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Health and Population

Social Health Insurance in
Developing Countries



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Social Protection in Health Care

European Assets and Contributions

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LIST OF ABBREVIATIONS

CSO –	Civil Society Organisation
DANIDA –	Danish International Development Agency
DFID –	Department for International Development, UK
EDF –	European Development Fund
EU –	European Union
GDP –	Gross Domestic Product
GTZ –	Deutsche Gesellschaft für Technische Zusammenarbeit (German Agency for Technical Cooperation)
HEARD -	Health Reform Database
IMF –	International Monetary Fund
MISSOC -	Mutual Information System on Social Protection in the Member States of the European Union
SHARED –	Scientists for Health and Research for Development
SWOT –	Analysis of the strengths, weaknesses, opportunities and threats
UK –	United Kingdom
USA –	United States of America
WHO –	World Health Organization

1 BACKGROUND AND SCOPE OF THE PAPER – GLOBAL TRENDS IN SOCIAL PROTECTION

Many societies in particular, and the world in general are facing a number of challenges resulting from structural, social and economic changes. The underlying causes include globalisation trends as well as technological, environmental, demographic and political developments.

The countries of Central and Eastern Europe, the Newly Independent States, and several Asian, Latin American and African societies are undergoing profound restructuring processes. In so doing, numerous low- and middle-income countries - particularly on the African continent - experience stagnation or even deterioration in their social protection systems, notably in the health care sector.

It is with this background in mind, that the authors of this report wish to present the case for an internationally-led debate on the fundamental importance of improving social protection systems in the health care sector in low and middle-income countries. Moreover, drawing on the long-standing European experience in the field of social protection systems, the paper invites European decision-makers and all interested parties to take an active role in consulting and supporting partner countries in the South on how to set up or to reform their social protection systems. It is hoped that the paper will contribute to the development of a more co-ordinated and concerted European approach to technical co-operation in the field of social protection.

The paper discusses the subject area as follows:

After the introduction to the topic “social protection especially in the health care sector” in chapter 2 the paper takes a closer look at the current situation and the major societal challenges facing the world today. These challenges can differ from country to country. Some are found in specific country groups only, others occur in almost every country around the globe.

Europe has over 100 years experience of setting up and developing social protection schemes and can offer a broad range of feasible system solutions, expertise and technical know-how. Moreover, the authors strongly believe that Europe’s systems for social protection are based on some intrinsic principles and values that deserve to be discussed internationally to determine whether they merit universal application. Accordingly, the paper’s 3rd chapter outlines nine examples of important assets Europe has developed in the sector of social protection, especially for the set up of health care systems.

The 4th chapter then reflects on the possible European contribution to the field of technical co-operation.

Following the elaboration of some conclusions (chapter 5), the provision of a glossary of technical terms (chapter 6) and the listing of the references the paper draws on (chapter 7), an annex is presented with the aim of providing some criteria for the analysis of existing systems, with special reference to health insurance schemes.

After many years of receiving a relatively low priority - especially during the height of the Cold War – social protection and health care are once again back at the top of the agenda of international organizations, governments, civil society organisations and society at large. The IMF and World Bank ,among others, have declared that they will pay special attention to the topic of “social protection”. Recent deliberations of the UN Security Council and the G7/8 summits serve to underline the prioritised position now given to health care.

The entry point to formal social protection mechanisms is very often represented by the set up of structures or systems with the aim of protecting the population against the financial risks of expensive health care (insurance function, Kutzin, 1998). Very often, even in very poor countries and/or in absence of sophisticated formalised social protection schemes, some form of institutionalised health care provision can be found. However, these services may not always be accessible to all population groups. Today, half of the world’s population has no access to quality health care. Those population groups living in remote rural areas and the urban poor in particular, are faced with the hardships of insufficient access to and provision of health care. Often, even the publicly owned facilities offer their services only to those who can afford to make the (in many cases under-the-table) co-payments. At the same time, private systems are established for the rich sections of society thereby fuelling the further deterioration of the public services. In consequence, the poor quality of public facilities forces even the indigents to seek advice and treatment at expensive private facilities. All these factors lead to a situation where illness can easily result in the financial collapse of households. Against this background, it can readily be understood that the set up of health care systems represents one of the most urgent issues to be addressed when the introduction of and/or reform options for social protection systems are discussed: This holds especially true when it is borne in mind that health care addresses one of the basic needs of human beings, - the physical capability to work and to survive. From an economic point of view, it should be stressed that in many countries the health care sector offers significant employment opportunities and represents a leading sector of economy. These days, an increasing number of countries are searching for new approaches on how to organise the financing and provision of health care.

The cradle of the modern social protection systems is to be found in Europe. In the 19th century, the first systems were developed in response to the problems caused by increasing poverty and unemployment, due to technological and economic revolutions. These early systems have since spread and evolved in response to change and generated a large variety of solutions and successful experiments. Today, many countries rely on state-run health care systems being mainly publicly financed by taxes. The success of these schemes can be attributed to the existence of the following three factors: (1)the great majority of the population should be economically active in the formal sector of economy and(2) the systems to collect the taxes and subsequently to reallocate the funds to the different sectors should be working sufficiently smoothly. (3) the health care infrastructure should be more or less equally well-developed in the different parts of the country. Many countries exhibit shortfalls in one or the other of the areas mentioned above, leading to a situation where the poor segments of society do not possess access to quality health care. Therefore, the paper draws attention to some of the features of the Bismarckian model for the organisation of health care systems. A system of this type relies on the existence of a number of health insurance schemes, the latter traditionally being attached to specific professional groups or regions. The Bismarckian system is financed by contributions of the members to the - in many cases - compulsory health insurance schemes. The system is embedded in the re-

spective country's legal framework but at the same time the principles of subsidiarity are followed.

In many countries, the introduction of a system relying on health insurance schemes may prove to represent a feasible way to organise the health sector. Some advantages of this approach are listed as follows:

- Health insurance may improve
 - access to health care services when needed, at the same time ensuring effective protection of family income and assets from the financial costs of expensive medical care.
- Moreover, health insurance coverage of the entire population embodies important health policy and social welfare objectives, notably
 - equity of access and
 - poverty alleviation.
- Generally, health insurance schemes - unlike pension schemes - do not provide long- term benefits, and therefore offer more flexibility.
- Health insurance schemes offer immediate benefits - unlike pension schemes, or saving accounts, that involve long periods between joining the scheme and entitlement of receiving first benefits. They are therefore likely to gain greater acceptance.
- In terms of their basic set-up, health insurance schemes are administratively less difficult to establish than pension or unemployment schemes.

As mentioned above, this paper is addressed to European decision-makers and all parties interested in the set up of or the reform options for social protection systems, especially in the health care sector, in low- and middle- income countries.

The health sector faces serious challenges worldwide, and the major ones will be discussed in chapter 2. The authors hope that a closer look at the European experiences and assets in social protection (see chapter 3) in the context of health care, may provide fresh insights and new ideas and approaches to address current problems in this sector and also in other regions of the world.

It is hoped that the discussion on Europe's potential contributions to improve social protection and to combat poverty worldwide(see chapter 4) will feed into a more concerted European approach to technical co-operation.

2 CURRENT SITUATION AND CHALLENGES

GLOBAL COMPETITION AND FINANCIAL CONSTRAINTS

Today, the world faces an increasing interdependency of markets. Trade is increasing worldwide. International economic networks are growing. The world is on its way to becoming a single market.

World Merchandise Trade By Selected Region – Average Annual Percentage Change

Country group	Exports 1990-1999	Imports 1990-1999
World	6.5	6.5
North America (excluding Mexico)	7.0	8.5
Latin America	8.5	10.5
Western Europe	6.0	5.5
European Union (15)	6.0	5.5
C./E. Europe/Baltic States/CIS	4.0	3.0
Asia	7.5	7.0
Japan	2.5	4.5
Six East Asian Trades	10.0	7.0

Source: WTO International Trade Statistics 2000.

The globalisation of markets is accompanied by the need for producers to reduce costs in order to maintain or improve their competitiveness. Wages and wage-related costs such as contributions to social security schemes and taxes have a major impact on costs and, consequently, on prices –prices that have to remain competitive in world markets. This competition based on price can be observed in all countries, where export-oriented producers are struggling for world market shares. But the poorest countries are also affected: being exporters of agricultural products, raw materials and manufactured products like textiles, they depend on the development of the world markets.

Poor countries are affected in several ways:

- Growing global competition, together with decreasing prices for raw materials, reduces their ability to pay off their external debt and to increase internal revenue. This has an adverse effect on the availability of financial resources for urgently needed health care and social protection.
- Consequently, the external value of their currencies declines and the bill for essential imports (often to be paid in foreign currency), such as energy and drugs, increases. Their opportunities to benefit from new technologies in health care are consequently reduced.
- In addition, many countries allocate available resources preferentially to sectors considered politically important such as the military. This is done to the detriment of social sectors such as education, social security in general and health care in particular.

The willingness of some donor countries to provide the funds to close these gaps is decreasing as it is claimed that due to increased global competition, all countries face similar financial constraints and political pressures.

The combination of these factors tends to result in a further weakening of the sometimes already shaky social protection mechanisms within poor countries. Therefore, new resources for financing health care have to be generated, reliable and acceptable allocation mechanisms of funds have to be established, and comprehensive and transparent priorities in health care have to be established. Moreover, quality, effectiveness and efficiency of health care services have to be improved.

