum
Rio, March 2014

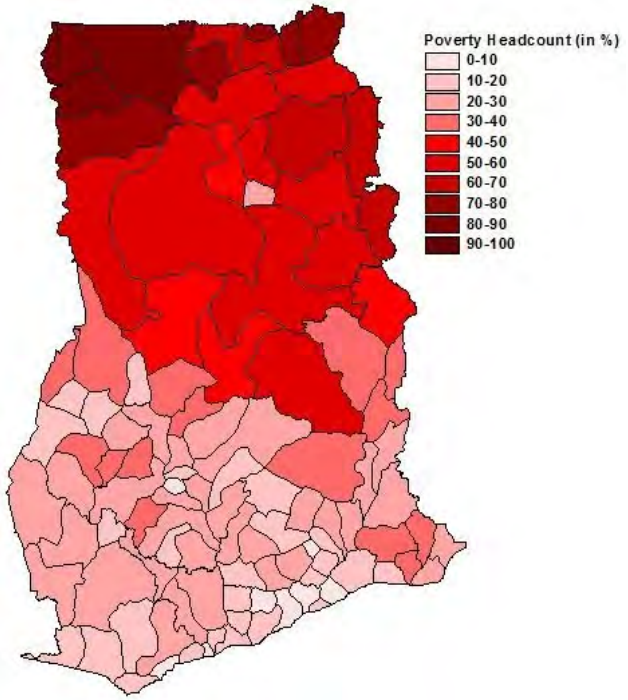
Lawrence Ofori-Addo
Deputy Director, Department of Social Welfare
LEAP Coordinator
Ghana

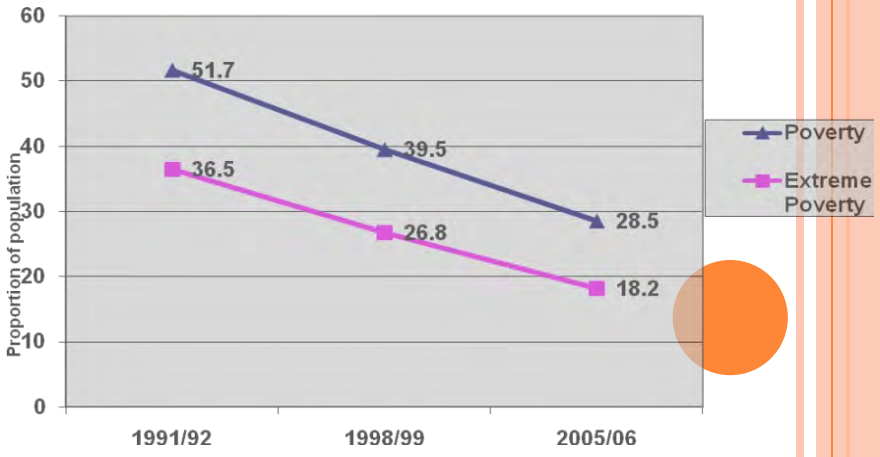
OUTLINE OF PRESENTATION

- **BACKGROUND**
- Poverty Trends in Ghana
- Case Study on Child Poverty
- **SOCIAL PROTECTION IN GHANA**
- Overview of SP Programmes
- Overview of LEAP
- Overview of NHIS
- **LINKAGES OF NHIS AND LEAP**
- **CHALLENGES**
- **AY FORWARD**

GHANA - BACKGROUND

- Population of 24.4 million
  - 45% below 18 years
- GDP of $38 Billion;
  - economic growth rate of 14.4% in 2011.
- Lower Middle Income Country
  - GDP Per Capita of $1,300
- Poverty halved between 1991 and 2005;
  - Poverty Rate: 28.5%, Extreme Poverty Rate: 18.2%
- Improving HDI: 0.38 in 1990, 0.54 in 2011; ranked 135 out of 187 Countries
- But inequality persists:

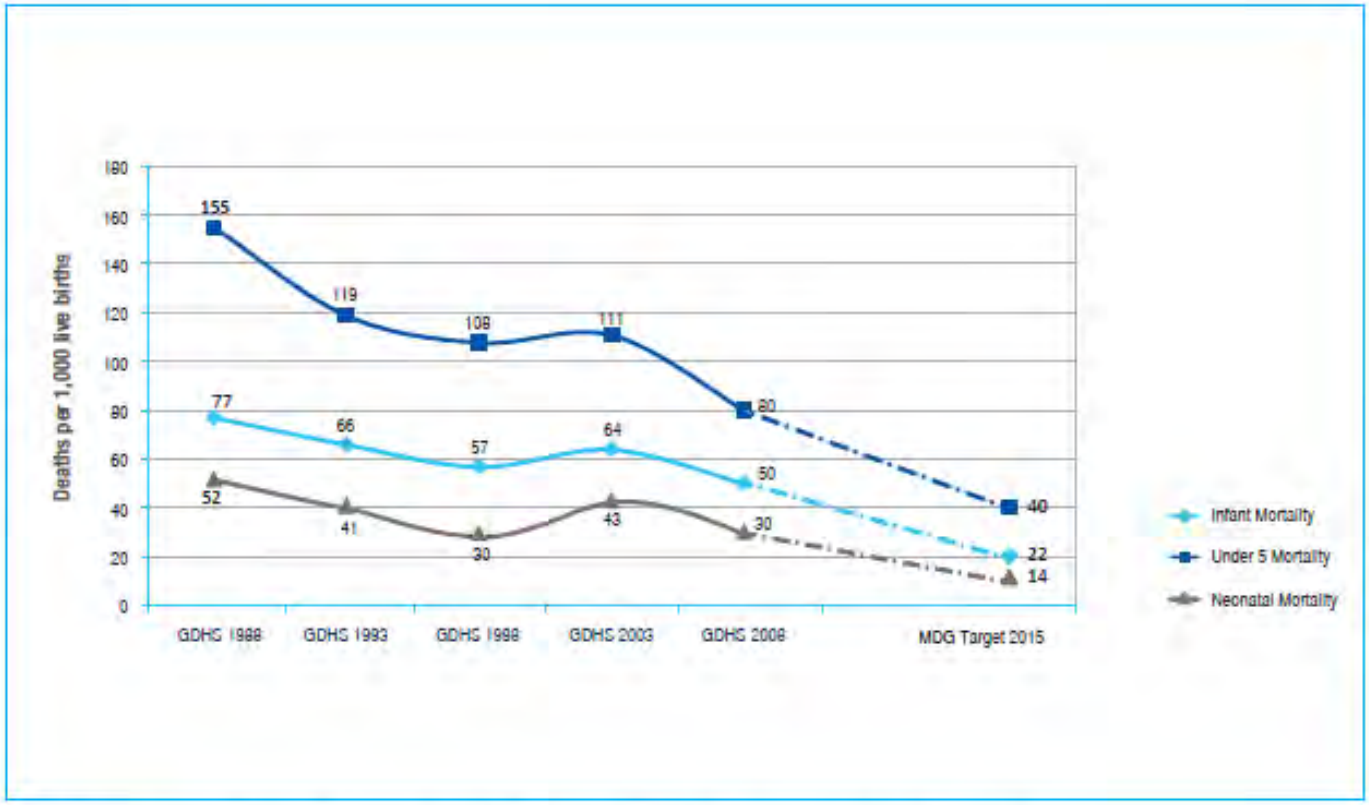




CHILD POVERTY AND DISPARITIES

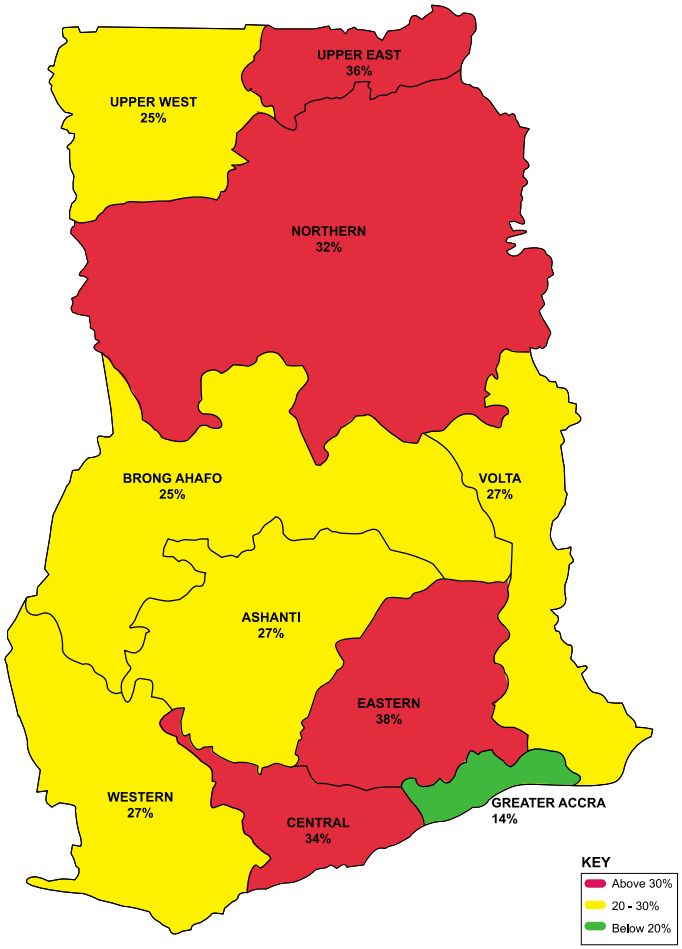
- An estimated **3.4 million** children live in poverty (2.2 million live in extreme poverty).

- But Ghana has seen a significant reduction in Child Mortality.

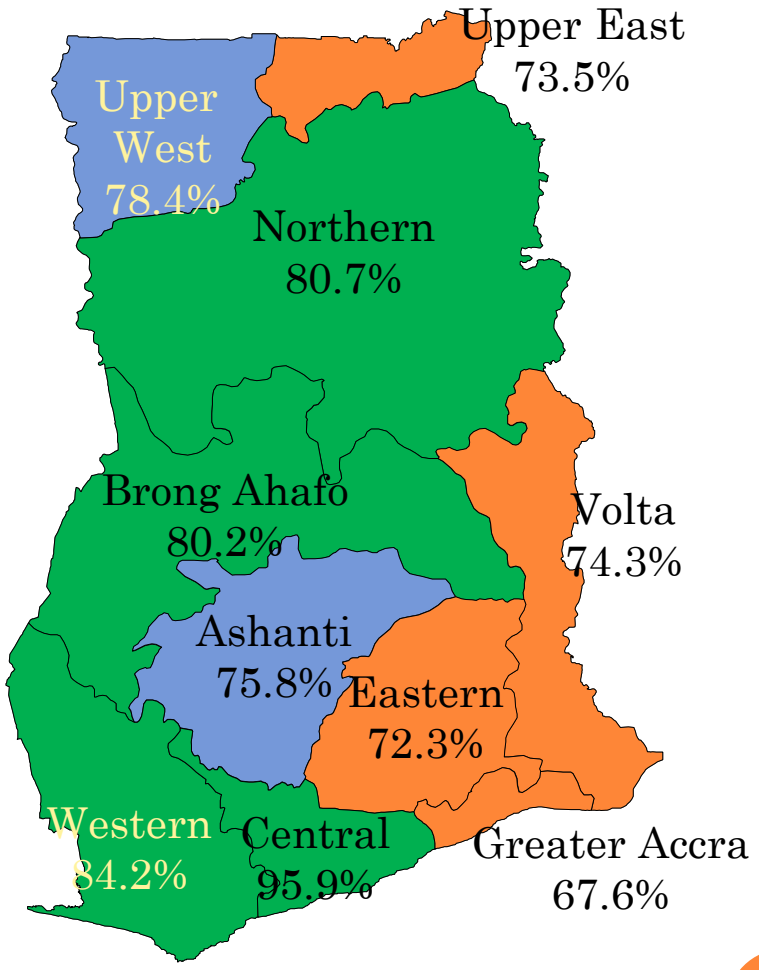


Source: GDHS 1988, GDHS 1993, GDHS 1998, GDHS 2003, GDHS 2008.

