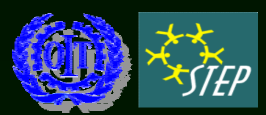


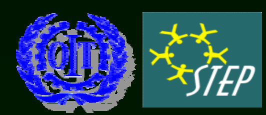
Community Risk Sharing Arrangements in Latin America

"Servicio Solidario de Salud de la CGTG"

GUATEMALA

Strategies and Tools against social Exclusion and Poverty

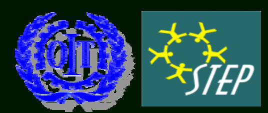
Cristian Baeza
Regional Director Latin America and the Caribbean
ILO - STEP



Part of STEP global program

- Global program of ILO on extending social protection in health and combating social exclusion through a synergic combination of conceptual and research work as well implementation of deeply rooted local and community based project

- 30 Field and research projects in 19 countries in 4 regions (Africa, Asia, Latin America and Eastern Europe)
  - Bangladesh, India, Nepal, Philippines, Argentina, Haiti, Dominican Republic, Chile, Gambia, Ghana, Kosovo, Tanzania, Mauritius,, Benin, Mali, Senegal, Burkina Faso, Guinea and Albania



STEP Global Program

- **4 Main Research Projects**
  - ILO-STEP / PAHO study for LAC
  - ILO-STEP / World Bank joint research on Purchasing and Pooling
  - STEP Worldwide compendium (more than 100 cases, to be published Oct. 2000)
  - Joint ILO-STEP / IBRD (HDD) / WHO (GPE) initiative on extension of social protection in health
- **33 Publications on Micro Health Insurance**

http://www.ilo.org/public/english/protection/socsec/step/frame.htm

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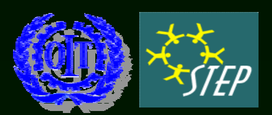

LAC Case Study

(ILO-STEP in collaboration with PAHO)

Obra Social Municipal Trenque Lauquén	Argentina
Seguro de Salud Universal de IPTK	Bolivia
Fondo Comunitario de Salud	Bolivia
Empresa Solidaria de Salud Coesperanza	Colombia
Seguro Comunitario de Solano	Ecuador
Policlínica Única J. Pedro Valera	Uruguay

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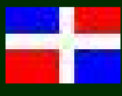
LAC Case Study

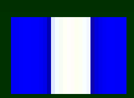
(ILO-STEP in collaboration with PAHO)

Fundación de Desarrollo Nacional — Honduras

Asociación Mutua del Campo — Nicaragua

Seguro Agricultor las Yaras Tacna Peru

Asociación Mutual de Trabajadores de los Bateyes  Dominican Republic

Servicio Solidario de Salud de la CGTG  Guatemala

GUATEMALA CGTG
Origin

- **Whose idea:** Trade union associated to CGTG
- **Why:** Target group had no social protection in health
  - Income: poor indigenous and low income informal sector
  - Legal: Informal sector has no access to Social Security Agency
  - Lack of quality and/or too expensive services by SS.
- **Who initiated:** Led by special Committee of CGTG with
  - Support from Spanish donor (CESAL, technical assistance)
  - Voluntary doctors
  - National training institute (IGEFOS, for consultative seminars)
- **When started:** Official inauguration in 1996 but, only in 1998 it started to receive premium payments by members of CGTG

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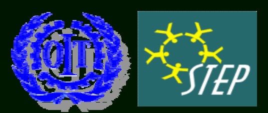
GUATEMALA CGTG
Design

- **When and how:** **1996 with CGTG members participation**
  - **General Assemblies, seminars and meetings by associated unions**
  - **Needs assessment discussions and basic surveys**
  - **Basic Feasibility studies which were the base for defining objectives, beneficiary package and premiums**
- **Basic features at design**
  - **Location:** **Urban and sub-urban area of Guatemala City, Guatemala**
  - **Affiliation:** **members of CGTG, individual and voluntary with family members as additional beneficiaries (spouse/partner and children below 18 years)**
  - **Financing:**
    - **Founding grant from donors (CESAL and COLACOT)**
    - **Flat (non risk related, non benefit package related) contributions for members**
    - **Single benefit package, mainly PHC, with pharmaceuticals and Lab exams at subsidized prices**

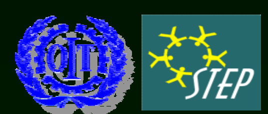
Summary Current Status

- **Location:** Still mainly Urban and sub-urban area of Guatemala City, Guatemala
- **Affiliation:** Individual Voluntary affiliation for Members of CGTG, with family members as additional beneficiaries (spouse/partner and children below 18 years of age) and, recently, non members of CGTG under same conditions except the premium price.
- **Total Scheme Members:** 948 members (down from 1,150 in 1998), of which 40% women, with approximately 4,740 beneficiaries