Official Development Aid Numbers – DAC Countries

Year	Mio. US\$
1990	52961
1991	56678
1992	60850
1993	56486
1994	59152
1995	58926
1996	55622
1997	48497
1998	52084
1999	56378

Source: OECD 1999. DAC-Countries: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, United States

Countries in economic transition face very special challenges. On the one hand, they are in the process of changing their entire economic and legal systems towards market economies, on the other, they have to meet the requirements for successful participation in the global economy.

These changes give rise to the need to restructure their systems of social protection. In many of these countries, a sharp decline in GDP imposed severe budget constraints in the early 1990s. This had repercussions on the health sector, too. Hence, these countries face a double challenge: not only do they have to manage rapid political, economic and social changes, but also they have to regain/structure their health care services in a situation of dwindling financial resources.

Another challenge is that of the structural change affecting many national economies. This change is to be observed in almost all countries. It occurs in various patterns and involves different sectors of the economy. In some sectors, particularly in the industrial sector, jobs are being lost, while in others like the service sector, new jobs are being created.

Often, this structural change involves increased unemployment and represents a simultaneous threat to public revenue generation as well as to public spending. Public services are privatised and public expenditure is lowered. This affects not only the public health care systems but also other social and public sectors.

The issue of rapidly growing populations and of demographic change is relevant to numerous countries. In many instances, population growth outpaces economic

growth, resulting in shrinking GDP per capita, thereby reducing available resources for health care and increasing poverty. In many countries severe economic and social challenges emerge, because growing proportions of the population (e. g. children, the elderly, the handicapped people) are not only becoming dependant on the productive activities of a reduced workforce, but also are absorbing increasing human and financial resources for their necessary care (see also the next paragraph).

2.1 POPULATION GROWTH AND URBANIZATION

In many low and middle income countries, a growing population means that even if the economy is growing, GDP per capita is actually decreasing. In most instances, resources available for health care and family planning purposes decrease accordingly. In consequence, most of these countries find themselves in a vicious circle: per capita income decreases because GDP growth fails to keep pace with population growth, and at the same time the population grows because there are insufficient resources available for effective social protection. The situation is further exacerbated by the inequitable distribution of resources.

Sound social protection and health care system structures may have a positive impact on population growth in two main areas of concern:

- Child mortality is reduced leading to a relatively high probability that the (few) children of small families will survive.
- In many developing countries, many tasks traditionally have been shouldered by extended family structures. As family bonds are disintegrating due to migration & urbanization (for details see below) these tasks have to be taken care of by structures outside the family. Social protection reduces the dependency on relatives in difficult situations, such as serious illness or other health problems, death of the breadwinner, infirmity, or disability.

Population and GDP per capita in selected African countries, 1960-98

	1960	1970	1980	1990	1998
Ghana	6 774 177.6	8 612 251.9	10 736 412.3	15 020 381.0	18 500 390.0
Niger	3 028 147.9	4 165 153.1	5 586 447.4	7 731 319.6	10 100 190.6
Nigeria	42 305 99	56 581 214	78 430 1 130	108 542 296	121 300 300
Zambia	3 141 199.4	4 189 415.8	5 738 626.4	8 138 416.1	9 700 330
Zaire	15 333 215.1	20 270 232.9	27 009 520.5	37 391 191.9	48 200 110

Population in thousands, GDP per capita in US\$ (second figure).

Source: World Bank 2000.

Thus, as per capita income is not adequate to keep pace with population growth, and spending for health care in poor countries is heavily reliant on private households, the need for public involvement in health care constantly increases. In most cases, however, the possibilities of increasing public spending are very limited

Urbanization – Percentage of Urban Population

Country	1990	1998
World	40	46
Low Income countries	22	30
Excl. China & India	22	31
Middle Income countries	56	65
Lower middle Income countries	51	58
Upper middle Income countries	63	77
Low & middle Income countries	32	41
East Asia & the Pacific Region	22	34
Europe & Central Asia	59	66
Latin America & the Carib.	65	75
Middle East & N. Africa	48	57
South Asia	22	28
Sub-Saharan Africa	23	33
High Income countries	75	77
Europe	74	78

Source: UNDP 2000.

In many developing countries, population growth is associated with accelerated urbanization. People migrate to find work in the cities, because their means of subsistence in the rural areas are no longer sufficient. As migration increases, very often family bonds disintegrate leading to a deterioration of traditional solidarity structures for tasks such as the care of the elderly, etc.. In the cities, these migrants very often form the population of the growing slums with their well-known problems of disease, exclusion and poverty.

2.3 *DEMOGRAPHIC CHANGES, AGEING SOCIETIES AND CHANGING MORBIDITY PATTERNS*

Overall, the world's population is ageing (see table below). Regarding the age structure of countries however, there are major variations and differences between regions and countries, particularly accentuated by the impact of the AIDS epidemic in an increasing number of cases. In consequence, population estimates regarding size and age structure of several countries may have to be revised.

HIV/AIDS Worldwide

Year	Adult prevalence rate	Newly Infected	Persons living with HIV/AIDS
1996 (Estimates)	No numbers	3.1 Mio.	22.6 Mio.
1997	1.0%	5.8 Mio.	30.6 Mio.
1998	1.1%	5.8 Mio.	33.4 Mio.
2000	1.1%	5.3 Mio.	36.1 Mio.

Source: UNAIDS 2000.

Until now, in certain regions such as Africa and South Asia, the phenomenon of an ageing society has not been as prominent as in the industrialized nations or in China.

Age structure of the world population, 1950-2030 (percentage)

	1950	1980	1990	2000	2030
0 to 4	13.5	12.1	12.0	11.0	8.4
5 to 14	21.0	23.0	20.4	20.5	16.7
15 to 59	57.5	56.4	58.3	57.8	59.7
Over 60	8.0	8.4	9.3	10.6	15.2

Source: World Bank 1999

In most countries, the ageing population leads to an increase in health expenditure, since in general, older people need health care services more often and on a regular basis. This fact will possibly lead to a debate on how to define, or adapt, the concept of solidarity to this changing environment. Some countries are already discussing whether and how priorities in social security schemes have to be set or adjusted. Often, health insurance schemes compete with pension schemes for scarce resources.

At the same time, the ageing of the population will result in fewer economically active and more economically inactive people in society (an increase in the dependency rate). This in turn will increase the burden on the economically active population to cater for the dependants, and possibly will lead to attempts by this population group to lower this burden.

Some experts even argue that the demographic ageing of particularly Asian developing countries is responsible for the emergent crisis in health care.

2.4 TECHNOLOGICAL PROGRESS IN HEALTH CARE

The development of new technologies and the growth of the “information society” has led to a need to restructure economies, employment and production. Health care can be considered as part of these sectors. Medical technology has advanced significantly in recent decades. Progress in electronics and biotechnology have brought and have yet to bring about radical changes in the treatment of many diseases. The role of health care services will change accordingly.

Technical advances in medicine have two main impacts: on one hand, they will lead to new patterns and opportunities of prevention and treatment; on the other hand, they will raise the issues of accessibility, eligibility and prioritisation.

The eventual outcome of both these trends is still open to question, but, in the short run, new technologies will require major investments in equipment, training and restructuring.

Even today, the question arises as to which of the new technologies are to be made available to every one and which are to be available only to those who can pay for them. Currently the gap between what is medically possible on the one hand and is available to the poor on the other is still widening, and the poor benefit only to a very limited extent from medical advances.

2.5 POVERTY AND UNEQUAL ACCESS TO HEALTH

More than 1 billion people have to live in extreme poverty on less than one US Dollar daily. These people represent one fifth of the world's population, and one quarter of the population of developing countries. Access to health care is still inadequate and inequities persist between countries and within countries. It remains a global challenge to ensure universal access to essential health care, including reproductive and sexual health services.

In most of the low-income countries, health problems and reform issues are particularly difficult to tackle. Health care providers and governments in the world's least-developed countries struggle to cope with the huge efforts involved in building a basic health care infrastructure and providing the essential services to cater for the majority of their citizens-the poor. At the end of the last decade, essential health care was available to less than half of the world's population. Population groups living in rural areas represent a major part of the world's population, yet very often because of limited access and poor infrastructure, they are particularly disadvantaged.

Health indicators — World averages

Country group	Life expectancy at birth	Infant mortality rate 1997	Fertility rate 1997	Public Health expenditure as percentage of GDP 1990 - 97
East Asia and the Pacific Region	68	37	2.1	1,8
Europe and Central Asia	68	23	1.7	3,9
Latin America and the Caribbean	69	32	2.7	2,6
Middle East and North Africa	66	49	3,7	2,3
South Asia	61	77	3.5	0,8
Sub-Saharan Africa	51	91	5.5	1,7
Low and middle income countries	65	60	2,9	1,8
High income countries	77	6	1.7	6,0
World	67	56	2.8	2,5

Source: World Bank 2000.

Improvements in the health status of people lead to increased individual productivity, increased life expectancy and higher quality of life. However, the health care infrastructure and provision needed to achieve gains in health status requires enormous investments and resources. Numerous countries are, though, not in the position to generate and sustain these resources by themselves. They depend on external assistance and the solidarity of the better-off nations.

However, international assistance in most of the least-developed countries covers less than two per cent of total health care expenditure. An exception is Sub-Saharan Africa, where external aid represents more than 10 per cent of total health care expenditure.