WIDE DISPARITIES IN CHILD MALNUTRITION AND EDUCATION



More than 30% of children in Upper East, Northern, Eastern and Central Regions are ***stunted***



Net enrolment in primary *schools is fairly high, although enrolment is not the same in all regions…*

EXISTING SOCIAL PROTECTION PROGRAMMES

- **HEALTH**
- Health Insurance Scheme and the pro poor exemptions for indigents, aged 70+
- Free Maternal and Child Health
- **EDUCATION**
- Free Compulsory Basic Education
- School Feeding Programme
- Free School Uniforms
- **LIVELIHOODS**
- **Livelihood Empowerment Against Poverty (LEAP)**

EXISTING SOCIAL PROTECTION PROGRAMMES (CONT.)

- Labour Intensive Public Works (LIPW)
- Block Farming Initiative
- Fertilizer Subsidies
- **ENERGY**
- Electricity Cross Subsidy

- Contributory Pensions Scheme.

LEAP: Flagship National Social protection programme since 2008

- **LEAP provides cash transfers to extremely poor households** who have one of the following "eligible members".
  - Orphans and Vulnerable Children
  - The Aged/Elderly (65 years and above)
  - Severely disabled people who cannot work

- **LEAP Conditional on accessing health and education** services:
  - All children 5-17 years in household must be enrolled in school
  - All children below 5 years must be immunized and have regular health screenings.

- Current **expansion plan** is to reach ~150,000 households by 2014 Initiated with 2000 households in 2008 with current enrolment standing at 74,000 households

- All members of the household get **free National Health Insurance** Scheme for indigents

NATIONAL HEALTH INSURANCE SCHEME

- The NHIS was introduced in 2004 to replace a Cash and Carry System.

- The Scheme has a Social Assistance component providing protection for extremely poor and vulnerable segments of the population through exemptions in the payment of registration and premiums.
- These are **pregnant women, children below the age of 18, the aged above 70 years and indigents.** Approximately 5% of each scheme was to benefit under the Social Assistance component.

LINKAGES OF NHIS AND LEAP

- **Legal reforms:** in 2009 the NHIS was reviewed and it includes the selection of the extremely poor and vulnerable. This allowed NHIS to use LEAP data to increase coverage to the extremely poor and vulnerable sections of the population.
- Based on the revision of the selection of beneficiaries for the exempt category, all members of LEAP household get **free National Health Insurance** Scheme for both registration and renewal of membership, increasing coverage of LEAP beneficiary households from 26% in 2010 to 92% in 2012.

DATA TRANSFER OF BENEFIARY INFORMATION

- Management Information System of LEAP contains data on all LEAP selected beneficiary households. Based on MoU between NHIS and LEAP, the LEAP registry is periodically sent to the NHIS for registration and enrolment of all LEAP beneficiaries on their scheme.

Impact of LEAP – Health and education

Children are 14% points more likely to have health insurance and 7% points less likely to be ill.

	(1) Illness	(2) Curative care	(3) Preventive care	(4) NHIS enrollment
2012	**0.07**	0.17	0.10	**0.16**
	(5.23)	(0.89)	(0.58)	(8.52)
T	0.04	-0.35	0.51	**-0.27**
	(0.58)	(0.28)	(0.65)	(2.32)
DD	**-0.07**	0.00	-0.13	**0.14**
	(4.07)	(0.02)	(0.68)	(4.87)
Observations	3,360	232	153	3,345
R-squared	0.13	0.69	0.81	0.41

LEAP reduces the likelihood of children 5-17 years old missing any school by 6%, and reduces the chance of repeating a grade by 11%.

	(1) Missed any school	(2) Currently enrolled	(3) Ever repeat grade	(4) Missed entire week
2012	**-0.11**	0.01	**0.05**	**0.54**
	(7.21)	(1.01)	(2.56)	(28.61)
T	-0.03	-0.07	0.18	-0.06
	(0.37)	(1.04)	(1.55)	(0.49)
DD	**-0.06**	0.02	**-0.11**	**-0.05**
	(2.99)	(1.25)	(3.98)	(1.98)
Observations	3,329	3,558	2,933	3,327
R-squared	0.22	0.20	0.23	0.47

Impact of LEAP – Quotes from Beneficiaries

- *"LEAP has allowed for improvements and **changes in the diets** of beneficiaries. Beneficiaries now able to cook with good magi and more fish. There is also more variation of foods we eat …" (Female Beneficiary, Dalung, Northern Region).*

- *"Some of the beneficiaries have **started small businesses**. They have put up temporary tables where they sell sweets, biscuits, matches etc. Others also fry koshe and kulikuli and they sell them in the market on the road". (Female beneficiary, Tali)*

- *"Before LEAP it was all about survival. **Some people might have died, but for LEAP".** (beneficiary in Agona Abrim community)*

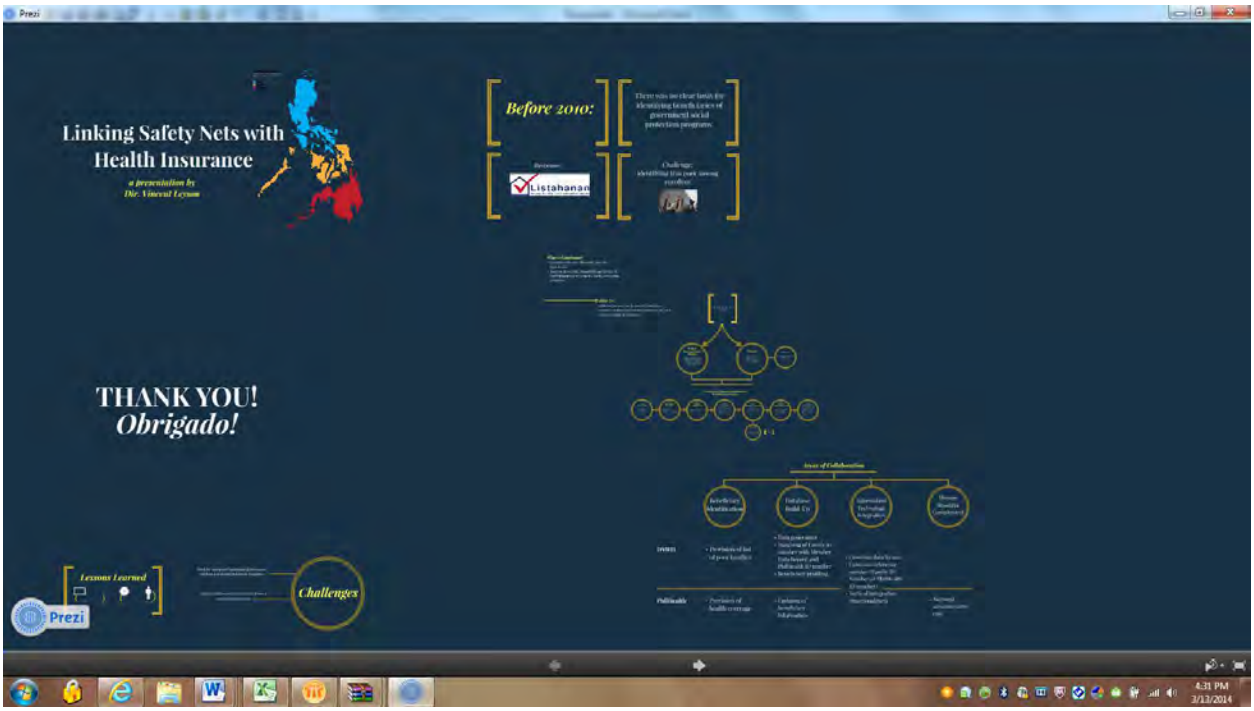
CHALLENGES

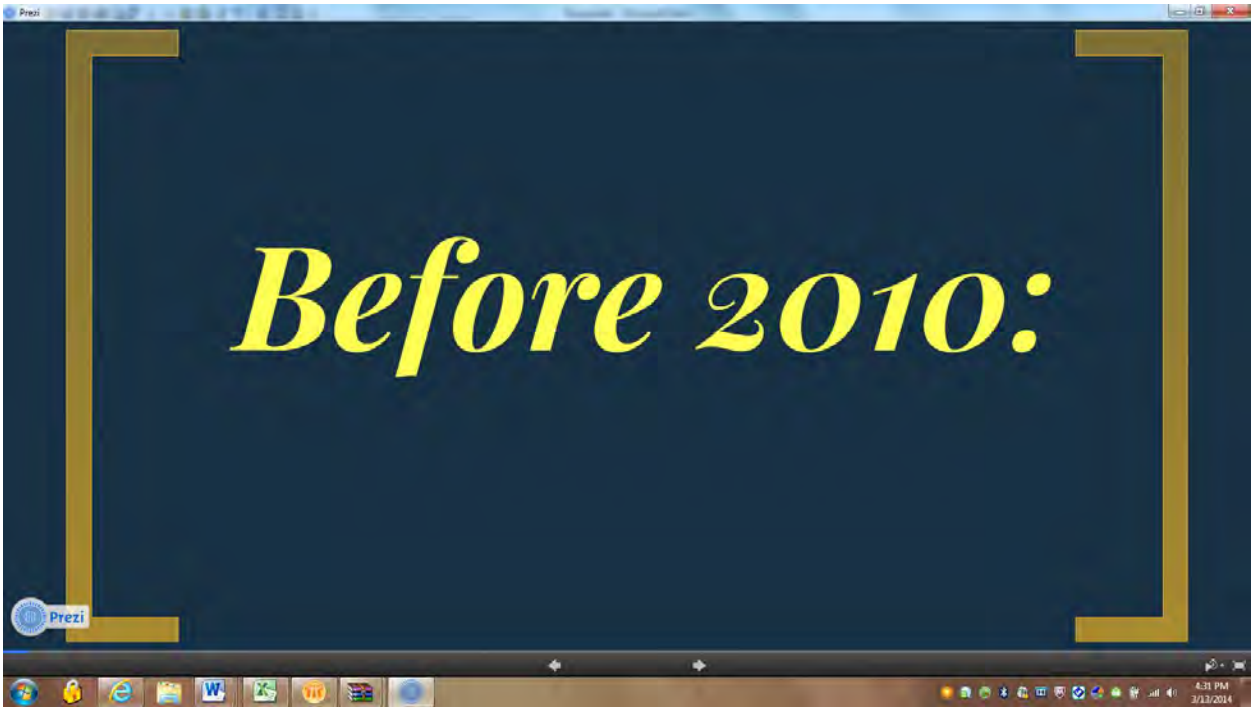
- Limited coverage of the LEAP programme (target for 2014: 150.000 households, approx. 600.000 individuals) does not allow the NHIS to meet their annual beneficiary target which is 1 Million for 2014.
- Challenges with the two programme databases which currently do not allow inter-operability and integration of the two MIS.
- Difficult to verify data from the LEAP database due to lack of national ID. Thus enrolment of the LEAP beneficiaries into the NHIS is complicated.

