Social Health Protection

An ILO strategy towards universal access to health care

- Draft for consultation -

Social Security Department

International Labour Office

March 2007

GLOBAL CAMPAIGN ON SOCIAL SECURITY AND COVERAGE FOR ALL

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Foreword

The Social Security Department of the ILO recently published a first version of a general policy paper outlining its vision on social security for worldwide consultation. The consultation on that general policy paper is being complemented by a series of strategy papers dealing with different aspects of specific social security systems, benefits and regional approaches. The present paper is the first in the Department's series of papers in the field of social health protection and is a contribution to the assignment bestowed on the International Labour Office by the International Labour Conference, namely to launch a major campaign for the extension of social security to all.

This paper is thus of a consultative nature. We hope that it marks the beginning of a wider debate between stakeholders in social health protection, researchers, practitioners and decision-makers on how to provide social health protection to the majority of the world's population and ensure that the human rights to both health and social security as laid down in the United Nations Universal Declaration of Human Rights become a reality in the shortest possible time. In the course of that debate we shall almost certainly have to modify some of our views, but we hope that the basic approach that underpins our thinking, that is, a rights-based approach that advocates universal access to social health protection, is flexible and open enough to achieve a wide consensus on the two central objectives of social security: poverty alleviation and granting to all people the opportunity to live their lives free of debilitating insecurity.

Based on the Department's policy orientation, the first draft of the paper was written by Xenia Scheil-Adlung; statistical and country information was provided by Jens Holst. Many other people have contributed to the paper, however, either by drafting major parts thereof or by providing comments in writing or orally during various meetings. Equally important has been the support by Department staff and colleagues through their practical and conceptual work for the Department, as well as research on various topics or work carried out in the context of technical cooperation projects in various parts of the world that the Department conducts at any point in time. All this experience has helped us draw the policy conclusions presented in this paper. Its central messages have been aired in various forums within and outside the ILO, in meetings with ILO stakeholders and donor agencies.

This paper was made possible by inputs, contributions and feedback on the draft by members of the ILO's Social Security Department, our colleagues in the field and a number of friends working in other agencies.

We are looking forward to receiving reactions from as many more interested people as possible.

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Director

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1. Introduction

Affordability of health care is a key issue in most countries: in high-income countries, increasing costs, financial constraints of public budgets and economic considerations regarding international competitiveness are calling for reforms in social health protection as a political priority. In middle- and low-income countries, ensuring affordable health care is high on the development agenda given the large numbers of people lacking sufficient financial means to access health services: worldwide, more than 100 million people are pushed into poverty every year by the need to pay for health care. [1]

Denied access to medically necessary health care has a significant social and economic impact: aside from effects on health and poverty, the close link between health, labour market and income generation affects economic growth and development. This is due to the fact that healthier workers have higher productivity, and labour supply increases if morbidity and mortality rates are lower.

Universal social health protection ensures that all people in need have effective access to at least essential care and is thus a key mechanism for achieving these objectives. It is designed to alleviate the burden posed by ill health, including death, disability and loss of income. Social health protection coverage also reduces the indirect costs of disease and disability, such as lost years of income due to death, short and long-term disability, care of family members, lower productivity, and hampered education and social development of children due to sickness. It hence plays a significant role in poverty alleviation.

However, for many years, an objection frequently raised against the introduction and extension of social health protection in developing countries was that they were not economically mature enough to be able to shoulder the financial burden associated with social security. This argument demands focusing on macroeconomic growth first and postponing redistribution through social transfers in cash or in kind to the time when the economy has reached a relatively high level of prosperity. This view associates social health protection only with consumptive costs.

At present, social health protection is increasingly seen as contributing to building human capital that yields economic profits through gains in productivity and higher macroeconomic growth.

> ***Everyone, as a member of society, has the right to social security and is entitled to realisation, through national effort and international co-operation and in accordance with the organisation and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality."***
>
> [Art. 22, Universal Declaration of Human Rights, 1948]

The current debate also focuses on the links between ill health and poverty: they play an important role in Poverty Reduction Strategy Papers (PRSP) and have been addressed in the Millennium Development Goals (MDG) aimed at halving extreme poverty and improving health. Implementing universal social health protection might turn out to be a milestone for achieving the MDG by 2015.

The ILO's approach to social health protection is founded on the human rights to health and social security and on the significance of such protection with regard to rights at work

[1] WHO (2004b, p. 2).

and employment. Since its founding in 1919, the ILO has emphasized the role of social health protection in reducing poverty, generating income and increasing wealth.

