THE INTERVIEW: ANNA LUCILA A. ASANZA

SOCIAL SECURITY EXPERT

Interview with Anna Lucila A. Asanza, social security expert and physician with more than ten years of experience in the Philippines

MICRO INSURANCE AND SOCIAL SECURITY IN ASIA

AMIN: In your opinion, is micro Insurance a sustainable and efficient solution for the extension of social protection in Asia? Do strategies based on MI schemes meet objectives in terms of extending social protection to excluded groups (informal economy and rural workers)?

Anna: I believe that microinsurance is an efficient solution for the extension of social protection in Asia but I also strongly believe that for it to be truly sustainable, there should be equity. Governments have to support these types of organizations through subsidies to introduce some redistribution in the whole system. I don't think it is right for informal sector workers to fully bear the burden of protecting themselves against illness. I think that microinsurance meets the objectives of extending social protection to excluded groups. Right now, only microinsurance provides social protection to the excluded as most governments are at a loss on how to effectively begin such work.

AMIN: What are the challenges and barriers that hinder the extension of coverage to all?

Anna: I see several challenges at the moment in the extension of coverage to all:

- Most national social security schemes do not trust organizations that they should work with in order to extend coverage to informal economy workers. Likewise, there is also some element of mistrust among the private sector or community-based organizations of national agencies. I think that to be able to provide wider coverage, there should really be collaboration between national agencies and community-based organizations.
- The benefits of social protection schemes like health insurance are not well appreciated by workers in the informal economy. Workers in the informal economy are not even aware that social protection is their right and that these mechanisms are meant to provide them with protection in times of certain risks. Not knowing that they are entitled to social protection and the responsibility that goes with it, it really takes some time for workers in the informal economy to understand the principles and benefits of several social protection schemes.

MICRO INSURANCE AND SOCIAL SECURITY IN THE PHILIPPINES

AMIN: You were part of the team that implemented the PhilHealth Programme in the Philippines. Later you evaluated it on its extension of health insurance coverage before implementing a pilot scheme linking PhilHealth with organized groups.

First of all, could you briefly explain the POGI and KASAPI programmes of social health insurance within PhilHealth?

Anna: PhilHealth is the agency administering the National Health Insurance Programme in the Philippines. A member of PhilHealth may have his/her spouse, children (legitimate, illegitimate and adopted children below 21y/o, physically and mentally dependent children) or parents over 60 y/o as beneficiaries. Universal coverage is part of

the programme's mandate but like most social security schemes, the program has a stronger and bigger membership base among the formally employed.

POGI or PhilHealth Organized Group Initiative is the first scheme that PhilHealth has tested to extend social protection to workers in the informal economy. POGI collaborated with cooperatives so they could lead in marketing to, recruitment of and collection of payments from members. Cooperatives are ranked based on their capacity to perform the above-mentioned tasks and are given incentives based on these tasks. A WHO-GTZ-ILO consortium evaluation revealed the following:

1. Members appreciated the ease of paying PhilHealth premiums to cooperatives which are easily accessible to them. Partnering with cooperatives also made members more aware of benefits that PhilHealth could offer since these community organizations are close to their constituents.
2. PhilHealth is an added service for cooperatives which they believe made prospective clients/members value the organization more highly.
3. The program did not attract as much membership as envisioned because of several factors: (a) there is an existing government program to enrol indigents and members tend to wait to see if they could be recipients of this program, (b) the accredited providers are not well equipped to provide services, (c) membership is voluntary.
4. During the evaluation, cooperatives felt that the program had a high transaction cost for them because they lead in the marketing, collection and remittal of payments to PhilHealth which has an office 2 to 3 hours away from the province. The incentives provided by PhilHealth were not enough to cover administrative cost.
5. There were very high out-of-pocket payments for members because of the cost of drugs and medicines which are not usually available in government hospitals. Members tend to buy their drugs from private pharmacies.

With the intention of registering more members at a greatly reduced cost both for PhilHealth and for organized groups, PhilHealth introduced KASAPI or Kalusugang Sigurado sa PhilHealth Insurance (*Assured Health through PhilHealth Insurance*). KASAPI worked with bigger community organizations like microfinance organizations, mutual benefit associations or bigger cooperatives. Bigger premium discounts are given to larger volume entities. Organizations still lead the marketing, recruitment, payment collection and assistance of members when they avail themselves of services from accredited providers. PhilHealth provides assistance during marketing and promotional activities and secures availability of enrolment and claim forms as well as a membership database that directly links information from the organized groups' station to PhilHealth's database.