WAY FORWARD

- Processes of developing a unified registry for Social Protection interventions in the country is underway. This will include several Social Protection programmes.
- There is ongoing development of a national identification system in Ghana foreseeing a unique Identification number for all citizens above 18 years. This will support validation and registration of Social protection beneficiaries.
- The LEAP MIS database is being upgraded to allow access of NHIS to the LEAP MIS and vice versa.

THANK YOU


Linking Safety Nets with Health Insurance
a presentation by
Dir. Vincent Leyson
Before 2010:
Listahanan
THANK YOU!
Obrigado!
Lessons Learned
Challenges
Prezi


Before 2010:
Prezi

There was no clear basis for identifying beneficiaries of government social protection programs.

Challenge:
identifying true poor among enrollees

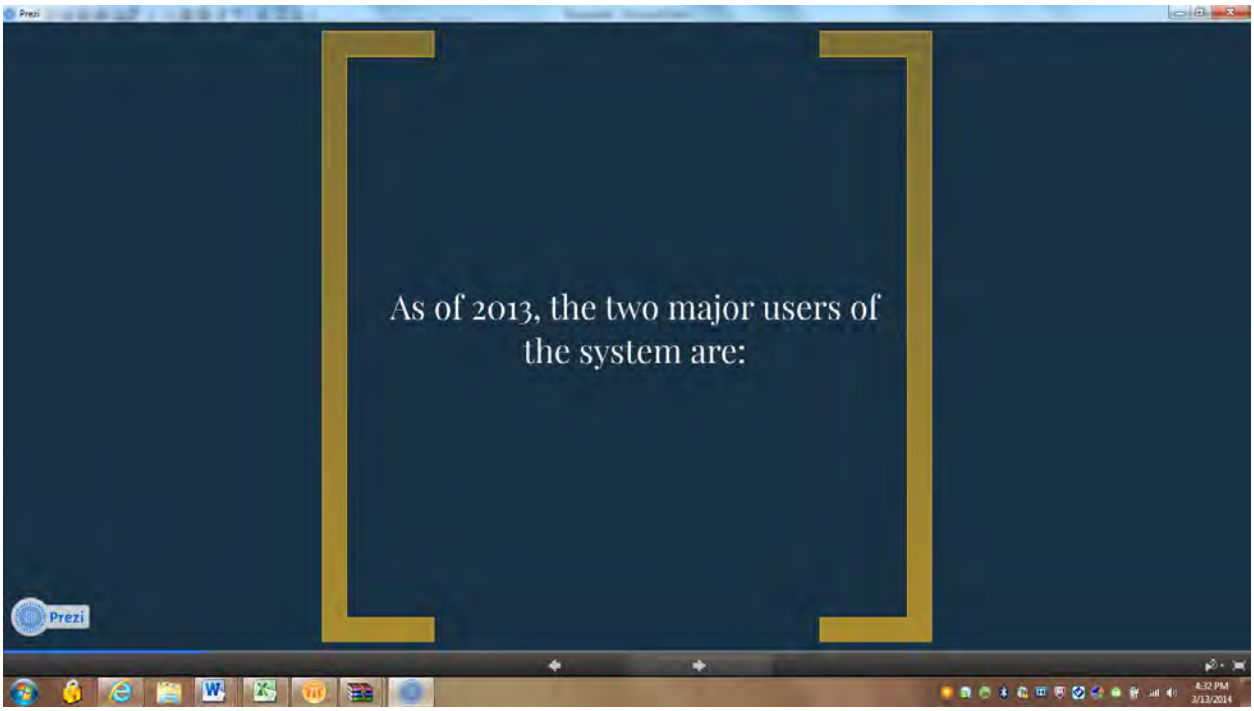
Response:

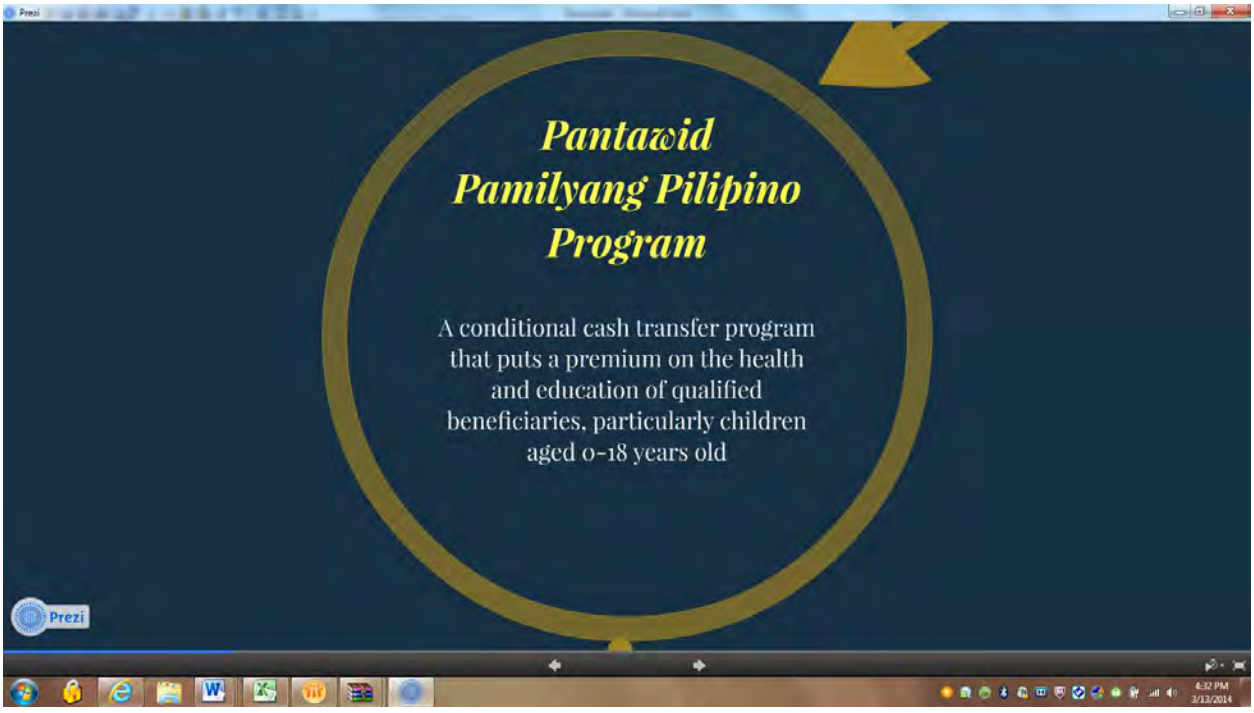
What is Listahanan?

- identifies who and where the poor are nationwide
- basis in identifying potential beneficiaries of the Philippine government's social protection programs

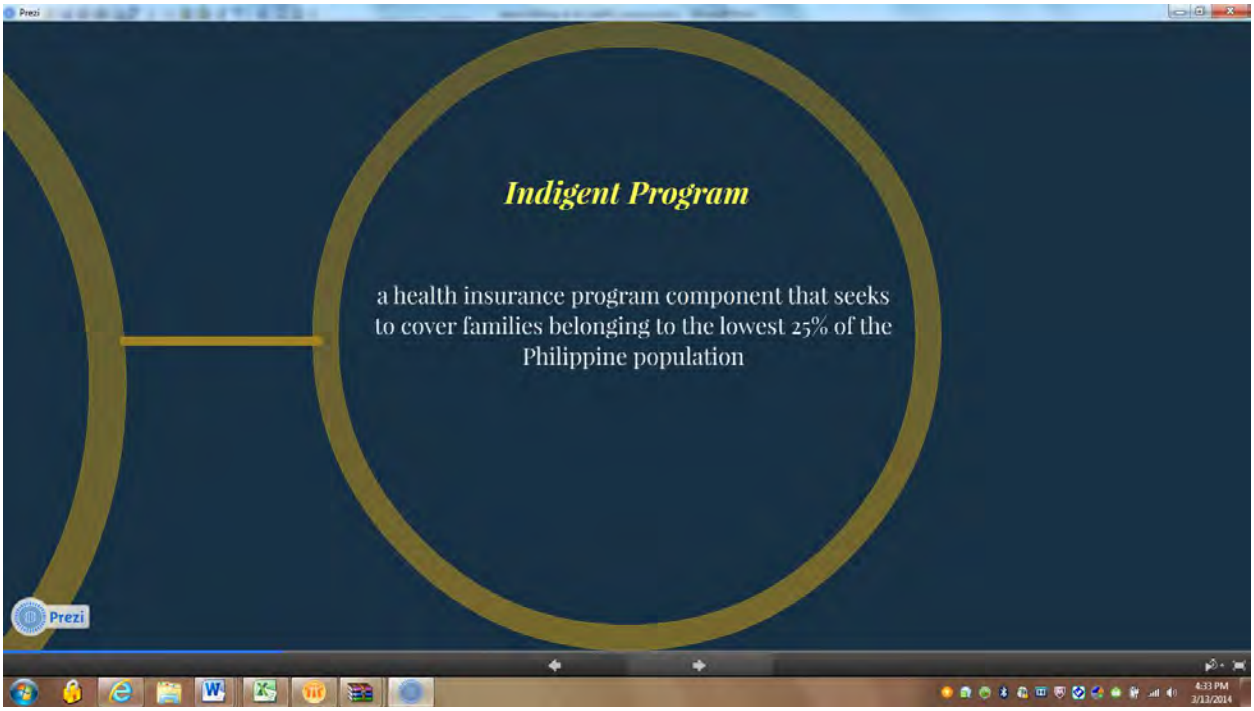
It aims to...

- address the increase in poverty incidence
- provide a unified criteria in identifying the poor
- reduce leakage of resources


As of 2013, the two major users of the system are:
Prezi


Pantawid Pamilyang Pilipino Program
A conditional cash transfer program that puts a premium on the health and education of qualified beneficiaries, particularly children aged 0-18 years old
Prezi


PhilHealth
a government health program that seeks to provide health insurance coverage to all Filipinos
Indiger
a health insurance pro
to cover families belon
Philippi
Prezi