Aid flows per capita, US\$ 1997

	1990	1997
East Asia and the Pacific Region	6	4
Eastern Europe and Central Asia	19	15
Latin America and Caribbean	12	13
Middle East and North Africa	45	19
South Asia	5	3
Sub Saharan Africa	40	26
Low income Countries	15	11
Middle Income countries	13	9

Source: World Bank, 2000.

As outlined above, one of the major challenges in the health sector of developing countries thus is maintenance, improvement and extension of existing health care systems.

However, it is not only developing countries that face the problem of insufficient and inequitable access to modern and well performing health care systems. In transition and in industrialised countries, there are population groups, such as the ur-

ban poor, ethnic minorities and migrant workers, facing severe difficulties in accessing adequate health care services.

The situation described above provides support to the thesis that economic development and growth alone are not sufficient to reduce poverty in a country. Poverty is determined not only by a low or marginal income, but it is also a form of deprivation, that includes elements of social, political and cultural exclusion. It involves gender and power issues. Thus, the extent and scope of poverty can be regarded as the result of a number of interdependent factors including: amount and distribution of income, type of economic order, presence or absence of good governance, a respect for human rights, participation in political decision making, presence or absence of societal stability, peace, the rule of law and the guarantee of the citizen's legal security.

2.6 INEFFICIENT AND INEFFECTIVE HEALTH CARE SYSTEMS

Efficiency and effectiveness are of crucial importance to any health care system.

However, there is a widespread perception that western - particularly European health care systems - are performing "well" (effectively and efficiently), achieving high levels of universal coverage and providing comprehensive benefit packages, mainly because of their (relative) richness in resources. It is argued that for this reason, developing (poor) countries would not be able to achieve similar, or comparable (high) levels of effectiveness and efficiency of their systems.

This argument fails to notice that I) there is no absolute, but only relative efficiency, and that II) effectiveness is the degree of achievement of predetermined and agreed objectives (which may differ from country to country). Moreover, important factors contributing to efficiency and effectiveness of health care systems, such as good governance, transparency, rule of law, civic participation, responsiveness and quality of services are neglected. For its World Health Report 2000 WHO developed a conceptual framework and accompanying criteria and indicators designed to measure and compare the performance of different health care systems. The report generated an intensely lively political and scientific debate, particularly with respect to its perceived methodological weaknesses and inherent value judgements. The report did however invite the scientific community to reassess its viewpoints and positions and offered some new approaches to the evaluation of health care systems (see WHO report 2000).

Many public services, including health care services, especially in poorer countries lack managerial know-how and suffer from system deficiencies. These include:

- inefficient and insufficient resource generation ;
- inappropriate resource allocation and planning mechanisms, e.g. input orientation instead of output- and outcome orientation,
- centralization of decision-making and lack of civic and political (community) participation,
- excessive bureaucracy and high administrative costs.
- lack of private initiative and an unwillingness to assume local responsibility according to the subsidiarity principle, and to provide a counterbalance to centralization trends
- imbalance between public and private responsibilities,

- lack of equipment, materials and consumables, inadequate maintenance systems,
- insufficient standard setting, supervision and regulation;
- lack of responsiveness by services to their clients and neglect of quality of care
- selective and inequitable coverage of services;
- very limited, insufficient benefit packages or benefit packages that sometimes include unnecessary, inefficient or non-effective (sometimes even harmful) services and products;
- monopolies and over-pricing, especially in the drug sector;
- insufficient remuneration of staff and providers, leading to low morale and motivation, increased corruption and “under-the-table payments”, “brain drain “ etc;

Given the amount and gravity of these deficiencies, profound and sometimes radical reforms of the health care sector seem inevitable.

2.7 COUNTRY GROUP SPECIFIC CHALLENGES

When the different challenges facing social protection and health care are studied from a regional perspective, four basic patterns emerge. Each pattern presents a distinct set of challenges demanding specific health policy reform measures.

The **first pattern** typically is found in industrialized nations and some developing (“threshold”) countries that have achieved relatively high levels of health care provision.

These countries exhibit low infant and maternal mortality rates, fertility tends to be low, life expectancy at birth is relatively high and the proportion of elderly people is growing.

The health-related problems of these countries are those associated with an ageing society, long life expectancy, unhealthy lifestyles and environmental threats. Cardiovascular diseases, cancer, mental and neurological disorders, degenerative and chronic diseases and conditions, often induced by unhealthy behaviour, predominate.

Health care tends to become a large and competitive market in these countries. Health care financing is still largely dominated by public (or quasi-public) funding. However, private financing is increasing for co-payments and for additional and/or optional services considered necessary to promote or improve the individual’s health or well-being.

The major challenges that these countries face are caused by the need to::

- strike an appropriate balance between the principles of solidarity¹ and subsidiarity²
- extend coverage to previously excluded and possibly marginalized population groups;
- provide state-of-the-art treatment (incl. therapies made possible by the latest technological advances) for all serious medical conditions to all citizens/insured on equal terms ;
- provide long-term care for the growing proportion of an ageing population;
- bear the financial burden that such care implies; and finally
- contain costs, taking into account the pressures of world-wide competition.

The **second pattern** is found in the transition countries of Central and Eastern Europe.

For many decades, these countries have pursued strategies in health care that have been entirely distinct from the Western, industrialized countries, e.g. physician and hospital bed ratios had been higher than those in the rest of Europe. Despite the set up of a large medical sector, the epidemiological and environmental situation compares unfavourably with that of the rest of Europe. In fact, life expectancy in those countries is roughly five to seven years shorter (than?)and actually is declining in some countries.

Environmental factors, such as contaminated water supplies, air pollution, unsanitary waste disposal and inadequate food safety, have contributed to the relatively low health status of the population, as has unhealthy individual health behaviour. The latter includes high rates of smoking, excessive consumption of alcohol, high rates of abortions and unhealthy diets.

Many of these countries are undergoing major reforms to reorient their health care sectors towards insurance-based systems with an emphasis on preventive and primary care. Private health care provision is increasing while public services are being cut back. However, the change of system and priorities in many of these countries has (so far?)failed to result in better access to health care and improved health indicators.

Thus, the main challenges in these countries include the need to:

¹ **Solidarity**, as understood in Germany and, more generally, in Europe, is the ethical platform of joint efforts among people of economically different initial positions directed so as to achieve a common socio-economic goal to reduce social friction. Everyone in the solidarity system should have access to the same quality of care and same comprehensive benefit package, on equal terms. No family should be financially burdened by illness, and a family's contribution should be based strictly on the family's ability to pay and be completely unrelated to the size of the family or its health status.

² **Subsidiarity** (possibly best translated into English by "supplementary")(?) implies that tasks and obligations should always be fulfilled by the lowest possible level within society capable to shoulder the burden and/or to solve the problem. This principle implies that government should step in as a regulator of private affairs only if the private system fails to own up to shared social goals. It also implies that government should direct its monetary subsidies and other form of assistance mainly to those individuals in society who cannot help themselves (Reinhardt, 1993).

- respond more effectively to the changing epidemiological situation, and revise negative trends in morbidity, mortality and life expectancy
- combat environmental health threats and unhealthy life styles
- fight poverty, and economic, social and political exclusion as well as corruption and nepotism
- determine the objectives and activities in regard to health system and financing reforms on the basis of evidence,
- make a realistic assessment of the potentials and opportunities for reform, and give support to comprehensible and transparent policy making
- respect the principles of good governance, transparency and political participation of all stakeholders, and ensure law enforcement
- counterbalance the predominance and sometimes selfish interests of medical, paramedical and pharmaceutical professionals while safeguarding a decent and appropriate remuneration of health workers
- take existing inequities regarding accessibility and use of health care services into account
- balance private and public responsibility in health matters as well as social objectives and private involvement in health care provision (development of a social market economy)
- build up the capacity for and to update the know-how regarding modern diagnostics and treatment procedures, including quality assurance and quality management
- replace bureaucratic, centralised structures and procedures with a decentralised management system adapted to the requirements of the country.

The **third pattern** is observed in middle-income countries.

Many of these countries have made considerable progress in building up a health care infrastructure focussing on primary and essential health care.

Their past efforts have been rewarded by declining infant and maternal mortality rates, increasing life expectancy at birth and diminishing fertility rates.

The “traditional” causes of morbidity and mortality — infectious and parasitic diseases — remain the major killers, but new health problems, such as chronic and non-communicable diseases emerge. Often, these are associated with demographic transition, an ageing population and unhealthy (“modern”) lifestyles.

Thus, the main challenges in these countries include the need to:

- respond to current - and newly emerging – needs, demands and expectations within the limited resources available
- improve the quality of care
- develop solidarity mechanisms to distribute the limited funds in such a way that universal coverage can be achieved, particularly to provide essential health services to the rural and urban poor
- sustain the achievements and maintain the benefits that their health care systems have already established.

The **fourth pattern** mostly is found in the group of the world's least-developed countries, particularly in Sub-Saharan Africa and South Asia.

The outlook regarding health matters in this pattern is particularly distressing. These countries face critical and most difficult situations, but dispose of only very limited financial and human resources to develop their health sectors. Their rapidly growing populations live to a large extent in extreme poverty, and in deplorable and hazardous environmental conditions with regard to hygiene and health. Their most urgent health needs cannot be met by health care systems alone. Economic development as well as political, fiscal, social and economic reforms are also necessary. Public health expenditure alone is insufficient to ensure clean water supplies, sanitation facilities and access to basic health care for large sections of the population.