Today, social health protection is at the core of ILO's strategy for decent work. The relevance of social health protection for the Organization may be illustrated by the fact that in ILO Convention No. 102 on Social Security *health* ranks first among the contingencies covered. The importance of strengthening linkages between rights, employment and development was recently underlined in the report of the ILO World Commission on the Social Dimensions of Globalization. [2]

In view of the alarming deficit in social health protection coverage in many countries and ILO's long experience in this field, a new strategy has been developed with the aim of contributing to achieve universal coverage at a global level. This strategy reinforces the agreement on social security reached among representatives of governments, workers' and employers' organizations at the International Labour Conference in 2001 to give highest priority to "policies and initiatives which can bring social security to those who are not covered by existing systems". It is part of the Global Campaign on Social Security and Coverage for All.

The new strategy responds to the needs of uncovered population groups in many developing countries, the informalization of economies and persisting high rates of unemployment. The approach explicitly recognizes the contribution of all existing forms of social health protection and optimizes their outcomes with a view to achieving universal coverage.

This paper aims to set forth some basic notions about the ILO strategy on "Rationalization of the use of pluralistic financing mechanisms". It is based on the most recent information on social health protection coverage. After a brief introduction to the ILO's concept of social health protection, the paper outlines global patterns of social health protection financing and coverage. Given the lack of data and trends in social health protection coverage. the paper proposes a new indicator aimed at providing, for the first time, some assessment of the global deficit in access to health services. The ILO strategy takes account of the significant gaps revealed by the ILO ACCESS DEFICIT INIDICATOR and suggests new pragmatic policies to close the gaps, based on a rational and coherent approach.

[2] ILO (2004a).

2. What is social health protection?

Based on the core values of equity, solidarity and social justice, the ILO defines *social health protection* as a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings or the cost of necessary treatment that can result from ill health.

Equity, solidarity and social justice are understood here as basic characteristics of universal access to social health protection founded on burden sharing, risk pooling, empowerment and participation. It is up to national governments and institutions to put these values into practice.

Achieving universal social health protection *coverage* – defined as *effective access* to affordable quality health care *and financial protection* in case of sickness – is a central objective for the ILO. In this context coverage refers to social protection in health, taking into account:

- the size of the population covered;
- the financial and geographical accessibility of covered services;
- the extent to which costs of a benefit package are covered, and
- the quality and adequacy of services covered.

Social health protection consists of various financing and organizational options intended to provide adequate benefit packages to protect against the risk of ill health and related financial burden and catastrophe.

Financing mechanisms of social health protection range from tax-funded National Health Service delivery systems to contributions-financed mandatory social health insurance financed by employers and workers (involving tripartite governance structure) and mandated or regulated private non-profit health insurance schemes (with a clearly defined role in a pluralistic national health financing system comprising a number of different subsystems), as well as mutual and community-based non-profit health insurance schemes. Each financing mechanism normally involves the pooling of risks between covered persons, and many of them explicitly include cross subsidizations between the rich and the poor. Some form of cross subsidization between the rich and the poor exists in all social health protection systems, otherwise the goal of universal access cannot be pursued or attained.

Virtually all countries have built systems based on various financing mechanisms that combine two or more of these financing options. ILO's social health protection policies explicitly and pragmatically recognize the pluralistic nature of national health protection systems and advise governments and other key players in social health protection to pursue strategic systemic combinations of national financing systems that aim for:

a) universal and equitable access;
b) financial protection in case of sickness,
c) overall efficient and effective delivery of health services.

In this context it is important to ensure that national health financing systems do not crowd out other social security benefits.

In addition to the organization and financing of health care, other social factors play a pivotal role in achieving desired results in health, such as poverty alleviation, the creation of decent workplaces, and social and economic development in general. Social health protection thus cannot be pursued as an isolated policy: it is and should always be seen as a component of an overall national social protection strategy.

Social health protection needs to tackle specific issues focusing on the complex organization of public and/or private service delivery and purchasing and payment systems, ensuring quality and responsiveness of care, distribution of resources and services across different categories of care and geographic areas, issues related to decentralization, vested interests, and civil society participation.