Indigent Program
a health insurance program component that seeks to cover families belonging to the lowest 25% of the Philippine population
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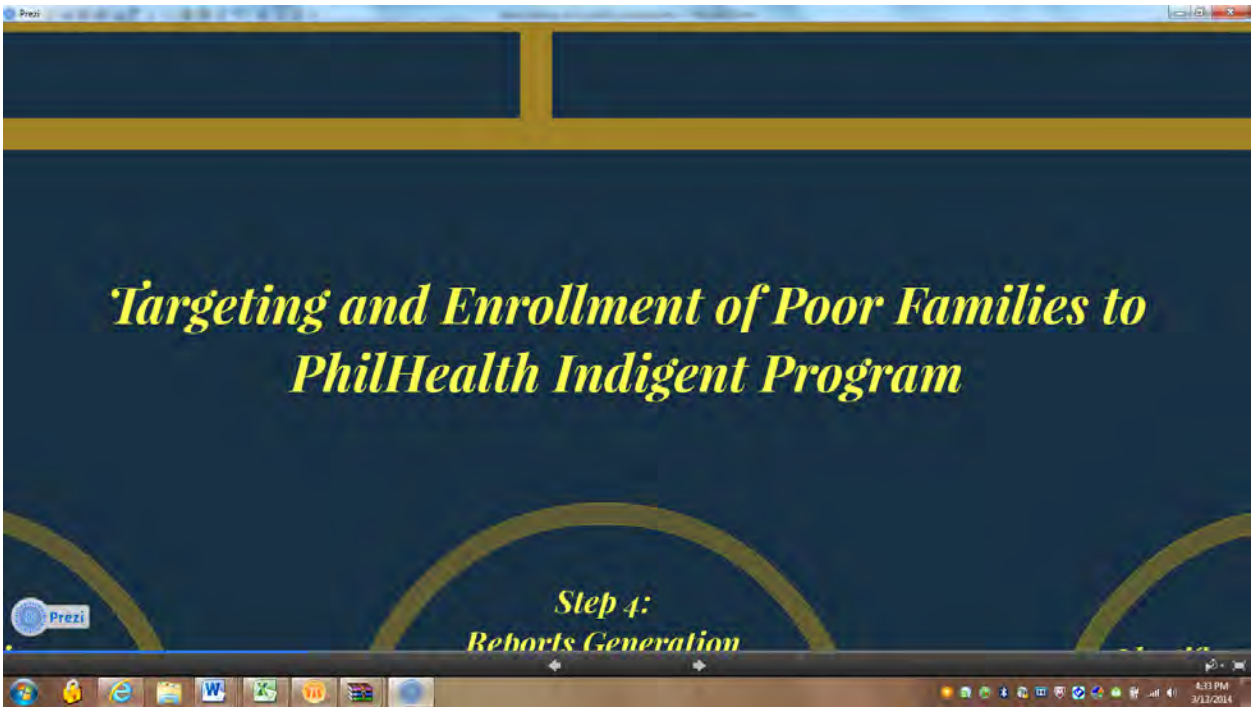
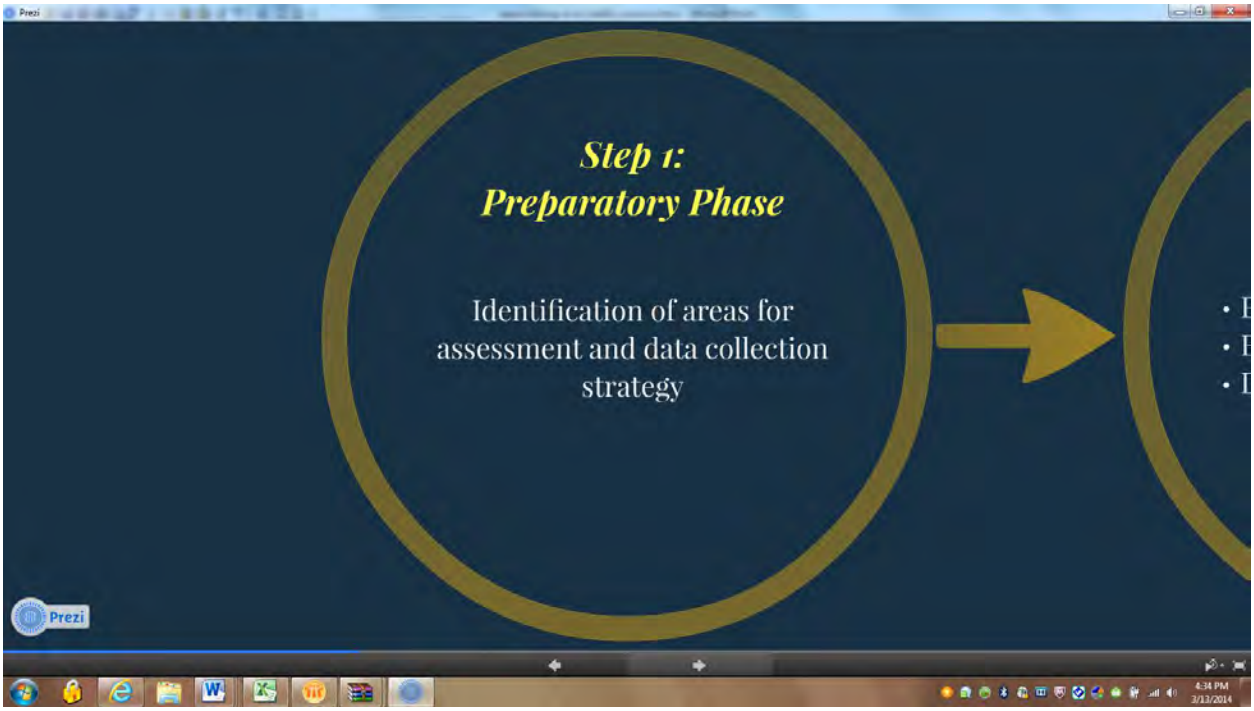
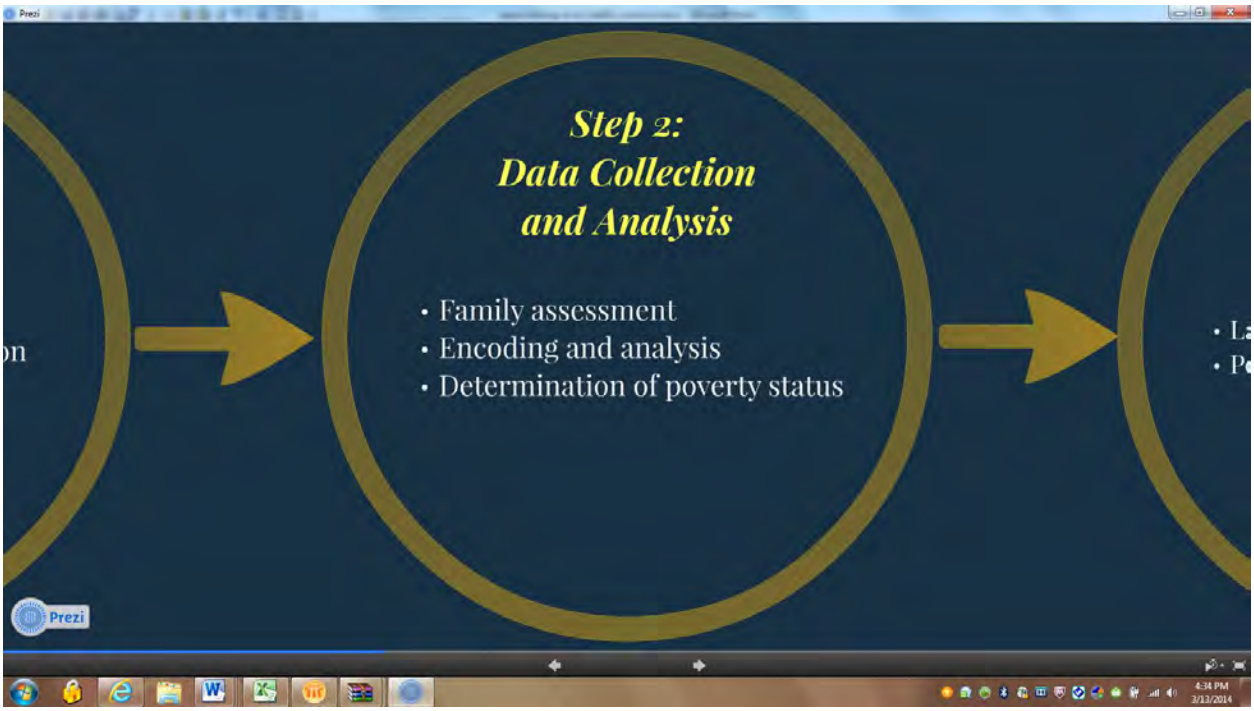

Targeting and Enrollment of Poor Families to PhilHealth Indigent Program
Step 4:
Reports Generation

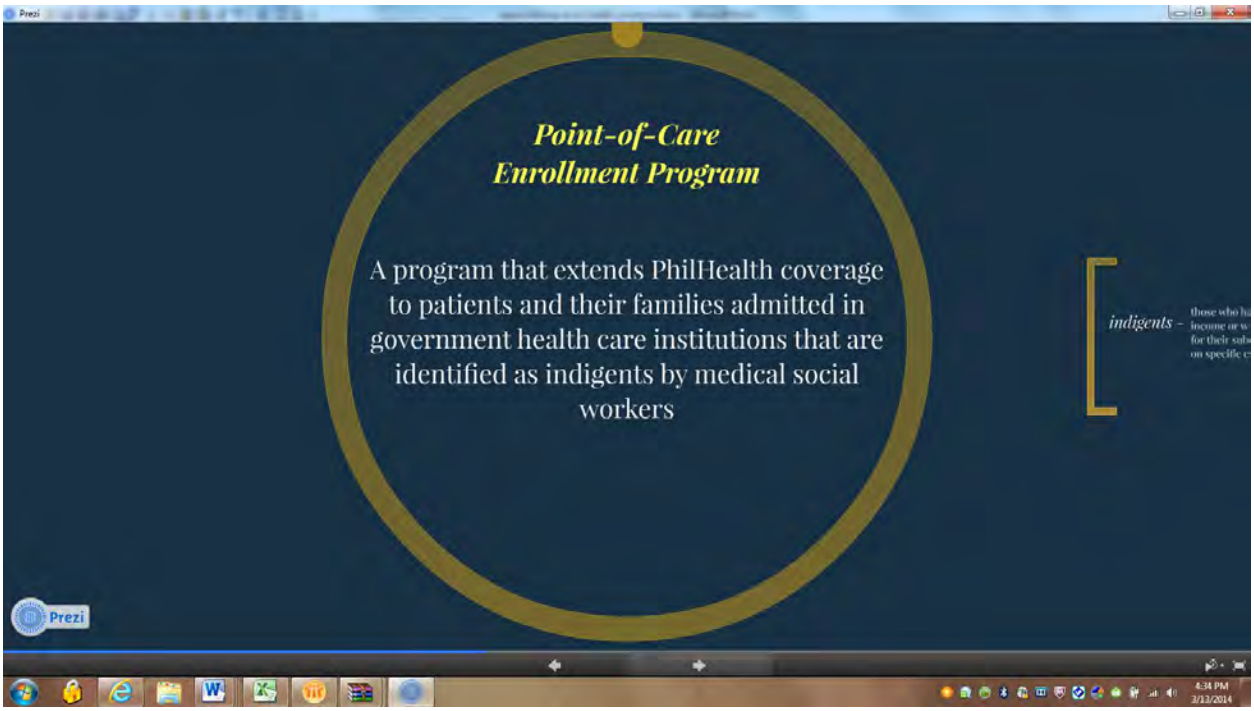

Step 1:
Preparatory Phase
Identification of areas for assessment and data collection strategy