Infectious and parasitic diseases, acute respiratory tract illnesses and malnutrition contribute to a large extent to high morbidity and mortality.

Health care services often are often the only kind of social services available to most of the people in these countries. They face three main challenges.

They need to:

- optimise performance and achieve results with the (very limited) resources available by setting clear priorities, by improving allocation mechanisms, and by taking into account all relevant public, private-for-profit and private-not-for-profit health care providers
- considerably improve resource generation, both domestically and through international assistance.
- safeguard traditional solidarity mechanisms, and at the same time to develop modern social protection schemes, which take into account the objectives of universal coverage and equitable access

In this context it seems worth mentioning that in many of these countries, large and inappropriate portions of the state budget are spent for military and security purposes, even in the apparent absence of external aggressors.

3 EUROPEAN ASSETS IN THE FIELD OF SOCIAL PROTECTION –PRESENTING NINE EXAMPLES

This chapter examines European experiences and assets in view of the challenges stated in chapter 2. In the field of modern social protection and social security, Europe can draw on an expertise developed over a time span of more than a century. The contribution Europe has to offer to the international debate regarding social protection and health care therefore goes far beyond technical matters. It comprises conceptual and ethical foundations and theoretical knowledge as well as the practical know-how and skills to put the principles into use. The debate on social protection and social security schemes, with special focus on the health care sector, is largely dominated by issues such as:

- What is the ethical platform, i.e. the value base of social protection in a country- and culture specific context?
- How to balance shared social goals and private, individual aspirations and preferences?
- How to trade-off between equity, efficiency and effectiveness?
- How to set up responsive and appropriate organisational arrangements, into account the different roles and interest of all stakeholders
What is the role of the state and public institutions?
- How to cater for the indigent and the disadvantaged?
- How to balance public involvement and private responsibility regarding finance, allocation of funds and provision of services?
- How to generate and sustain sufficient financial resources?
- How to prevent fraud and moral hazard on the user as well as on the supplier side?

The following nine European assets illustrate the richness that European systems exhibit regarding these conceptual, political, procedural and technical aspects in social protection and social security schemes. At least as many lessons have been learned as there are EU member states.

3.1 THE FIRST ASSET: SOLIDARITY IS THE FIRST STEP TO STABILITY

One of the most fundamental European principles that has crystallised over time is the experience that mutual support and solidarity are crucial pillars of economic and social stability.

- In economic terms, solidarity mechanisms - particularly those implemented in social security schemes - contribute to a stabilisation of demand, to a growth of the internal market and to capital formation.³
- In social terms, solidarity mechanisms contribute to poverty alleviation, to a more equitable and just society, to security, social harmony and social cohesion.

This socio-economic stability may be considered as a public good. It is important to note that it benefits not only those in need of solidarity and support. It also has positive and tangible effects on those who are the “net payers” and on society as a whole. This is brought about in two ways:

- One day, “net payers” may become beneficiaries, too;

³ Through its resource generating and re-distributional effects.

- Those who do not need any form of mutual support because of their comfortable economic position, benefit from an stable and peaceful environment that does not threaten their way of life, nor the coherence of society.

Despite Europe's pluralism and variety of structural approaches, mutual support and solidarity has become a basic value involving all states and at all levels of society, though it may take many different forms:

- Each EU member state has developed its own structures and approaches concerning modern social security. This is particularly true in the field of health care with regard to financing and entitlement to benefits. All systems provide (almost) universal coverage, quasi-equitable access to health care, and provide comprehensive benefit packages. However, the systems are based either on citizenship, or on (mostly compulsory) membership. Some of them are predominantly, or exclusively, state-run (national) systems, found e. g. in Ireland, the United Kingdom or the Scandinavian countries. Some of them are insurance-based, publicly controlled or regulated systems, such as the social health insurance schemes of France, Germany, the Netherlands, Belgium or Austria. Some of them are contribution-based, some of them are funded by general taxation, some are financed by a mix of both.
- Internally a number of these systems exhibit variety and pluralism. They may have developed special schemes for different regions, sectors and/or population groups. In numerous member states, there are specific schemes that cater for the agricultural sector, for public servants, for the self-employed or for the formally employed. Whatever system prevails, solidarity mechanisms bridge the gap between the financial risks related to illness and the citizens' ability to pay. Some member states have introduced competition amongst social health insurance carriers and combined this measure with freedom of choice (of these funds) by the insured. In these cases, the solidarity principle is upheld by the use of risk-equalisation mechanisms amongst insurance carriers (Germany and the Netherlands). The Netherlands are even practicing with the redistribution of funds from the private to the public insurance sector, .
- **Solidarity goes beyond national borders in Europe.** The European Union has instituted various arrangements to ensure the social security of, and solidarity amongst, its populations and member states. The main mechanisms and instruments are:
 - The principle of the portability of health care benefits;
 - The European Social Fund;
 - The European Agricultural Fund;
 - The European Regional Fund.

These solidarity funds were created 35 years ago, and have been used ever since to narrow the gaps between and within member states or disadvantaged regions, with regard to poverty, structural and socio-economic development, and the living standards of their populations.

The underlying principles of these funds are:

- Partnership: the institution of partnerships on all levels of implementation, with special consideration given to local partners and sector wide approaches (SWAp).⁴
- Subsidiarity: in this case meaning that countries must first try to solve their problems using local and national means and capacities before the EU may step in.
- Co-financing: European solidarity funding should be used only to complement national funding and not to replace it. This principle aims mainly at achieving financial sustainability⁵.

3.2 THE SECOND ASSET: PROCESS-ORIENTATION RATHER THAN MODELS AND IDEOLOGY

One important lesson from European experiences is that systems were not initially designed as such, but are the result of complex continuous processes. These processes are affected by numerous and interdependent historical, political, cultural, social and economical factors and developments. In its present form, the European Union, and its various institutions and instruments, are the result of very adaptive and flexible processes. The EU institutions have taken a large variety of different cultures, interests, economic strengths, historical assets and burdens into consideration. The result is one of the largest peaceful unions of countries in history.

The basis and the heart of these successful processes are a set of agreed values and guiding principles that draw on the historical experiences of EU member states: these include mutual respect, desire for peace, democracy and political participation, freedom of movement, social market economy, solidarity and social protection, the willingness to co-operate, and the protection of minorities. In most instances, the different speeds of decision-making, different priorities and different economic possibilities of member states have been respected.

The process itself was at least as important as the vision of a single system, or model. However, the European Union has evolved into a unique multidimensional legal, political and economical system that reaches far beyond the traditional concepts of states, federations, associations and unities.

3.3 THE THIRD ASSET: RESPONSIBILITY, SELF-RELIANCE AND SELF-GOVERNANCE

It is often argued that solidarity and mutual support reduce individual initiative and responsibility. That is why the principle of subsidiarity (see glossary) forms an integral part of European policy. In particular, subsidiarity counteracts 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, services and local governments, but also of civil society organisations, communities, households and individuals. In Europe this principle is applied as follows:

⁴ For an explanation of SWAp please refer to the definition later in this paper.

⁵ These solidarity payments are, in many cases, of considerable economic significance. In Portugal, for instance, these payments (national plus EU funding) amounted up to 7% of GDP.

- On the EU-level, only those issues which demand joint efforts, and where central intervention holds the promise of creating some form of synergy. are regulated and managed, Increasingly ,regions and provinces within EU member states are being given more responsibility along with opportunities to influence the central EU-level. Decentralization of power to lower administrative levels, services and local governments is also gaining significance. At the household and individual level, policies are increasingly aimed at supporting self-help initiatives instead of simply providing allowances, or financial means. This approach is particularly important for the labour market, but it is also relevant to the health care sector.
- The delegation of responsibilities and functions from the state to non-state institutions is an essential part of the European concept.
 - The economy of the social sector, the **“Social Economy” is one of the largest sectors in terms of economic importance as well as in terms of participation.** It includes all civil society organisations (CSO) that are based on non-profit and participatory ideas, such as associations, mutual health organisations, friendly worker societies and co-operatives. These organisations including charity organisations and religious organisations have long since, played an important role in the health sector in Europe. They have taken over functions and tasks that, in other contexts, are assumed by the State. These include: provision of all kind of preventive, curative, rehabilitative and long-term care, organisation of the financing of health care (mutual health organisations (“mutualities”), social health insurance schemes, social assistance funds), advocacy and voicing of patients’ and health workers’ interests and rights, provision of continuous and specialist training and organisation of information, education and information (IEC) activities as well as awareness raising campaigns, etc(bullet points?). All these activities tend not only to reduce the burden of the state regarding its obligations, but also to generate new employment and, thus, contribute to economic growth.
 - In line with the principle of subsidiarity, some EU member states (e. g. Germany) have delegated a number of the above stated tasks to **autonomous, non-profit and decentralised bodies, ruled by public law.** These bodies assume – on behalf of the State – important functions, such as assuring adequate financing of health care (“sickness funds”), provision of health care (“association of panel doctors”), specialist training, implementation and supervision of the code of conduct of medical doctors (“medical board”). They have been granted self-governing status, which means autonomous administration, financial sovereignty and self-sufficiency and democratic control by elected representatives of the members (employers and insured employees). Collectively, they have the right and duty to enter into contracts with the other actors in the system. Thus, the implementation of the public laws governing the health- care sector, has been left to the actors of the system themselves - at least to a large extent. The reasoning behind this set-up is that the actors of the sector show the greatest interest in and know best how to tackle issues and how solve problems that concern their field of work.