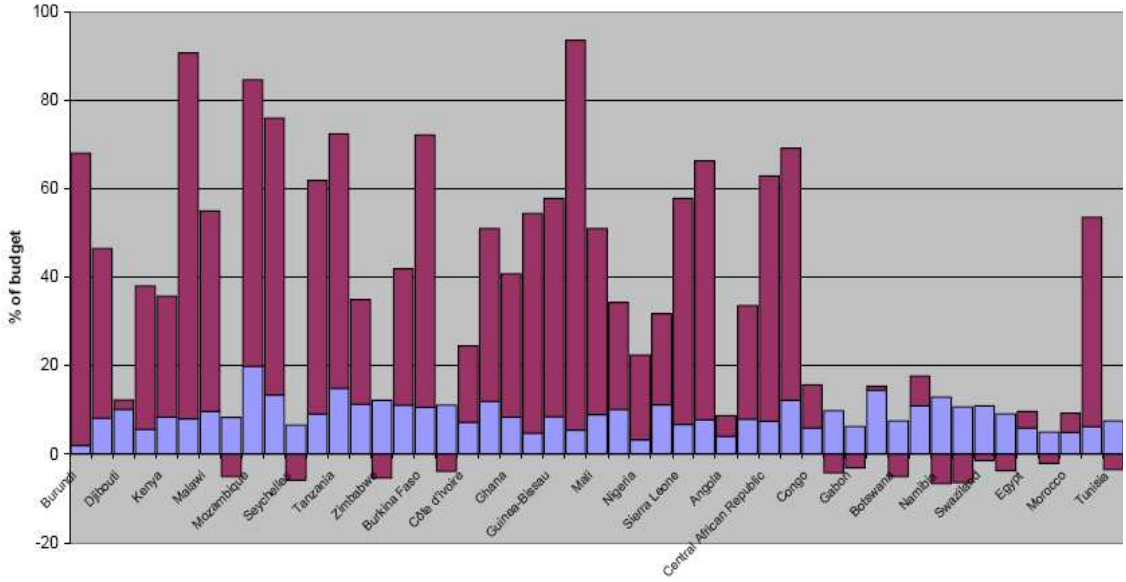
Social health protection can be organized in various alternative ways, particularly with regard to the purchasing and provision of services, as well as the composition of services covered under benefit packages. The concrete nature of these arrangements significantly impacts on the adequacy and quality of care, on the availability of care and on the access, volume and structure of utilization, and hence ultimately on the overall cost of the social health protection system.

The financing of social health protection is therefore a mixture of taxation and contributions to public and mandated private insurance. Through risk pooling, these funds provide for equity, solidarity and affordability of services.

3. Financing social health protection: The current situation

Current concerns in low-income countries often relate to the fact that key health policy targets, such as those formulated in the MDG, cannot be achieved within the limited funds available. In Africa, the financing gap for reaching the US$34 per capita target set by WHO is estimated at between US$20 and 70 billion per year until 2015.[3] Figure 1 illustrates the share of public spending by country required to close the financing gap for Africa.

Figure 1. Share of public spending required to achieve per capita public health expenditure of US$ 34 in African countries



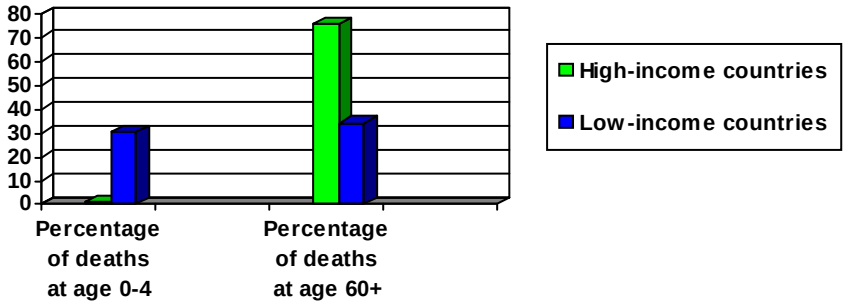
Source: WHO (2005a).

The impacts of funding gaps for people in poor countries are enormous: people not only lack access to health services but they are also more likely to die from diseases that are curable in richer countries, e.g. respiratory infections, which account for 2.9 per cent of all deaths in low-income countries but do not cause many deaths in high-income countries.[4]

[3] WHO (2005a).

[4] Deaton (2006).

Figure 2. Income level of countries and death at ages 0 – 4 and 60 +

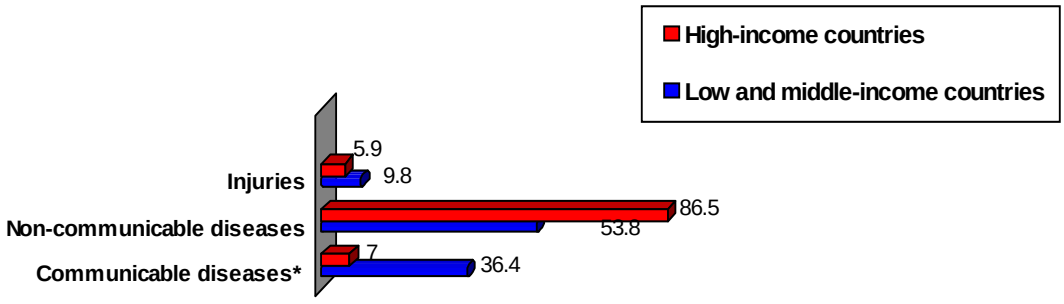


Source: Deaton (2006).