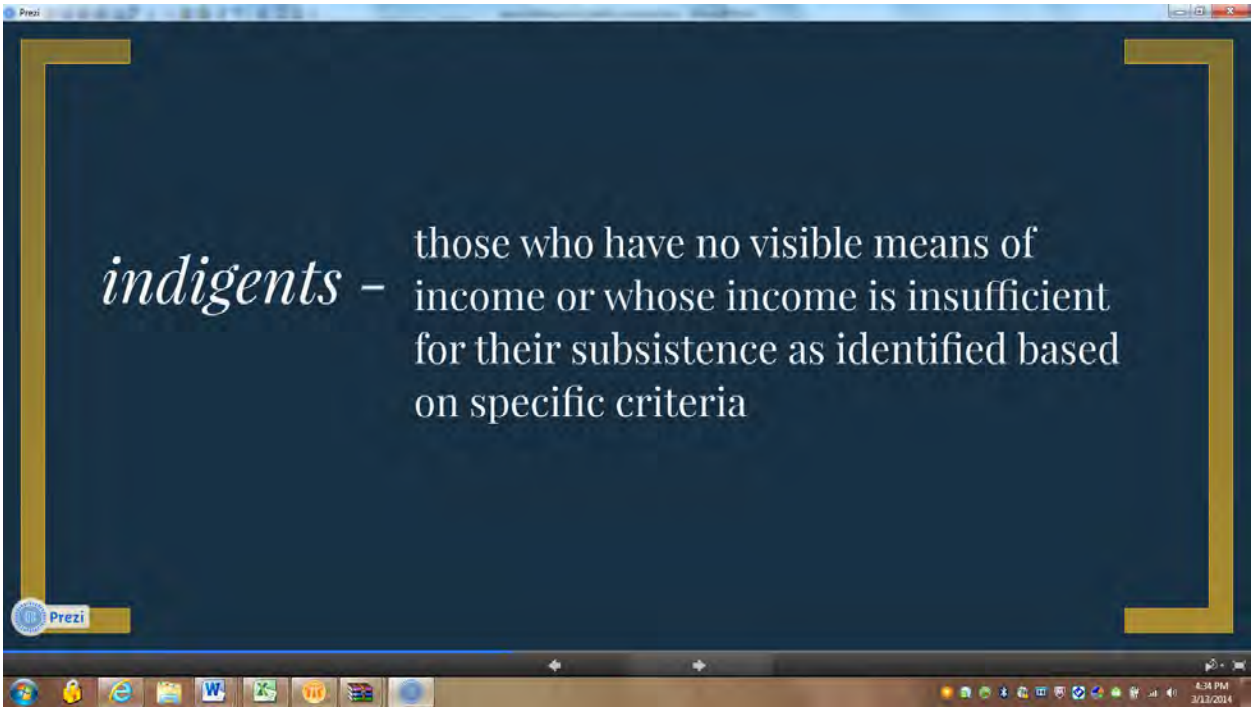

Step 2:
Data Collection
and Analysis
• Family assessment
• Encoding and analysis
• Determination of poverty status
Prezi


Step 3:
Validation
and Finalization
• Launching of on-demand application
• Posting of initial list of poor
Prezi


ation
Step 4:
Reports Generation
• Sharing of the final list of poor
• Use of targeting system thru MOA
• Technical assistance on database management
• Collecting data user feedback
Prezi


Step 5:
Identification of Beneficiaries
• Listahanan identified (includes Pantawid Pamilya beneficiaries)
• Point-of-care
Prezi


Point-of-Care
Enrollment Program
A program that extends PhilHealth coverage to patients and their families admitted in government health care institutions that are identified as indigents by medical social workers
indigents –
Prezi


indigents – those who have no visible means of income or whose income is insufficient for their subsistence as identified based on specific criteria
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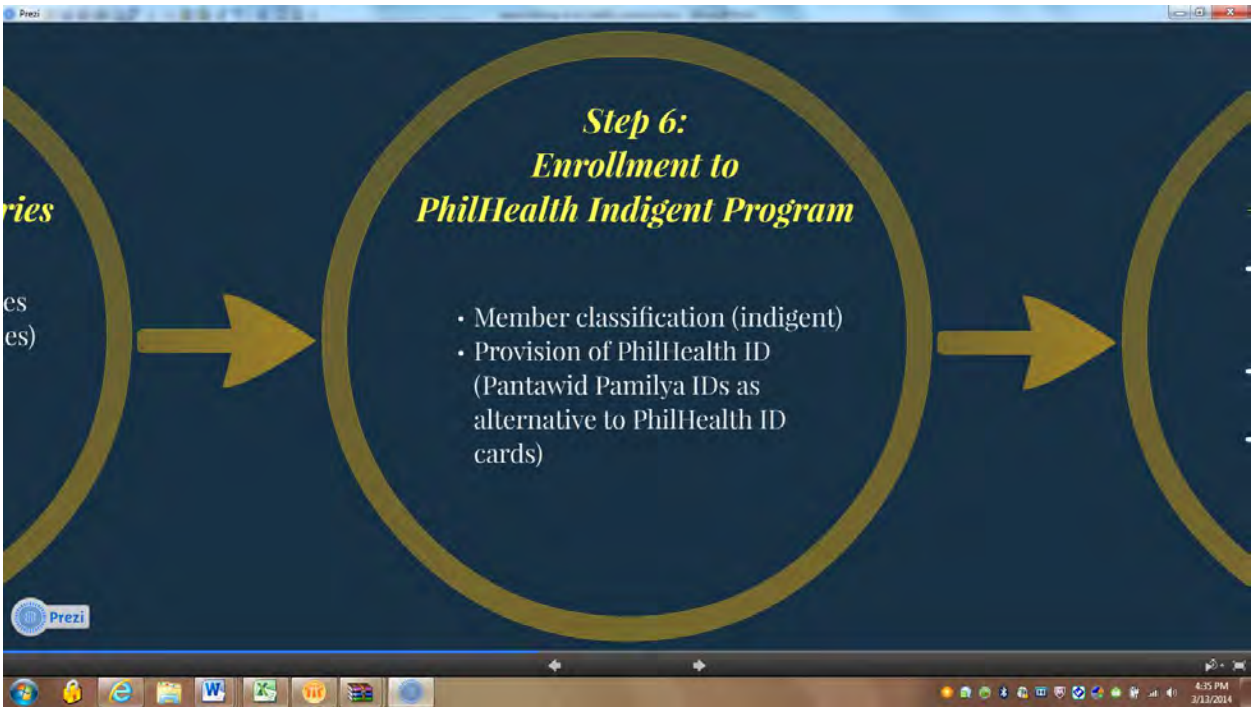
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Step 6:
Enrollment to
PhilHealth Indigent Program
• Member classification (indigent)
• Provision of PhilHealth ID (Pantawid Pamilya IDs as alternative to PhilHealth ID cards)
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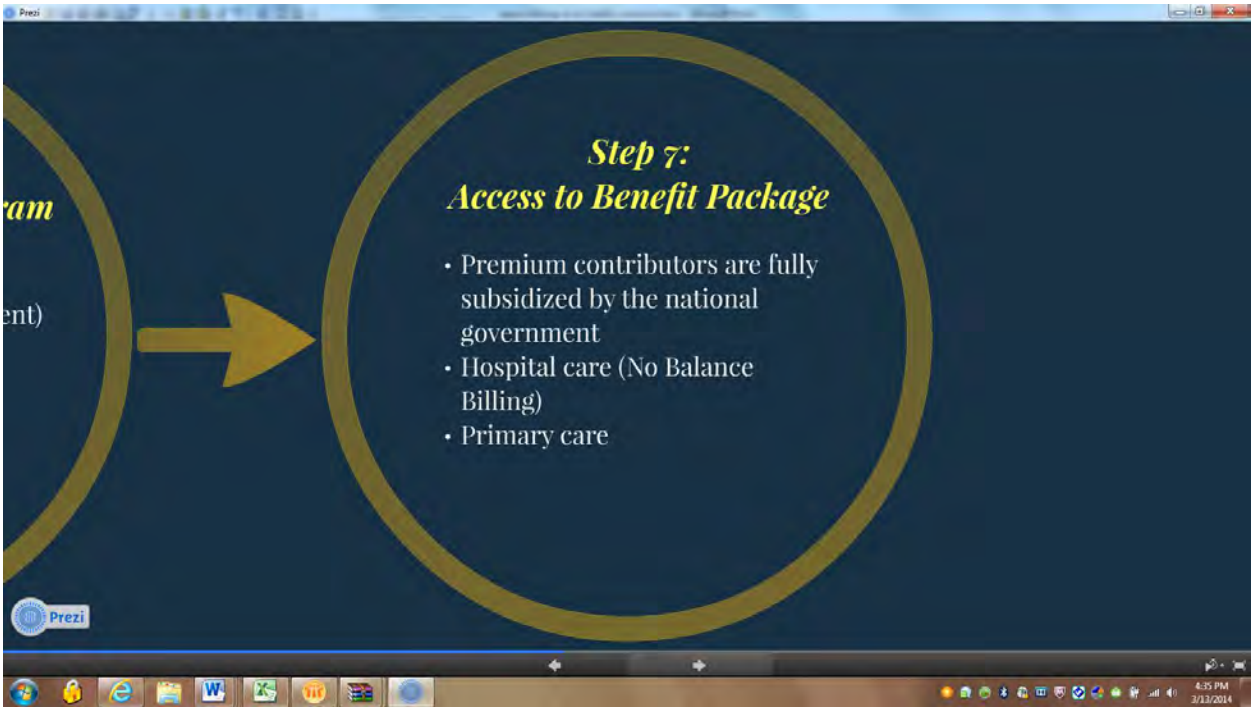
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Step 7:
Access to Benefit Package
• Premium contributors are fully subsidized by the national government
• Hospital care (No Balance Billing)
• Primary care
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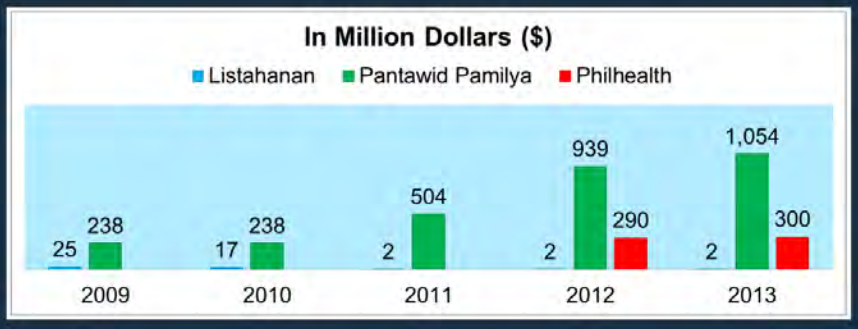
Areas of Collaboration

	Beneficiary Identification	Database Build-Up	Information Technology Integration	Human Resource Complement
DSWD	• Provision of list of poor families	• Data generation • Matching of Family ID number with Member Data Record and PhilHealth ID number • Beneficiary profiling	• Common data format • Common reference number (Family ID Number or PhilHealth ID number) • Vertical integration (functionalities)	
PhilHealth	• Provision of health coverage	• Updating of beneficiary information		• Augment administrative cost

How much did government spend for Listahanan?