AMIN: What are the key features of PhilHealth's Kasapi Programme and which of those could be replicated in other countries?

Anna: I think that there are two values that KASAPI could share with other countries: (1) a social security scheme can extend coverage to the informal economy workers by working with organizations that already work closely with them such as cooperatives, micro-finance institutions and the like, and (2) there is no need to create a separate fund for the informal economy workers fostering solidarity as a nation. Of course, the element of trust from both parties – government and the private sector, in this case a community organization – has to be present. If this can be replicated then the ideal situation of the rich protecting the poor and the healthy taking care of the sick is possible in its truest sense.

AMIN: What is the current coverage of PhilHealth? What is the current coverage of the KASAPI Programme?

Anna: As of December 2008, PhilHealth claims to cover 60% of the population which is approximately 49 million people. From the same reference point, KASAPI had 12,000 members or approximately 60,000 beneficiaries which is still very small. Organized groups still have a wait and see attitude because there are still a lot of challenges that PhilHealth has to respond to, like fixing the link between its database and that of the organizations, prompt service of PhilHealth personnel especially relating to needs of the organizations and ensuring that members of the organizations who decided to enrol in PhilHealth get quality service and minimal out-of-pocket payments.

Another reason for low membership that is being investigated is the type of services being covered by PhilHealth. Admittedly, several organizations and many of their members feel that out-patient care should be covered, among other things in order to prevent riskier and more expensive hospital care. At present, PhilHealth covers in-patient care plus some out-patient services such as chemotherapy, radiotherapy and haemodialysis. PhilHealth has to make sure that accredited providers improve their services and, until then, it cannot ask its partner organizations to make membership compulsory or automatic.

AMIN: Are there barriers to the extension of this programme? How could this programme be further extended and improved?

Anna: As mentioned above, the type of medical care covered by PhilHealth is considered a barrier to encouraging more members to participate. Other barriers to extension could be:

- The type of service that accredited health providers give. Most members of KASAPI partners go to government-owned hospitals which do not really provide that good a service, while going to privately-owned facilities do not really give members better financial protection.
- PhilHealth has to be more prepared to handle collaboration with partner organizations. Admittedly, those are not its usual clients and PhilHealth should have a unit dedicated to respond to their needs. Otherwise those organizations might feel - as some already do - that the partnership is not worth the effort.

AMIN: Could you explain what the MI MBA is? What is the MI MBA's role?

Anna: A mutual benefit association (MBA) is a community-based organization providing social protection services to members who are not formally employed. In the Philippines, these organizations offer life insurance, health insurance, credit insurance, death benefits and the like to members of organizations like cooperatives and micro-finance institutions. They usually ride on ("piggy back") collection activities of micro-finance institutions or cooperatives.

Almost all the countries with SHI systems and large informal economic forces seem to have tried to solve the problem using substantial state subsidies. However, this does not seem feasible in the Philippines. What kind of tools can be used then?

First, PhilHealth together with the national and local government subsidizes the premiums for the very poor but, as it is, there is a need to develop a better tool for identifying the poor. A better means testing tool is needed to give benefits to those who truly deserve to receive free membership.
Second, I think that the government should support the "thinking" of community organizations that the entrepreneurial capacity of the poor has to be supported in order to lift them out of poverty. And social security organizations like PhilHealth can support these initiatives by offering their services to these organizations. PhilHealth could protect the "working" poor from the risk of illness by partnering with organizations, who work more closely with the poor, improving their services in order to better respond to the needs of the poor.

HEALTH CARE SUPPLY

AMIN: How is health care supply organized in the Philippines? Who are the main actors?

Anna: There are two main groups of providers in the Philippines:

1. Government providers
2. Private providers

Government providers handle public health care, primary health care and hospitals (primary to tertiary types). They provide public and primary health care for free and ask for a minimal fee for hospital care, which usually consists of the cost of drugs, diagnostic services and operating room costs.
Private providers offer the same type of services for a higher fee. The services provided by private health care providers are admittedly much better than government facilities.
There are more privately owned facilities than government facilities. However, unlike privately owned facilities which can only establish their practice in populated areas, government facilities can also be found in remote communities.