The strong link between poverty, access to affordable health services and death is reflected in the significant difference in child mortality between high- and low-income countries (see figure 2). Low-income countries record 30.2 per cent of all deaths in the 0-4 age bracket, as compared to 0.9 per cent in high-income countries. On the other hand, the share of deaths at age 60 and over exceeds 75 per cent in high-income countries but stands at about 34 per cent in low-income ones. [5]

More generally, death due to communicable diseases, pregnancy and nutrition is more likely to occur in low- and middle-income countries (36.4 per cent) than in high-income ones (7 per cent), while non-communicable diseases account for the majority of deaths (86.5 per cent) in high-income countries (figure 3).

Figure 3. Causes of death in low-, middle- and high-income countries, 2001 (%)



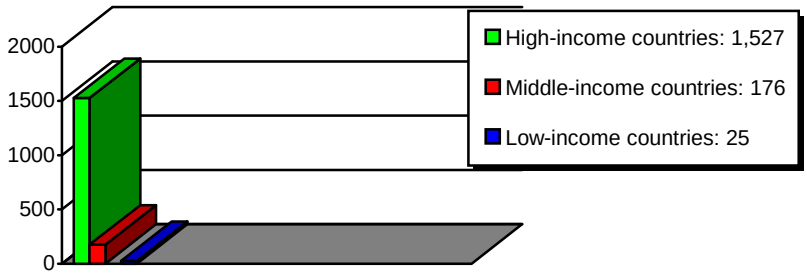
* Includes communicable diseases, pregnancy outcomes and nutrition deficiencies.

Source: World Bank (2006b).

Against this background, it is not surprising that the level of per capita health expenditure also varies significantly between low-, middle- and high-income countries. As shown in figure 4, it ranges between US$1,527 in high-, US$176 in middle- and US$25 in low-income countries. This includes funds from various public, private and other sources.

[5] Deaton (2006).

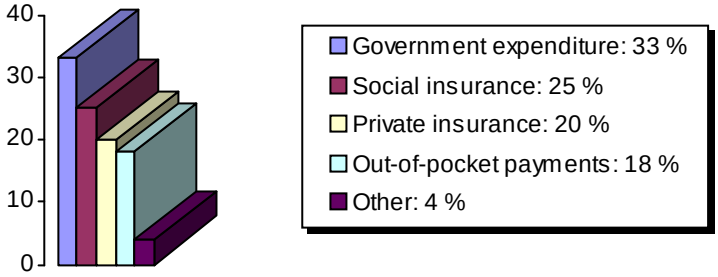
Figure 4. Per capita health expenditure, US$, 2004



Source: World Bank (2006b).

The *financing of health-care costs* is shared between governments, which contribute 33 per cent to global health expenditure, social insurance (covering 25 per cent), private insurance (20 per cent), and out-of-pocket expenditure and other private expenditure which accounts for 22 per cent of worldwide expenditure (figure 5).

Figure 5. Financing of global expenditure on health, 2003



Source: WHO, National Health Accounts, 2006.

The high global share of out-of-pocket payments (OOP) is most worrying. A high share of OOP indicates a lack of coverage in social health protection. OOP is highest in low-income countries, where it ranges between 50 and 80 per cent of total expenditure on health, as in Africa and Asia, for example: OOP amounts to 76.8 per cent of total expenditure on health in Burundi, 57.9 per cent in Chad, 81.7 per cent in the Democratic Republic of the Congo, 58 per cent in Bangladesh, and 69.9 per cent in Cambodia. (For details, see Annex II, Table 1 b.)