- Investment on Listahanan is equivalent to **1.3%** of the total budget of the two (2) social protection programs from 2009 to 2013
- With 91% of Pantawid Pamilya beneficiaries proven to be among the poorest 40%, Listahanan saved the government around PhP27 Bn ($643 M) on CCT and PhP21 Bn ($500 M) on Philhealth from potential leakages


Technologies
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Innovations
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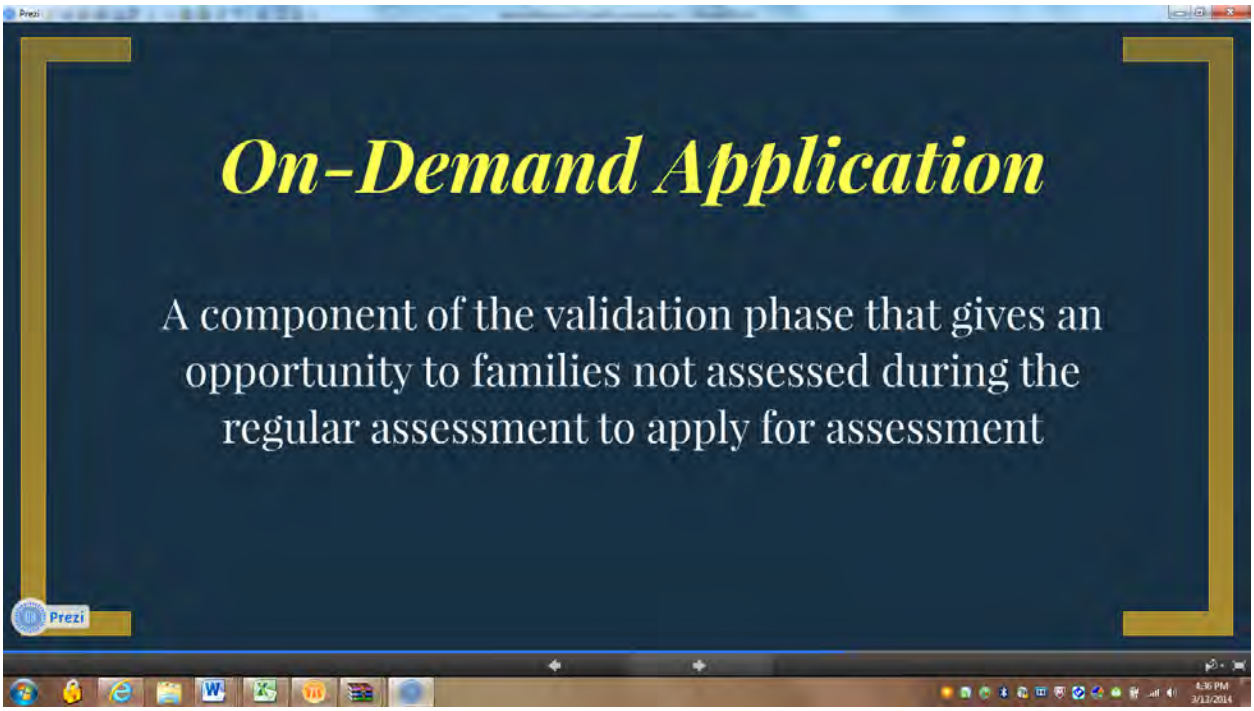
On-Demand Application
A component of the validation phase that gives an opportunity to families not assessed during the regular assessment to apply for assessment
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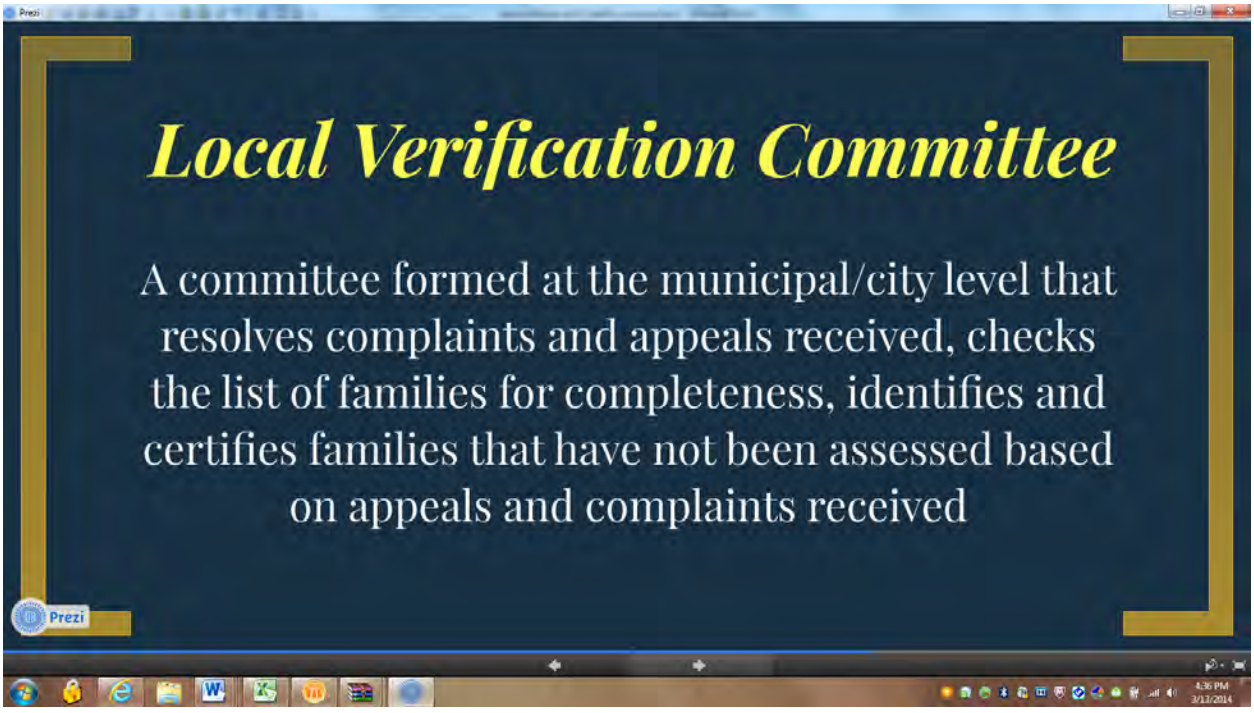
Local Verification Committee
A committee formed at the municipal/city level that resolves complaints and appeals received, checks the list of families for completeness, identifies and certifies families that have not been assessed based on appeals and complaints received
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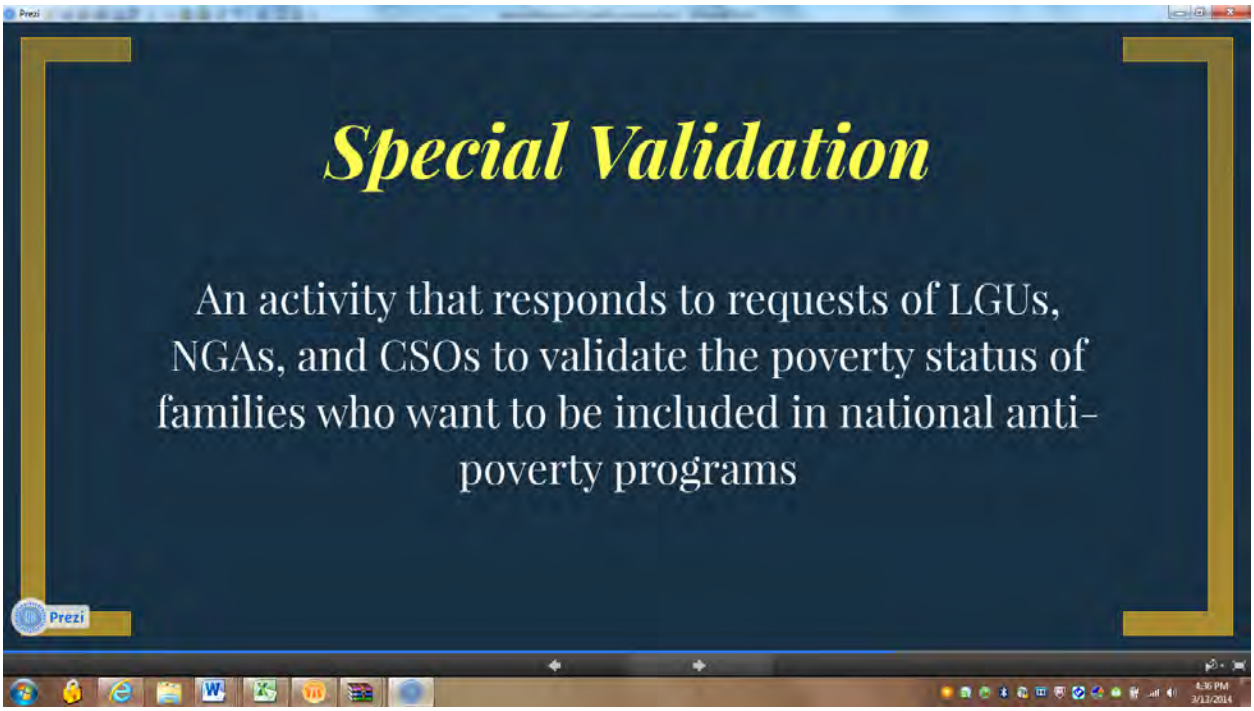
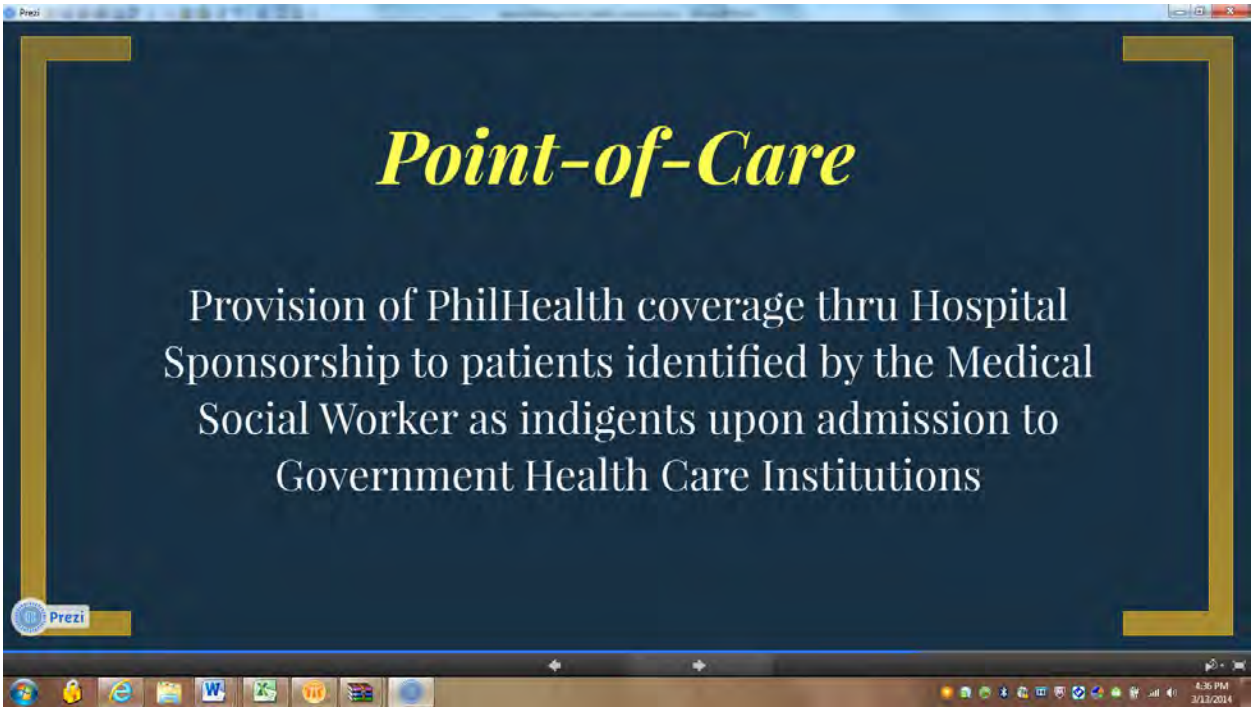

Special Validation
An activity that responds to requests of LGUs, NGAs, and CSOs to validate the poverty status of families who want to be included in national anti-poverty programs
Prezi