In summary, the civil society organisations of the ‘Social Economy’ and the self-governed bodies - representing actors and stakeholders of the health care system - play a vital role in European societies. By so doing, the internal cohesion of society is strengthened, accountability and responsibility of actors is

fostered. Thus, beneficiaries, actors and stakeholders directly contribute to the maintenance and further development of the welfare state.

3.4 THE FOURTH ASSET: COMPETITIVE MARKETS AND SOCIAL PROTECTION

In terms of GDP, the European Union is the largest internal market in the world. Europe is the largest exporter and importer of products in the world. Moreover, its member states run comprehensive (and expensive) social protection schemes that cover almost the entire population.

High employment rates and decent, regular income generation are means to achieve and maintain social protection in their own right. To a certain extent, these features contribute to securing societal and national stability. This is important since a country's competitive position in the world markets is not only determined by labour costs, or product prices, alone. Europe tries to achieve the right balance between labour costs and competitiveness of its economies on the one hand, and the costs of its social protection schemes and social stability on the other. It is not easy to reconcile the principle of solidarity ("sharing and caring") with the rules of the market ("the winner gets it all"). In Europe as elsewhere the best way to achieve a balance between the two competing requirements is the subject of keen and constant debate. In Europe, the health care sector - though being an integral part of the economy - is (still) considered as a sector that should be guided and regulated by the state⁶ thereby securing the social (not market-driven) distribution of health benefits.

So far, the European experience has proven that it is possible *and* advantageous to bring together comprehensive social protection and elements of free markets. Accordingly, the European concept of a **social market economy** combines private ownership, freedom to enter into contracts, and competitive rights along with societal responsibility. Ultimately, this has led to increased productivity, innovation and success on the world markets. Hence, the European example shows that "social protection" favours market development in the long run (see "first experience", page 23).

3.5 THE FIFTH ASSET: THERE IS MORE THAN PUBLIC – PRIVATE MIX

Privatisation is one of the most fiercely debated issues worldwide. In the narrow sense, privatisation refers to a particular form of ownership of capital. Private is everything else not owned by the public (be it the central state, local governments, or publicly capitalised, but autonomously managed entities)⁷. In the broader sense, privatisation refers to the shifting of capital and/or responsibilities from the public to the private sector.

⁶ The USA, considered as a state where social protection is absent, also runs a broad network of social protection mechanisms, which, however, is less comprehensive and less "generous" than any of the European ones. Examples: pensioners over 65 and low-income earners benefit from in-kind health care benefits. Wage earners are entitled to sickness benefits, and most employees are entitled to unemployment benefits. There exist pension schemes, including disabled persons and surviving dependents.

⁷ However, there is the important distinction between for-profit and not-for-profit ownership. For-profit status indicates that private individuals have put up the business' capital, and expect to keep any accrued earnings. Not-for-profit describes an umbrella category for different organisational formats (civil society organisations, such as churches, charities, various associations, unions) where no group of individuals has contributed risk capital on which they expect to earn a profit (Stierle, 1998).

Sometimes, however, the concept of privatisation, and that of the public-private mix, is discussed only in ideological terms and in its narrow, mostly neo-liberal, interpretation⁸. Whilst holding on to the fundamental principles of solidarity and equity, Europe has set up a firm regulatory framework for the private actors in the social sector, proving her economic and social reality to be adaptable to change. It has not limited itself to a simplistic “either-or” view but has developed a large number of models which integrate private elements on the financing as well as the provision side. Some of the many examples include:

- The trusts within the British National Health Service represent a type of self-governance of public facilities which going far beyond the traditional concept of a public service administration organization.
- The German social health insurance carriers (“statutory sickness funds”) and their federal associations are non-profit, self-governed and autonomous institutions with a legal mandate and ruled by public (cf. page 26).
- In France, mutual health organisations (“mutualités”) and “Institutions de Prévoyance” provide social services that traditionally would be organised by state agencies, including the “Sécurité Sociale” of public servants.
- In many European Member States, prices and terms of health care provision are (often collectively) negotiated between health care providers and financing agencies, which may be either private, civil society organisation, semi-public, public, for-profit or not-for-profit.

In general, provided they are properly monitored and regulated, market mechanisms and private ownership of services seem rather well adapted and beneficial to health care provision. In contrast, financing - i. e. resource generation⁹ - and allocation of funds, seem to require much more direct public intervention and/or public regulation.

In consequence, all European systems apply - in one way or another - the principle of solidarity. All European countries have implemented some mechanisms to counteract market failures such as adverse risk selection. It is a broadly shared view in European societies that equitable and universal access to quality health care cannot be achieved by relying on the laws of the market alone, since these automatically marginalize those parts of society that are too weak or simply not attractive in economic terms, thereby intensifying social cleavages. This stance requires a strong state that has the capacities to regulate and supervise a privately administrated system, and to regularly update the legal framework governing the system.

⁸ It is often argued that privatisation would pave the way for (more) competition and efficient behaviour of organisations, and that the users would benefit from that. However, this does not always hold true. Privatisation is not necessarily linked to the process of competition. In the case of a monopoly, there is no competition, although resources are privately owned. In contrast, it is perfectly feasible, that competition (i.e. a market) can be introduced in a set of publicly owned organisations, including publicly owned health care services (Stierle, 1998).

⁹ Mostly through some form of compulsory membership and/or contributions, and through broad risk-pooling.

3.6 THE SIXTH ASSET: SUSTAINABILITY

The European experience demonstrates that political, financial and technical sustainability has rarely been achieved either through simplistic or uniform approaches, or through cohesion. In addition, history shows that it certainly has never been attained through dictatorship and violence. Rather, sustainability is a matter of:

- Involvement and participation of actors, stakeholders and beneficiaries
- Respect for smaller communities and minorities¹⁰
- Flexibility and tolerance/patience of the partners,
- Mutual support,
- Transparency¹¹, and
- Courage to search for new solutions, which may be inspired by existing models and which may have to be adapted to prevailing economic and social contexts.

3.7 THE SEVENTH ASSET: PORTABILITY DOES NOT MEAN UNIFORMITY

Europe represents a patchwork as regards the systems for social protection. For health care alone, it is possible to find almost all the system elements in Europe that are debated worldwide. The leading system concepts, namely “Beverage” and “Bismarckian”, are of European origin.

In Europe the portability of entitlements has been achieved gradually, step by step: German pensioners moving to Spain may now benefit from local health care services. whilst Italian tourists travelling to France are also entitled to access health care services. Migrant workers are protected by a comprehensive array of regulations and directives. Regulations regarding national social protection schemes are subordinate to the common objective of freedom of movement.

Special regulations have been established with respect to border areas and international commuters. In these cases especially, the co-operation between the carriers of social security schemes, in health care matters, is very close.

Moreover, the principle of portability does not apply only to beneficiaries, but also to health care providers. Many diplomas and other exams are mutually recognised throughout Europe. Licensing and registration of products (e. g. drugs) in one member state is valid in the entire Union.

Taking into account the differences of, and within, European health care systems, this experience shows that it is possible to pursue agreed social objectives without imposing uniformity.

¹⁰ An example are voting rules within European Institutions that do not always correlate to the population size of member States.

¹¹ Examples are the early publications of political plans and objectives to give stakeholders and the public the opportunity to comment and react.

3.8 THE EIGHTH ASSET: VARIETY, COORDINATION, CONVERGENCE

European Health Care systems exhibit all the approaches and elements that are debated worldwide. This holds true for all areas of health care financing and provision, including

Institutional set-up (cf. also page 24): there are (predominantly) state-run, national health care systems (Denmark, Greece, Portugal, UK, Ireland, Italy, Sweden and Spain) and insurance-based systems (Austria, Belgium, Germany, France, Luxembourg, the Netherlands). Among the social health insurance schemes, some are very pluralistic (Germany and the Netherlands), and some are run by a few organisations only (Spain, Italy (What about Finland ?)

- **Membership versus citizenship:** Some systems base entitlement to benefits on citizenship (state-run systems), some base entitlements on membership. In the latter case, some systems focus partly on voluntary membership (Ireland), while other systems combine compulsory membership of social health insurance schemes (for the majority of the population) with the option to opt-out to private health insurance for the richer layers of society (Germany, the Netherlands).
- **Financing:** Most state - run systems are financed through general taxation (sometimes combined with some form of user fees or co-payments). Some systems are organized by regions, but financed through contributions (Spain). Other systems are predominantly contribution-funded (Germany). Some systems have a mix of all (Italy).
- **Benefit packages:** Here the range spans from systems with rather restricted (basic) packages (Spain, Portugal, Greece), to other countries providing rather comprehensive and ‘generous’ packages (Netherlands, Germany). In between these positions, countries such as Denmark and the UK offer medium level packages. Accordingly, complementary and supplementary benefit packages are of varying importance. In Ireland, for instance, the better-off are covered only for inpatient care, whereas for the poorer layers(sections/members?) of the population primary care is included.
- **Purchaser-provider split:** In several countries, purchasers and providers of health care services are sometimes owned by the same body or organisation (Spain and the UK). In other countries, financing and provision of health care are secured by distinct and sometimes rather numerous organisations, who enter into negotiations and, thus, subsequently build up contractual relationships (Germany, the Netherlands). There exist various and quite distinct forms of contracts and types of provider payment mechanisms.