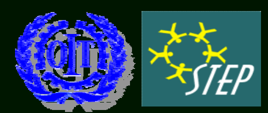
Management

- **Executive Committee** CGTG (highest body)- 9 members elected by members' Assembly responsible for general guidelines and final decisions
- **Health Service Commission** (administrative body) - 3 members including Administrator and two members of Executive Committee responsible for overall scheme administration
- **Members** – Through general and specific assemblies meetings and complaint box as well as CGTG election, influencing service package, premium amount and administration through assemblies,
- **Information Management** : various registries and forms, budget, balance sheet, financial statements, periodical reports but NO indicators of "technical cost" performance.
- **Control mechanism**: various internal controls (a.o. accountability, small safe, eligibility, inventory), annual audit CGTG



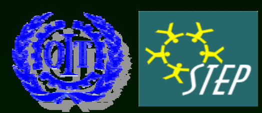
Provision and Provider Payment

- **Own Provision:** Through One health post - One doctor, one nurse and one laboratory staff on contract basis elected by Executive Committee and responsible for
  - Checking eligibility,
  - Providing primary health care,
  - Selling of pharmaceuticals at low prices (subsidized?)
  - Selling of Lab. Exams at low prices (subsidized?)
- **Health promoters** – Scheme members who have received training and perform training and health education for free



Affiliation and Benefits Administration

- Single benefit package: based on most common diseases, capacity and “interest” to pay of target group, existing resources to acquire necessary equipment (services at subsidized price)
- NO legal recognition
- Annual affiliation yet
- Cancellation after three month of no contribution or when moving out of the scheme defined geographical area
- Affiliation procedure:
  - Eligibility check: Done by health post personnel, with family data sheet and issuance of family identification card
  - Initial payment at affiliation: pay subscription fee (less than US$1), first month premium and one day salary--if member of CGTG



Financing

- Founding Grants by donors:
  - CESAL (for construction of health post and equipment)
  - COLACOT
- Premiums
  - Monthly Premiums (flat rate): US$2 per member (family members are non-paying beneficiaries) for CGTG members and US$4 for non CGTG members
  - Premiums were set based on capacity to pay (adjusted since 1998). Not risk related and not adjusted according to scheme expenses
- Other operational revenue
  - One day salary on subscription, only for CGTG members (US$2.67)
  - Enrolment fee (US$0.67) for CGTG members and US$2,67 for non-members

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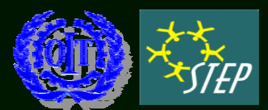
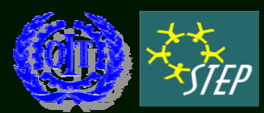


Source of Financing

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



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In the LAC context

Case	Self-financing	Participation in management	Coordination with health system
Colombia	Nearly 0%	+++	+++
Uruguay	100%	+++	
Argentina	30%	+	+++
Tupiza – Bolivia	21%	+++	++
Guatemala	80%	++	
Dominican Rep.	35%	++	
IPTK – Bolivia	24%	+	
Nicaragua	33%	++	
Ecuador	60%	+	++
Peru	28%	+	++
Honduras	N/A	+	

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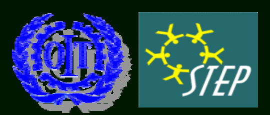
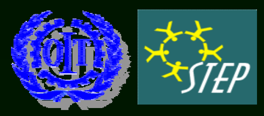


Penetration

Case	Penetration achieved (%)
Colombia	85 %
Tupiza – Bolivia	30 %
Uruguay	100 %
Dominican Rep.	6 %
Nicaragua	12,5 %
Guatemala	6 %
IPTK – Bolivia	10 %
Argentina	50 % (estimated)
Ecuador	23,6 %
Peru	10 %
Honduras	No information



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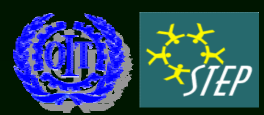
Conclusions

- **Micro-Health insurance includes a variety of very different community risk sharing arrangements:**
  - **Different levels of auto-financing and external subsidies. None of the studied schemes are financially self-sufficient. The importance of the role of subsidies.**
  - **Different levels of community involvement in management and benefits setting and administration**



Conclusions

- Most schemes are fairly recent (average aprox. 3 years). Sustainability issue still pending

- Most challenging issues:
  - Benefits administration, including setting the package, paying providers and ensuring eligibility for claims
  - Financial management including premium setting and collection and adverse selection