Point-of-Care
Provision of PhilHealth coverage thru Hospital Sponsorship to patients identified by the Medical Social Worker as indigents upon admission to Government Health Care Institutions
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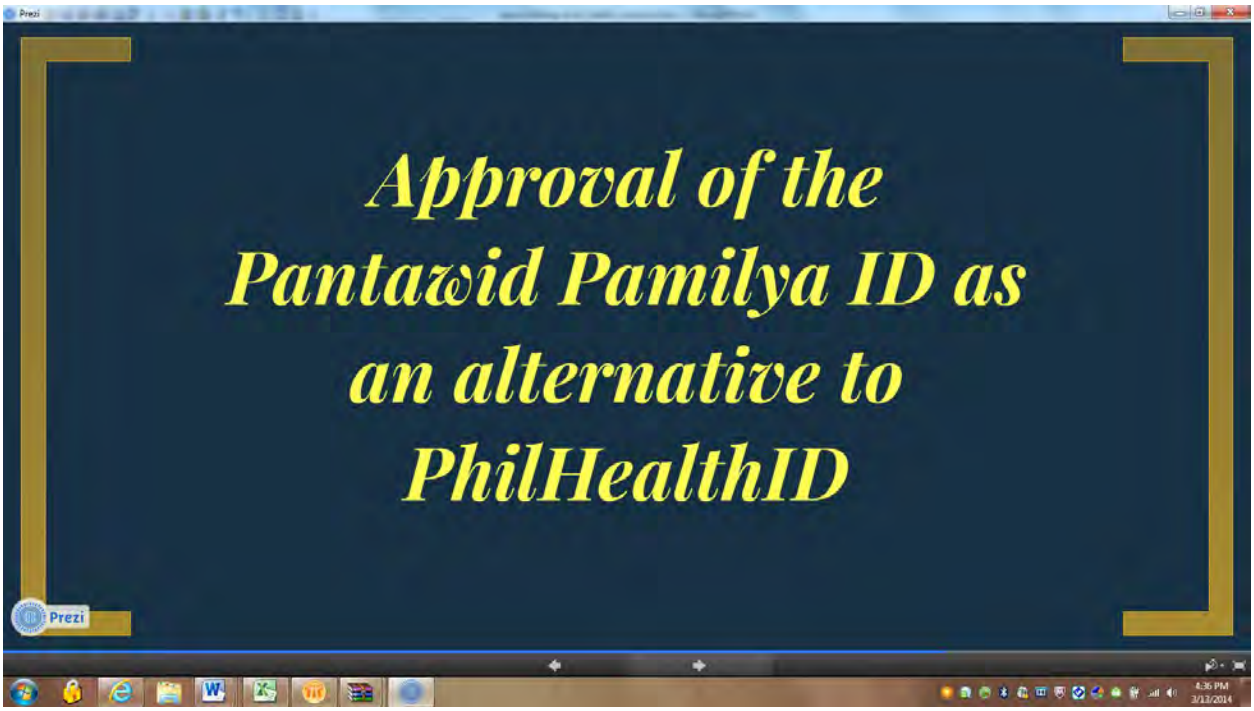
Approval of the
Pantawid Pamilya ID as
an alternative to
PhilHealthID
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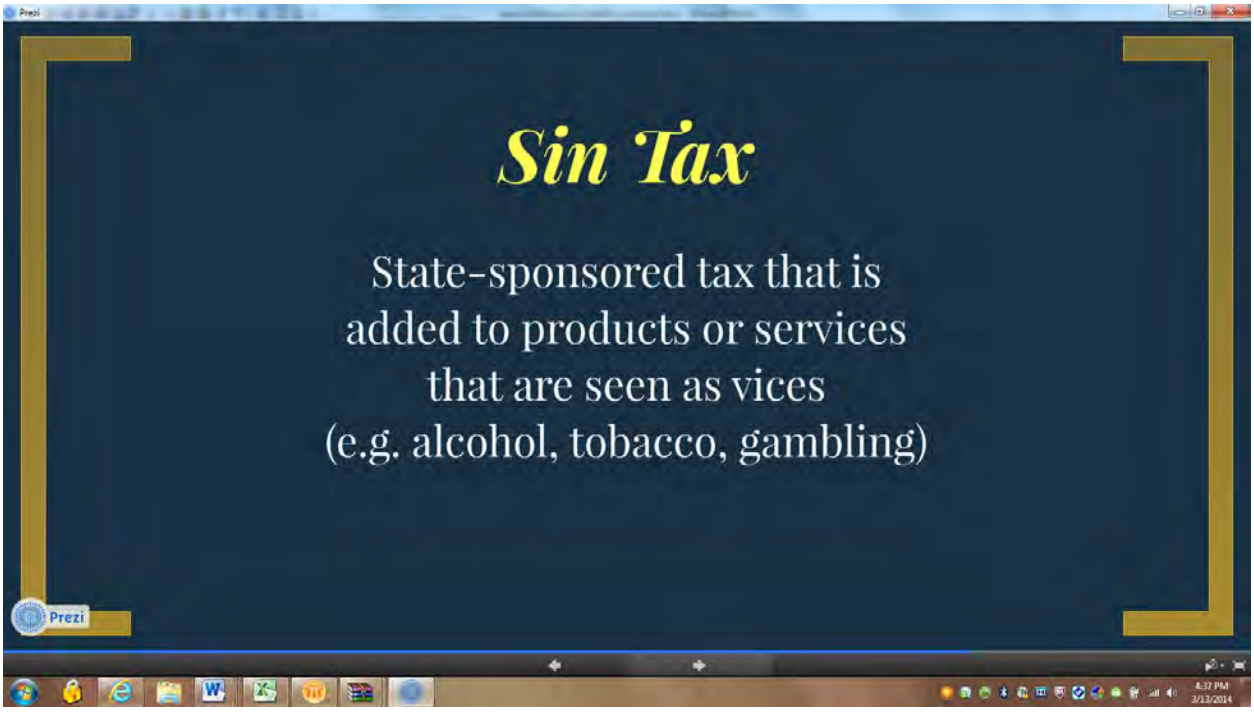
Sin Tax
State-sponsored tax that is
added to products or services
that are seen as vices
(e.g. alcohol, tobacco, gambling)
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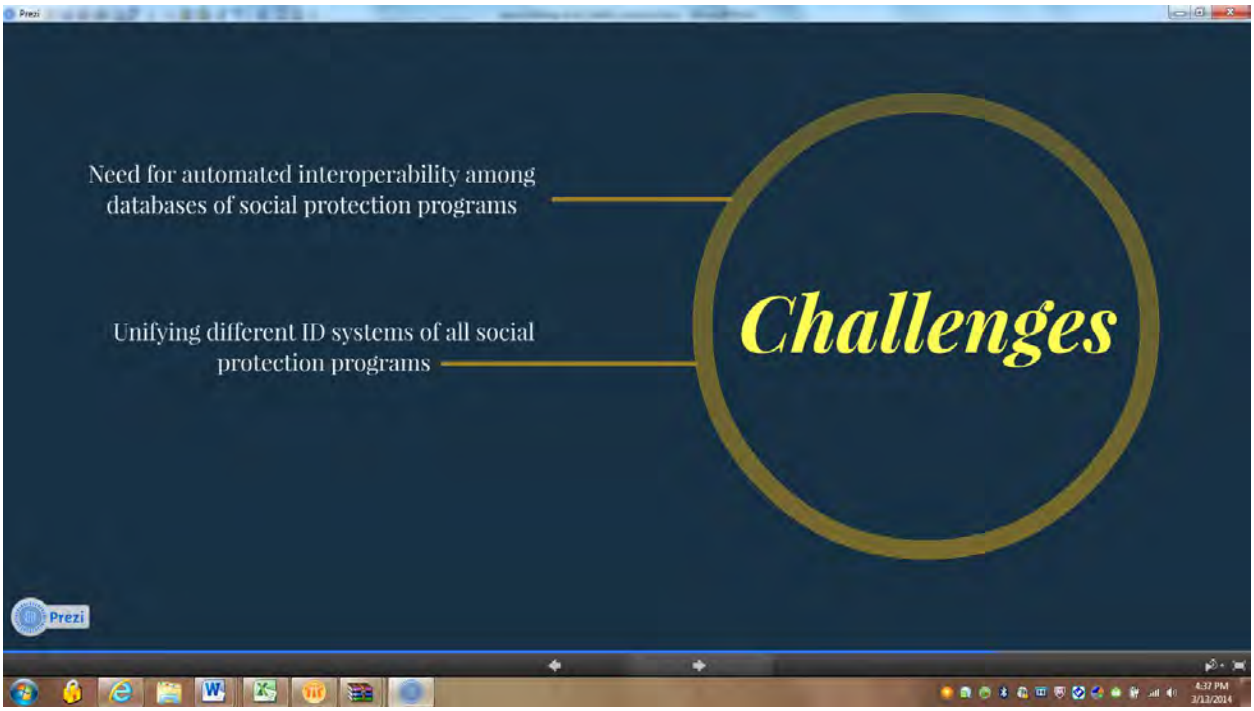
Need for automated interoperability among databases of social protection programs
Unifying different ID systems of all social protection programs
Challenges
Prezi