As already outlined in the paragraph on the 7th asset(see pp 29), this great variety of system features and characteristics requires a particular effort of coordination on the European level. However, so far, there are no plans to impose uniformity on the systems (‘harmonisation’). Close co-ordination is already implemented with respect to the following areas:

- Portability of entitlements
- Mutual recognition of diplomas and certificates (professionals), and licences and registrations (drugs and medical products).
- Close co-operation in border-areas.
- Regulation of private health insurance activities.

- Health information systems and public health activities.

In addition to this coordination of activities, the concept of convergence also plays an important role in European policy and in the visions of a future European Union. The concept aims to reconcile all future developments within, the European Union in such a way that gradually agreed objectives will be achieved. The ultimate goal is to achieve equal (or comparable) levels of socio-economic development, and, if appropriate, common structures and regulations.

3.9 THE NINTH ASSET: TRADITION AND INNOVATION

Fortunately, European citizens are not opposed to the more “coercive” elements of social protection, such as compulsory membership of statutory health insurance funds and compulsory contributions. This is for reasons that include a trust in the system, ethical considerations and a feeling of safety. In many cases, it is just tradition or sheer habit¹². However, tradition may also lead to inertia, which, in turn, may impede development and progress. In view of the rapidly changing environment and the challenges mentioned above, changes and adjustments are necessary to sustain the acquired assets. In Europe, innovations and adaptations of social protection schemes are constantly discussed and if need be implemented. Currently, the issues that are receiving particular attention include the following:

- How to counterbalance the negative effects of an ageing society with respect to the social protection of people in need of long term and nursing care?
- How to improve medical and social rehabilitation in order to reduce the strain on social protection mechanisms?
- How to increase flexibility of social protection mechanisms and, thus, improve responsiveness to individual demands and conditions?
- How to raise awareness and to enhance individual responsibility regarding small risks while safeguarding the protection against great risks?
- How to further develop and test solidarity mechanisms such as broadened risk sharing through risk equalisation mechanisms between funds.?

In general, improvements on the institutional and legal level are achieved through incremental modifications and process-oriented approaches rather than through radical changes of the systems as a whole. There is broad agreement on the underlying fundamental principles that should guide the sector, but at the same time all stakeholders and partners are aware of the need for adjustments.

In recent years, in contrast to previous decades, all member states of the European Union, have embarked on sometimes far-reaching adjustments of their legislative and administrative arrangements for social protection . It has been estimated that in Germany alone, for instance, about 2.000 changes and

¹² In Germany, 62 % of the insured do not know the rate of their contribution to the social health insurance (which is monthly automatically deducted from their salary). Source: Deutsches Ärzteblatt. 2002. 99, Heft 1-2, page C1.

amendments of the health care laws have been passed during the last 20 years.

The reasons for this preference for the incremental process approach rather than radical system changes include the following:

- **Cultural rationale:** Despite the fact that most European citizens pay high taxes and social contributions, there is large (public) support for maintaining collective social protection arrangements. In Europe, it is the norm that prosperous societies organize solidarity to equalise, or balance, different opportunities to a certain extent. Incremental and small system-changes can maintain social protection for all members of society, and counterbalance changes caused by the environment.
- **Economic reasons:** Modern social protection represents a cost item for individual enterprises. For the nation as a whole, however, it has to be regarded as an investment. A system of sheer profit maximisation and deteriorating employment conditions leads to a lack of demand and decreased savings as well as to inequality in the distribution of wealth. In Europe, social cohesion can be considered a determining factor to achieve macro-economic stability and to create a pro-innovative environment within a national economy.
- **Political and social reasons:** Poverty and social exclusion are a threat to democracy. The continued existence of a democratic system based on the concept of a market economy is highly dependent on the legitimacy of the social order and on its acceptance by the population. The system of social protection is one major pillar of political stability. During the last decades, all European governments have refocused their interventions in the field of social protection towards improving the flexibility and efficiency of their systems and, increasingly, towards introducing market elements. At the same time, however, governments have intensified their efforts to improve education, infrastructure and social cohesion. Hence, the incremental approaches to applying mechanisms of the (free) market while maintaining social responsibility through public and state intervention and control: the “invisible hand” is complemented by an “invisible handshake”¹³, or the “visible hand”¹⁴.

¹³ Handy, C.: *Beyond Certainty: The changing Worlds of Organisations*, London, 1996.

¹⁴ Donaldson, C. and Gerard, K.: *Economics of Health Care Financing: the Visible Hand*. London: The Macmillan Press. 1993

4 EUROPEAN CONTRIBUTIONS TO GLOBAL DEVELOPMENT

4.1 EUROPE'S INTEREST IN THE PROMOTION OF SOCIAL PROTECTION

The assets associated with European social protection systems that were described in the previous chapter may be used to guide and facilitate European activities in international co-operation. The question now arises as to what are the motivations and interests of European decision makers and citizens in promoting the European view on social protection?

Basically, the reasons have been mentioned already. Nevertheless, they deserve a more explicit listing:

1. There is a desire to share the experience that solidarity and mutual support can contribute to economic and social stability. In a world where borders get less and less important, stability is a public good, benefiting everybody.
2. The process of globalisation reinforces the political, economic and social interdependence of the different regions of the world, and points to the importance of the principle of mutual responsibility.. The adverse effects of poverty in the South therefore should be of serious concern to the industrialized countries of the North.

In the short term, exploitation and an acceptance of the accompanying social hardships and poverty may lead to high profits, but these will benefit only a small and privileged group of the population in the respective country. These profits can mostly only be sustained by maintaining inhumane conditions for workers and their families. In view of the ethical values that European societies lay claim to, Europe should condemn such practises as "social dumping" and seek to prevent them with all force provided for by international law.

3. Last but not least, the authors believe that the principles of social protection referred to above should be considered to be universally applicable. Therefore, Europe should contribute actively to the international community's debate on how to define universal standards in social protection.

4.2 PRINCIPLES TO GUIDE EUROPEAN CO-OPERATION POLICY

As, described in Chapter 3, the European assets were developed in response to emergent challenges in the field of social protection. That would seem to justify some reflection on how best to share the knowledge gained and the experience gathered in the context of European co-operation policy. The authors consider that three types of assets may be shared with the international community namely :

- Principles and concepts, -specifically those concerned with solidarity, equity, equality and poverty reduction,
- Procedural and political approaches,
- System techniques.

1. Principles and concepts

Solidarity is one of the key values practised and promoted in Europe . It is also a leading principle in international co-operation. In practice, solidarity means providing support and assistance in different ways to those who are in greatest need. The goal is to promote social, political and economic development.

The combination of solidarity and subsidiarity is a particular European asset.

Naturally, social protection mechanisms should be carefully adapted to the needs of the people and the local circumstances. The variety of solutions developed in Europe should serve as a rich source for inspiration and should encourage others to try out different roads.

These principles are an important part of the success-stories of European “models”, and thus may serve as the foundation of co-operation and support to countries and communities in need.

At present, most Western-European solidarity systems are under strain due to economic shortfalls, demographic changes and technological advances in the field of medicine. In addition, the absence of the above stated principles in a globalised market add pressure.

2. Procedural and political approaches - how to get people on board, and how to implement change

European experience shows that procedural and political approaches are at least as important as structural know-how and system techniques. This realisation is relevant to, and may be transformed into action in, many environments in the world. However, two basic concerns of people have to be acknowledged:

- On the one hand they do not want to be left alone to cope with their problems without any source of support, and
- on the other hand they don't want any limits on their personal freedom and individual economic opportunities.

These two concerns are (naturally) in conflict with each other and may be best reconciled through positive experience, participation and targeted dialogue.

3. System techniques

The third group of assets is the existence of a large variety of European experiences and “models”. The solutions and experiences to be found in Europe can be considered as a source of know-how, skills, attitudes, approaches and models which may help others to take their own systems and policies one step further.

It is primarily this third type of asset that has influenced European co-operation policy. Nevertheless, the two other types of assets seem to have inspired European actors to a considerable extent should therefore not be neglected.

4.3 THE ACTORS

International co-operation is not simply a matter for governments and bilateral agreements. Europe has at its disposal a large variety of organizations that actually contribute, or could contribute, to international co-operation - including the objective of achieving universal, effective and efficient social protection. Basically, there exist four types of organisations:

1. Specific aid organisations:
 - The EU-Institutions such as the Commission and the EDF.
 - Member state organisations such as Government agencies (DFID, DANIDA, GTZ, etc.), and
 - CSOs and NGOs
2. European (national) institutions and organisations possessing practical experience and know-how in the field of social security, as they represent the administering bodies of social protection and health care schemes.
3. Scientific and training institutions such as universities, academies, research institutions, foundations and the consulting industry/ business.
4. Enterprises running their own social protection schemes, based either on voluntary, on group, or on compulsory membership. Examples of this type of organization can be found in France (mutualités, institutions de prévoyance) or in Germany (Betriebskrankenkassen, Pensionskassen).

Currently, in one way or another, all of these organisations and institutions are engaged in activities of international co-operation. Unfortunately, co-operation and co-ordination amongst these players are often poorly developed or lacking altogether.

4.4 POTENTIAL FIELDS OF ACTIVITY

Today, social protection is one of the major topics the European Commission has to deal with. In March 2000 the EU special summit on social policy identified two key challenges, facing Europe:

- how to adapt current social security arrangements to the requirements of the “information society”, and
- how to support social integration and to reduce poverty and social exclusion.