AMIN: As almost 50% of all bed capacity in the country is provided by the private sector, how

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can the public sector have an impact on the evolution of the private sector or work with it?

Anna: The government encourages private-public partnerships but there is really no active and lasting collaboration as of now. The two entities have not created a seamless relationship that takes advantages of their strengths and support weaknesses of each entity.

AMIN: Is there a specific maternal and child care policy at the national / district level in the Philippines? Are there specific initiatives at the community level? What has been done and what could be done to further reduce maternal death and improve maternal and child-care?

Anna: A program on maternal, newborn, child health and nutrition (MNCHN) is established in the country. This is established by the national government through the Department of Health but has to be implemented by the local government units, which is a challenge right now because there are two different types of government agencies implementing the same program. The policy encourages linkages with the private sector during its implementation, for constituents to have a more comprehensive service.
I am not aware of specific activities at the community level, but I am aware that the national government has advocated for local governments to have outreaching activities to promote and provide MNCHN services.
At present, the national government is extending a performance-based grant facility to local government units (LGUs) that effectively provide MNCHN services to their constituents.

CAREER PATH

AMIN: What were your activities within the STEP programme? What were the objectives, activities and main achievements of the project you were managing?

Anna: The main objective of the project was to extend social protection to women in the informal economy. However, when we were trying to evaluate how to effectively introduce the project, the need to include men came up. We did not want to put additional burden on women by sending the message that only women will be included in the project when we believed that health is a concern of both men and women in families.

The project worked with the Department of Agrarian Reform (DAR), which introduced a community-based health insurance scheme to its beneficiaries. The project of DAR basically aimed at protecting their beneficiaries from the effects of illness. They have explored the possibility of enrolling them in PhilHealth but the premiums are too high for their beneficiaries. DAR and farmer cooperatives were given inputs on the setting-up, management, monitoring and evaluation of health insurance schemes. A training manual was produced after the conclusion of the project, which served as guide to field staff of DAR. Up to the present, that is already 3 years after the project, DAR's initiative is still going strong. They are now in the process of developing linkages with PhilHealth to increase benefits of DAR beneficiaries.
I also worked with a local government unit (LGU) which supported a women's organization in setting up a health micro-insurance scheme. The project was able to assist the women with the feasibility study as well as looking for health care providers.

AMIN: You have worked within the International Programme for the Elimination of Child Labour (IPEC) of the International Labour Organization. Can you explain to us what your tasks were?

Anna: I had a short-term consultancy with them after the STEP project to assess the feasibility of establishing a social protection mechanism for families affected by the worst forms of child labour. In summary, the assessment showed that:

- Social protection schemes can be initiated depending on the "maturity level" of the community involved. For example, there was a community that was just being organized against child labour with initial activities of advocacy and capacity building to explain families how to protect their children. Introducing a health micro insurance scheme was not applicable. It was better to introduce occupational safety and health, work improvement and neighbourhood development (OSH-WIND). The community simply did not have the capacity to pay premiums during that time. On the contrary, in some areas where IPEC has been in operation for several years and has introduced a lot of innovations to help families, communities

are more ready for micro-insurance because they have better capacity to pay for premiums.

One has to be very careful in promoting micro-insurance among a certain community. One does not want to elicit a very negative experience that discourages the community/group from going into micro-insurance when it is more capable.

AMIN: Thank you Anna!

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WHAT IS AMIN?

AMIN is a regional network of micro-insurance practitioners initiated by 22 of the most important micro-insurance schemes in Asia in collaboration with ILO/STEP programme. Thanks to its 600 members AMIN plays a central role in the collection and dissemination of information about micro-insurance in Asia; it facilitates exchange of knowledge among practitioners and the development of partnerships, as well as awareness raising on the importance of the extension of social protection.

WHAT IS THE STEP PROGRAMME ?

Strategies and Tools against social Exclusion and Poverty

STEP, a global Programme of the Social Security Department, is a key tool in the "Global Campaign on Social Security and Coverage for All" launched by the ILO in June 2003.

More information

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