Lessons Learned
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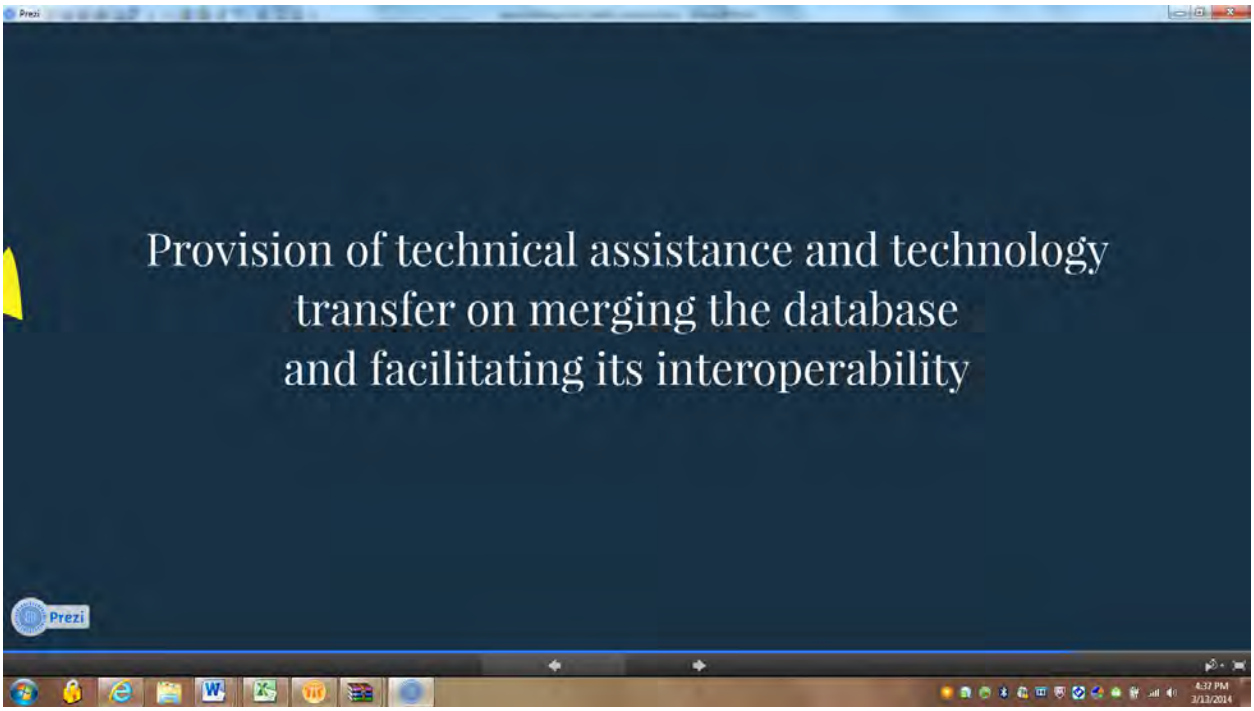
Provision of technical assistance and technology
transfer on merging the database
and facilitating its interoperability
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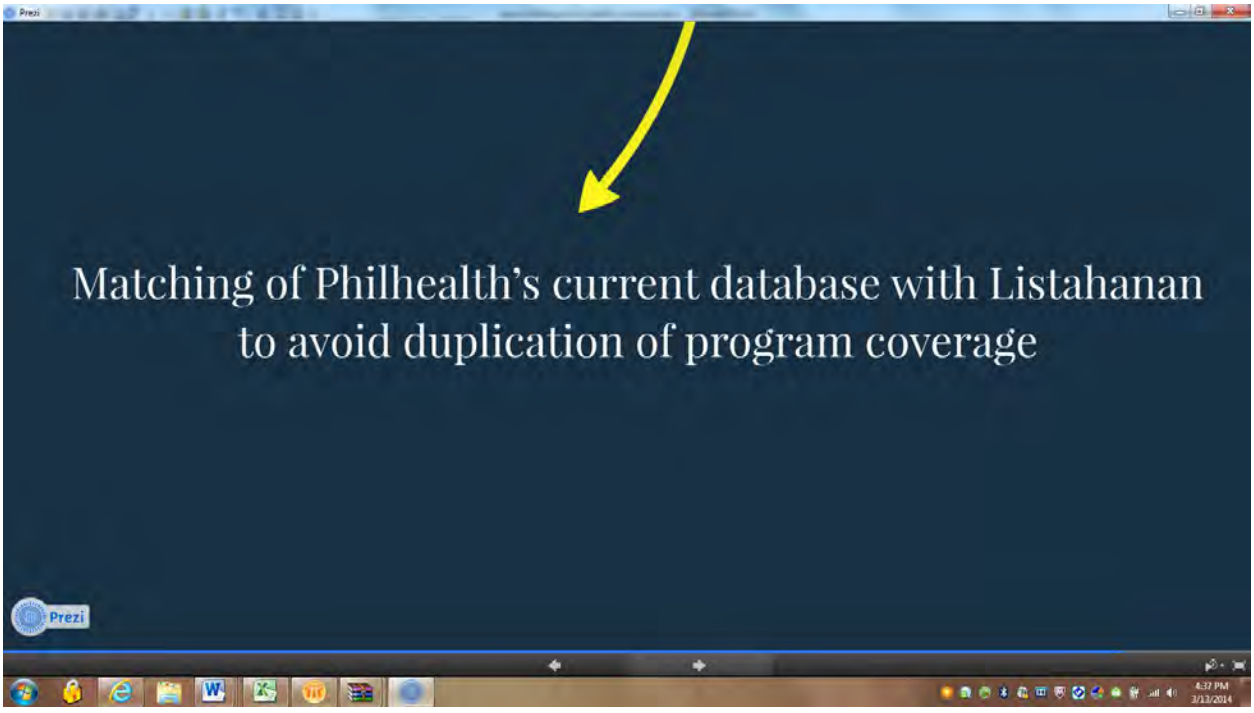
Matching of Philhealth's current database with Listahanan
to avoid duplication of program coverage
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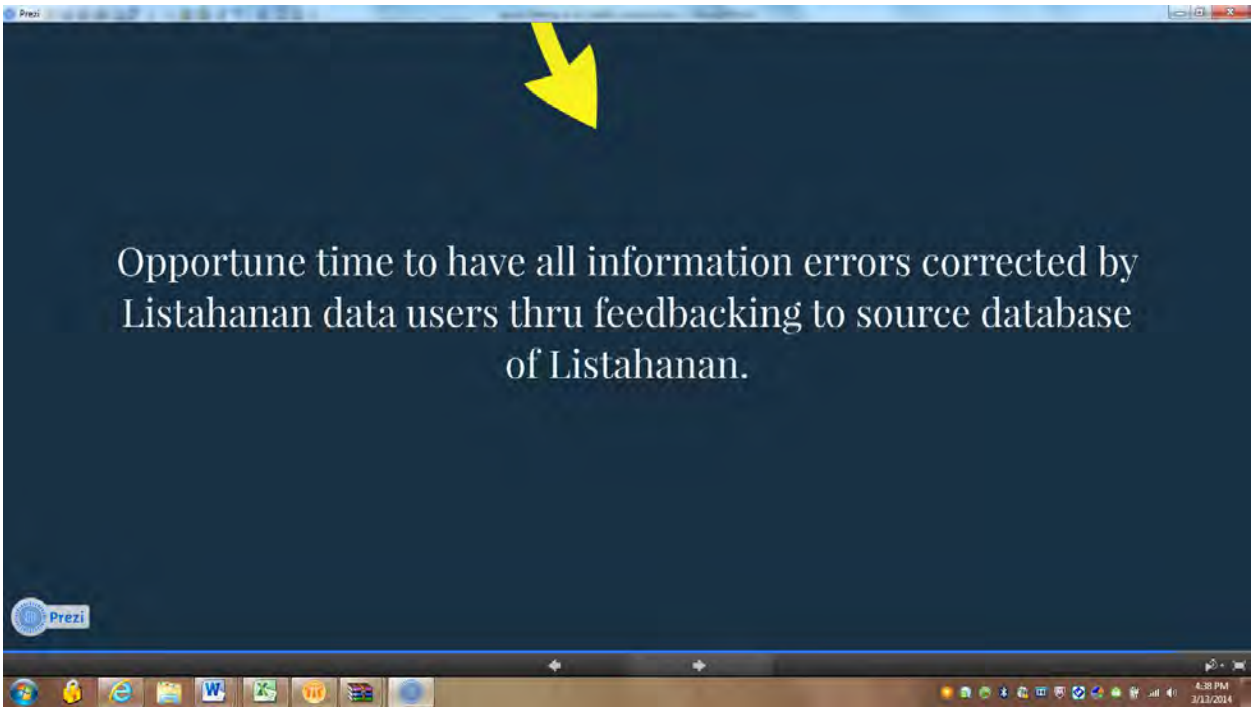
Opportune time to have all information errors corrected by Listahanan data users thru feedbacking to source database of Listahanan.
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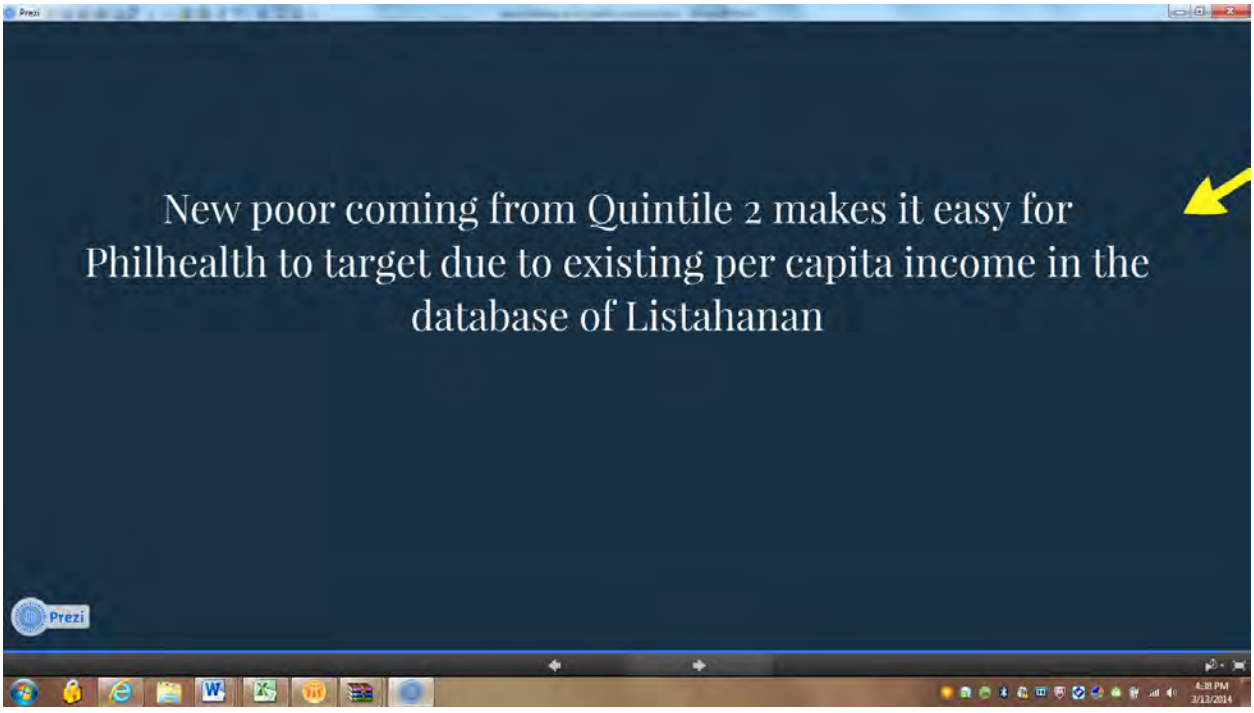
New poor coming from Quintile 2 makes it easy for Philhealth to target due to existing per capita income in the database of Listahanan
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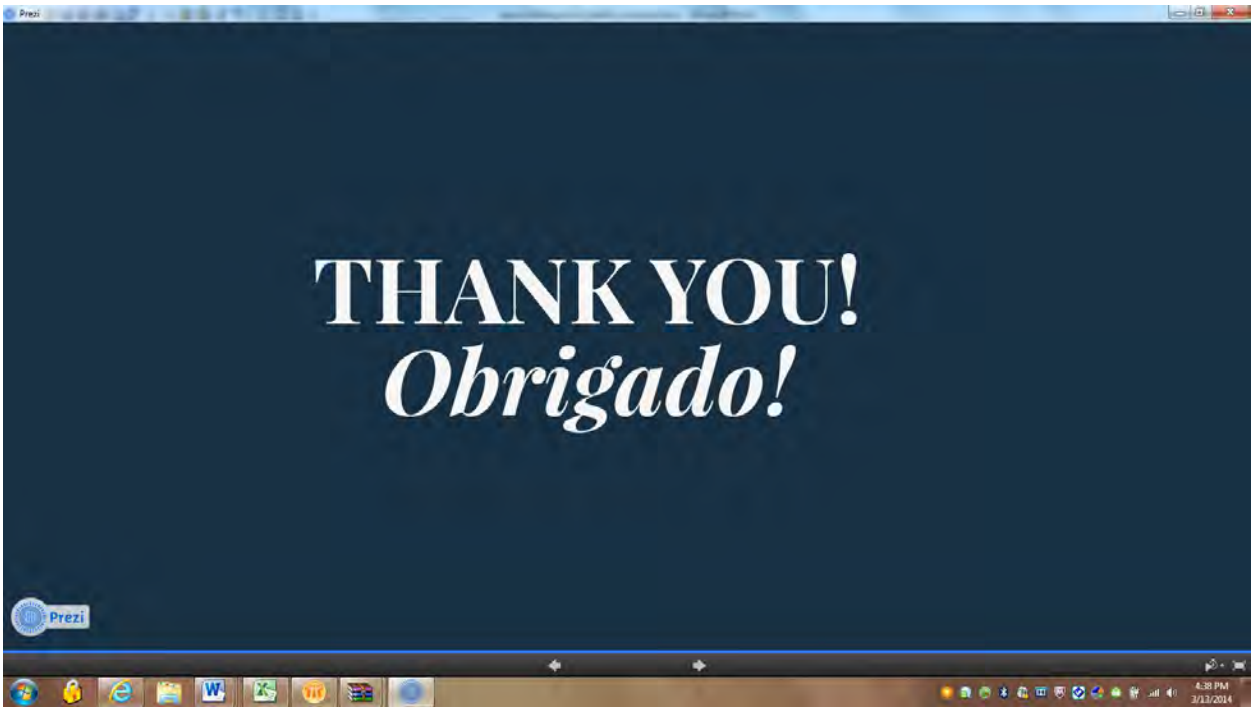
THANK YOU!
Obrigado!
Prezi