The 1994 White Paper of the European Commission contained some fundamental statements concerning the importance of solidarity. This paper, as well as other EU documents, not only focuses on EU member states, but also underlines the global importance of matters concerning social protection.

Technical co-operation is only one possibility amongst others to support and assist low and middle income countries. However, the following suggestions focus on technical co-operation, since the authors of this paper are mainly acquainted with this area of development activity. In the following, the authors would like to elaborate on some examples of how the European Commission and the EU member states could offer support to strengthen modern social protection in health care world-wide, by drawing on European Assets in the most effective and efficient manner and producing synergies from the differ-

ent activities of the various partners. Key areas of action could include the following:

- **Policy consultation and dialogue:** When their underlying political and social values are taken into account, European assets in the field of social protection and health care have a relevance that extends far beyond mere “national models.” . Policy dialogue should always draw on these overarching principles, and focus less on specific advantages, or disadvantages of one particular European “system” or “model”. Rather, the policy objective is to achieve well working, efficient, effective, equitable and sustainable social protection systems worldwide, adapted to the local context and needs. In principle, it is of no importance what kind of European national system represents the starting point for further considerations. Therefore, the intention to implement particular national technical features and/or structural elements should not form the “hidden agenda” of technical co-operation.
- **Co-operation and co-ordination on the European level** with regard to planned (national) programmes, activities and priorities, including the exchange of experiences among European and bilateral donor agencies. One particular approach, which could complement bilateral technical co-operation, and which is a “typical European” feature, is the *sector wide approach*¹⁵.
- Strengthening of the **co-operation between developing countries and the EU**, and facilitation of the **debate on structural and policy options:** the large variety of social protection schemes and experiences in Europe exhibits the different *strengths and weaknesses* of their respective systems. Partners and beneficiaries of technical co-operation could particularly benefit from an open, knowledgeable and professional debate. This could be achieved through:
 - a) support to the participation of partners in relevant conferences, workshops, seminars and training courses,
 - b) provision of access to internet-based information and discussion¹⁶.

Box 2: Strengths and Weaknesses of System Elements

The issue of compulsory versus voluntary membership of social protection schemes is a suitable example to highlight the strengths and weaknesses of the respective systems. Compulsory social health insurance makes it easier to achieve large risk pools, to prevent adverse risk-selection and to introduce solidarity amongst different social and economic groups. However, the disadvantage is that it requires either a large formal sector or enormous administrative efforts.

In contrast, voluntary health insurance has the advantage that technical implementation and consensus building is easier. The disadvantages consist of adverse risk selection, and the problem of how to achieve broad mutual support (payment related to the ability to pay of individuals or households).

- Facilitation of **co-operation and exchange of knowledge and experience among developing countries**, particularly **among countries**

¹⁵ Cassels, Andrew: A Guide to Sector Wide Approaches for Health Development. WHO 1997

¹⁶ The Internet will become a major sources of information for developing countries. Training courses always should include modules on how to use new information and communication technologies.

with comparable socio-economic features or countries of the same region This approach may be furthered by offering to:

- a) Finance regional conferences, seminars or workshops,
- b) Finance training courses,
- c) Provide training by experts from similar/comparable countries,
- d) Provide access to information on countries facing similar challenges, e. g. via an internet-based resource pool,
- e) Develop and finance twinning projects between developing countries¹⁷ by for example:
 - focusing on developing countries exhibiting similar political, socio-economic and/or cultural features,
 - extending the twinning projects to CSOs and NGOs and *non-acquis communautaire* issues¹⁸. (This may include health care providers, health insurance carriers, associations, self-help groups, etc.)
 - providing training to European twinning partners, e. g. language courses, country studies and/or workshops on locally and regionally available know-how,
 - facilitating communication and exchange between twinning partners through meetings, conferences, etc. (including provision and use of new communication and information technologies).
- Support of the internal dialogue structure within partner countries through community development and empowerment of disadvantaged population groups, communication and information activities, promotion of political, social and cultural participation, fostering gender equality, etc.
- Supporting the development of **quality standards, quality assurance activities and quality management systems**, such as
 - a) Elaboration of standards and benchmarks for social protection schemes, including health care financing matters ,
 - b) Elaboration of standards and benchmarks for project implementation and consultancies,
 - c) Providing incentives for successful project implementation and/or well performing schemes (with respect to target achievement),
 - d) Development of quality management systems adapted to local circumstances,
 - e) Providing adequate training and support services to local staff of projects and/or schemes (regular up-date of skills and know-how, provision of an expert-pool, online support, hotlines).
 - f) Creation of adequate mechanisms and structures to deal with complaints and suggestions of clients, customers and staff,

¹⁷ Similar to the twinning model practised with PHARE countries.

¹⁸ “*Acquis communautaire*” means the assets commonly acquired within the EU.

- g) Establishing regular and standardised client and staff satisfaction surveys.
- o Development and/or strengthening of adequate **information sources** and decision-oriented **monitoring systems**, including
 - a) A **know-how resource database** drawing on European technical and policy expertise and practise¹⁹. This database could also be helpful in the process of political consultation and policy dialogue.
 - b) A **resource (project) database** drawing on experience gathered in development projects and from different schemes in partner countries²⁰. Generally, there is a strong interest in sharing experience, learning about best practice, and identifying lessons learned on the implementer and user side.
 - c) A **success indicator database**, measuring the successful implementation of TC-projects, and their impact on the target groups. It could be used by the EU and partner countries. Indicators might include measures of health status, poverty, access to health care, gender, equity and economic evaluation techniques.
 - d) Long term **monitoring** and SWOT²¹ analysis of social protection schemes and project implementation, including
 - development of a standardised evaluation methodology,
 - identification of factors determining the performance of schemes (e. g. requirements for implementation, social, cultural and economic factors, etc.),
 - identification of “best practices”, to be fed into the know-how- and project database.

¹⁹ It could be built on the experiences gained by MISSOC. Experiences gathered in projects and in schemes of partner countries could gradually be incorporated, cf. b).

²⁰ This database could be built on the experiences gathered by databases such as SHARED (developed by GTZ for the Commission), InfoSure (GTZ) or HEARD (DSE). The possibility of merging this database with the proposed know-how resource data base should be explored.

²¹ Strengths, weaknesses, opportunities, threats.

5 CONCLUSIONS: INNOVATION, QUALITY AND RESPONSIBILITY

This paper describes the current status of social protection systems in the field of healthcare worldwide, and reflects upon the challenges that face this sector. The paper is addressed to European decision-makers and all interested parties and invites them to actively contribute to an international debate on how to pursue the set up of appropriate systems for social protection in the health-care sector in low and middle –income countries. In so doing, the paper points to the long-standing European experience in this field and elaborates on the rich and varied assets that Europe can contribute to the debate.

The authors would like once again to stress the fact that European social protection systems have over time proved adaptable to change. This makes them worth analysing in an attempt to find solutions for shortfalls or emergent crises in this sector worldwide. Furthermore, it is the authors' firm belief that it is the development of and adherence to the set of fundamental principles underlying the European systems that make the European experiences and assets worth examining, sharing and discussing with other actors in the field. The universal appeal of the principles they embody makes it possible to adapt elements of the European systems to circumstances and needs found in other parts of the world. Concerning international technical co-operation in particular, the authors want to point to the fact that Europe, as well as being able to contribute substantial technical know-how in the field, can also draw on principles and lessons learned that should be enrich any debate on the future of social protection. This paper argues strongly that the achievement of effective and equitable risk protection in health care needs much more than simply financial inputs, or sheer technical considerations. Social protection is, first and foremost, a matter of shared societal values, and adequate social and political processes. Of course, sufficient financial resources have to be made available, but system and structure deficiencies have to be tackled, too. Thorough attention has to be given to the following issues:

- Clarification of the value base,
- Agreement on guiding principles, such as solidarity, subsidiarity, and responsiveness to needs
- Co-operating, co-ordination and twinning,
- Balancing of power and interests, participation,(Is ensuring/encouraging participation perhaps a separate point?)
- Priority and standard setting,
- Establishment of information systems,
- Monitoring social processes, technical procedures and quality,
- Creating an open-minded environment that not only facilitates the exchange of ideas and information, but also facilitates the debate on strengths and weaknesses of different systems and reform options.

Developing processes to address these issues forms an integral part of the work of every modern and innovative organisation. That is why the authors think that the support to innovative processes and their monitoring could represent one of the main targets in technical co-operation.

At this point, it is necessary to ask the question arises, who should be responsible for tackling the issues mentioned above?. Two different types of actors can be identified with this respect. On the one hand there are the donors and technical co-operation agencies, on the other there are the beneficiaries, be it nations, institutions or the users.

On the donors`/technical agencies` side it is important to acknowledge that the implementation of effective modern social protection mechanisms takes time. In most cases, changes in attitudes and behavioural patterns are slow processes. It may take decades until social security schemes are fully implemented - as illustrated by the experience of the European systems. Ultimately, the crucial question is whether the beneficiaries claim and take on ownership of a system. Therefore, it is important to clarify who will be responsible not only for the decision-making, but also for the implementation and monitoring processes. This is particularly important during the period until implementation activities show a positive impact, and sustainability is achieved.

On beneficiary side it will therefore be important to develop full ownership for the planning, implementation, monitoring and evaluation procedures - even in the presence of strong technical assistance. If schemes are to be effective, then reliability, responsiveness, open access, effective anti-corruption policies, decentralisation, public information, participation and transparency are all crucial. . This is the case no matter what type of scheme is envisaged-state-run schemes, para-statal/ quasi-public social protection carriers, private organisations and/or mixed systems

In order to maintain, improve or extend systems of social protection worldwide it will be necessary not only to develop the technical expertise and the managerial know-how in the field but also to pay particular attention to the values and principles that guide societal development in any given country. The authors believe that solidarity mechanisms, empowerment of citizens, equal and adequate access to fundamental services addressing basic human rights and ensuring the best possible mental and physical health status of the individuals are the values and principles that should guide societal development and that adherence to these should be the concern of everyone.

6 GLOSSARY OF TECHNICAL TERMS

This glossary provides the definition of some technical terms as used by the authors in the paper.

Equity:

Equity is often confused with *equality*. *Equity* refers to a system of justice based on conscience and fairness. *Equality* is 'the state of being equal' (Longman New Universal Dictionary, in Donaldson, C. 1993). *Equality* may be considered as a particular interpretation of *equity*. *Equity* is different through its incorporation of the idea of social justice. It may be judged fair to be unequal. A variety of definitions of equity exist, including:

- equal health,
- equal access to health care,
- equal utilisation of health care,
- equal access to health care according to need, and
- equal utilisation of health care according to need.

Given the importance of social justice in the concept of equity, it seems fair to suggest that the last two definitions come closest to European thinking. These definitions comprise two important dimensions of equity: financial equity (access) and equity of opportunity to use health care resources.

A useful distinction is made between *vertical* and *horizontal* equity. Horizontal equity implies *equal* treatment for *equal* need. Vertical equity implies the *unequal* treatment of *unequal* need (which may be judged fair).

The different interpretations and definitions of equity may give rise to conflicting health care equity objectives. Moreover, it seems that there is no universal equity measure. In consequence, each health care system has to decide upon its own equity objective(s), and to confront and resolve any potential conflict between equity objectives, and to monitor achievement of objective(s) (Green, A., 1992, Donaldson, C., 1993).

The World Health Report 2000 proposes an index of fairness regarding health care financing. Wagstaff, A. (2001), however, argues that this index cannot discriminate between health financing systems that are regressive and those that are progressive. Moreover, the WHO index cannot discriminate between horizontal inequity and progressivity/regressivity of a financing system. Therefore, he suggests the use of an approach developed in the income redistribution literature used in the late 1990s to study the fairness of various OECD countries' health care financing systems. He argues that policymakers should be not so much concerned about the distribution of health care payments *per se* (and, in consequence, de-link payments and health care utilisation). Rather they should be concerned to ensure that the distribution of health care payments does not have an unduly adverse effect on the distribution of disposable income of households (to buy other goods and services). This is a strong argument in favour of most European health care financing systems.

Poverty

Extreme poverty is defined as a purchasing power of less than one US dollar per capita per day. According to this definition over a billion people are living in extreme poverty. The majority of them are women and girls. Some two thirds of the poor in developing countries live in rural areas, yet urban poverty also is on the increase.

Poverty does not just mean that people have low incomes but also that they are faced with limited opportunities and have inadequate means of taking part in political and

economic life, that they are particularly exposed to risks, their human dignity is not respected, their human rights are abused and that they lack access to resources. __

Social Protection:

Means the entire system of measures to protect citizens against the risks of sickness, natural disaster, accident, old age, unemployment, occupational hazards, and lack of basic means to lead a decent and healthy life. Forms of social protection comprise traditional, informal and formal arrangements. These include families, solidarity-based groups (voluntary membership and/or self-help), cooperatives, (compulsory) membership-based systems of social security (such as social health insurance), private insurance (for-profit, or not-for-profit), government-based forms of social security as well as social assistance.

Social Security:

Defined as systems for formal social protection, that are run either by public, private or by state-owned carriers. There exist mixed systems. All social security systems are ruled by (mostly public) law, and/or controlled by the state, or public organisations. Social security includes tax-financed national health services, social health insurance schemes, pension funds, unemployment funds, occupational accident funds (occupational hazards), long-term care insurance, and social assistance. They are designed to effect a distribution of income considered desirable, and to prevent poverty of affected individuals or households. Benefits are either provided in kind or in cash. In many instances, the term social security schemes is used for member- and contribution-based social insurance systems only, excluding tax-based systems (such as national health services).

Social Safety Net:

Includes measures to reduce poverty, such as social assistance and disaster funds.

Solidarity:

As understood in Germany and, more generally, in Europe, is the ethical platform of joint efforts among people of economically different initial positions directed so as to achieve a common socio-economic goal to reduce social friction. Everyone in the solidarity system should have access to the same quality of care and the same comprehensive benefit package, on equal terms. No family should be financially burdened by illness, and a family's contribution should be based strictly on the family's ability to pay and be completely unrelated to the size of the family or its health status.

Subsidiarity:

(possibly best translated into English by "supplementary") implies that tasks and obligations should always be fulfilled by the lowest possible level within society that is capable to shoulder the burden and/or to solve the problem. This ²²principle foresees that government should step in as a regulator of private affairs only if the private system fails to own up to shared social goals. It also

²² Federal Ministry for Economic Cooperation and Development (2001): Poverty Reduction – a Global Responsibility. Program of Action 2015: The German Government's Contribution Towards Halving Extreme Poverty Worldwide

implies that government should direct its monetary subsidies and other form of assistance mainly to those individuals in society who cannot help themselves (Reinhardt, 1993).

SWAp – the Sector-Wide Approach:

The main features of sector wide approaches to social sector development comprise the following :

- a strong and high-level *ownership- and leadership of a strategic vision* for social sector reform,
- a well-defined *policy and strategic framework*, including clear priority setting and pursuit and definition of performance targets and indicators,
- an *approved financing framework*, with clearly defined responsibilities of the Government, donors, private sector and community groups,
- a commonly agreed and *collaborative work programme* and implementation plan,
- a *plan for institutional reform* and development, including priority capacity building requirements for policy/strategy implementation, and
- agreed *strategic negotiation processes and performance review* mechanisms, including broad stakeholder participation.

7 REFERENCES

Atim, Chris: *Contribution of Mutual Health Organizations To Financing, Delivery and Access To Health Care. Synthesis of Research in Nine West and Central African Countries. PHR Report N°18. July 1998.*

Bannock, G., Baxter, R.E., Davis, E.: *The Penguin Dictionary of Economics. Penguin Books Ltd. London 1992*

Basaza, Robert: *Voluntary Health Insurance. The Impact of and Prospects for Voluntary Health Insurance in Sub-Saharan Africa. 1998.*

Cassels, Andrew: *A Guide to Sector Wide Approaches for Health Development. WHO 1997.*

Donaldson, Cam and Gerard, Karen: *Economics of Health Care Financing: the Visible Hand. London: The Macmillan Press LTD 1993*

European Commission: *Social Protection in Europe. Luxembourg 1994*

European Commission: *Social Protection in the Member States of the European Union. Luxembourg 1999*

Federal Ministry of Economic Cooperation and Development (2001): *Poverty Reduction – a Global Responsibility. Program of Action 2015: The German Government's Contribution Towards Halving Extreme Poverty Worldwide*

Green, Andrew: *An Introduction to Health Planning in Developing Countries. Oxford: Oxford University Press 1992*

Hohmann, Weber, Herzog and Criel: *InfoSure – Health Insurance Evaluation Methodology and Information System. Wiesbaden, 2001*

Hohmann, Jürgen: *Gesundheits- Sozial- und Rehabilitationssysteme in Europa. Göttingen 1998*

ILO: *Social Health Insurance. Geneva 1999*

Kutzin, Joseph: *Enhancing the insurance function of health systems: a proposed conceptual framework. In: Achieving universal coverage of health care (eds.: Nitayarumphong, S., Mills, A.). Office of Health Care Reform, Ministry of Public Health, Thailand. Nontaburi 1998.*

Normand, Charles; Weber, Axel: *Social Health Insurance – a Guidebook for Planning. Geneva 1994*

Office of Research, Evaluation and Statistics, USA: *Social Security Systems around the World. Washington 1999.*

Reinhardt, Uwe: *The German health system: providing equitable, universal access to health care and controlling its costs. Senior policy seminar on health financing in China. Beijing, China 1993.*

Stierle, Friedeger: *Financing Health Care in Poor Countries – Issues and Lessons Learned. Eschborn: Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) mbH, 1998*

Wagstaff, Adam: *Measuring Equity in Health Care Financing: Reflections on Alternatives to the World Health Organization's Fairness of Financing Index. Development Research Group and Human Development Network, World Bank. Washington 2001*

Weber, Axel: *Ordnungspolitische Aspekte Europäischer Gesundheitssysteme. In: MMG 15 (1990) p. 76*

Weber, Leienbach: *Soziale Sicherung in Europa. 4. Auflage, Baden Baden 1999*

World Bank: *Health Nutrition and Population. Washington 1997*

World Bank: *Innovations in Health Care Financing. Washington 1997*

World Bank: *World Development Report 1993, Investing in Health. Washington 1993*

World Bank: *World Development Report 2000. Entering the 21st Century. Washington 2000*

World Health Organization: *World Health Report 2000. Health Systems; Improving Performance. Geneva 2000-09-13*