OOP is the most inefficient and inequitable way of financing health-care spending. It weighs most heavily on the poor and is associated with a high risk of household impoverishment through catastrophic costs (WHO 2000, pp. 35, 113). Particularly in low-income countries, out-of-pocket payments may lead to increased poverty, catastrophic health expenditure and impact on income generation due to sale of assets and borrowing. In countries such as Kenya, Senegal and South Africa, representative quantitative studies have found that the impoverishment level due to health payments amounts to between 1.5 per cent and 5.4 per cent of households. In all three countries, out-of-pocket health

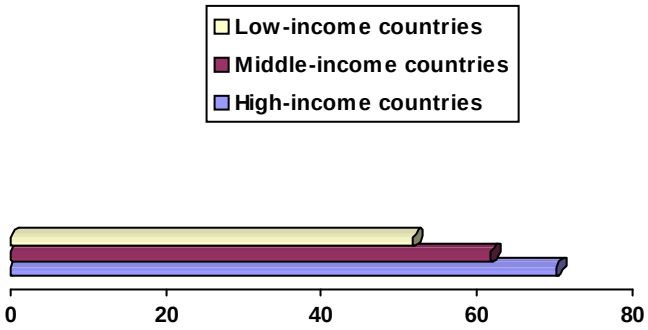
payments also deepen the level of poverty of people that are already poor (up to 10 per cent of households in Senegal, for example). [6]

Figure 6. Total health expenditure as a percentage of GDP

Source: World Bank (2006b).

The share of total health expenditure as a percentage of GDP amounts to 7.7 per cent in high-income countries, 5.8 per cent in middle-income countries and 4.7 per cent in low-income countries (figure 6). Public expenditure on health as a percentage of total health expenditure amounts to 70.1 per cent in high-income countries, 61.7 per cent in middle-income countries and 51.7 in low-income countries (figure 7).

Figure 7. Public expenditure on health as a percentage of total health expenditure



Source: World Bank (2006b).

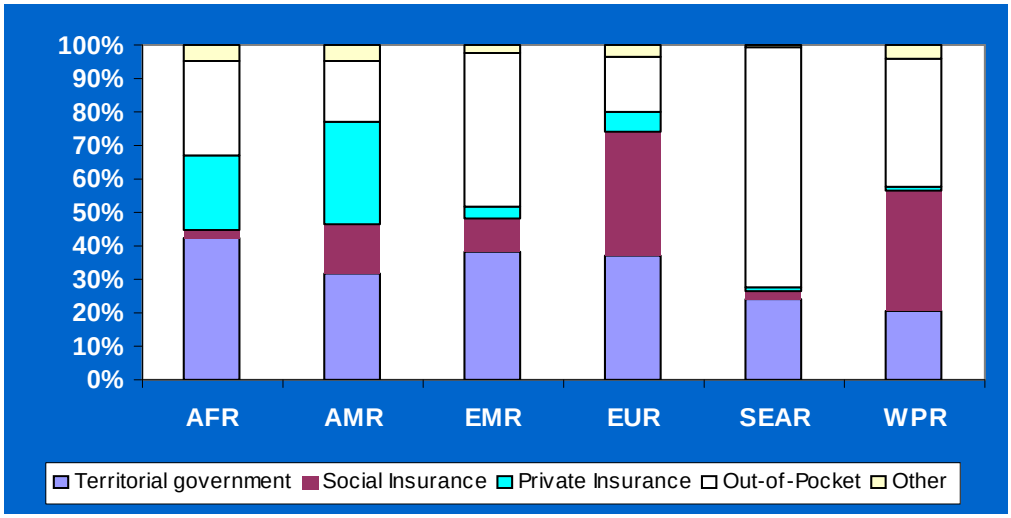
The growing share of public expenditure with rising income levels indicates the growing share of risk pooling through taxes and other forms of social health protection, such as mandatory social health insurance. It is linked to the overall social and economic development of countries, e.g. labour markets, financial markets, legislation, institutional infrastructure, and capacity to collect taxes, for instance.

As shown in figure 8, the share of different forms of social health protection in overall health spending varies significantly among regions. In 2001, tax spending was at 40 per cent relatively high in Africa, Eastern Mediterranean countries and Europe; social health insurance ranked particularly high in OECD and transition countries in the European

[6] Scheil-Adlung, et al. (2006).

region, in Western Pacific and in Eastern Mediterranean countries, while in the Americas private health insurance played a key role.

Figure 8. Sources of health protection by region, 2001



AFR: Africa, AMR: Americas, EMR: Eastern Mediterranean, EUR: Europe, SEAR: South East Asia, WPR: Western Pacific.
Source: WHO, National Health Data, 2003.

The trend to use various sources simultaneously has been developed over the last decade, when universal access to health services was widely accepted as an objective to be achieved in a short period of time. The corresponding financing mechanisms are considered as complementary at all stages of development.

The global profile of financing social health protection for many low and middle-income countries looks as follows:

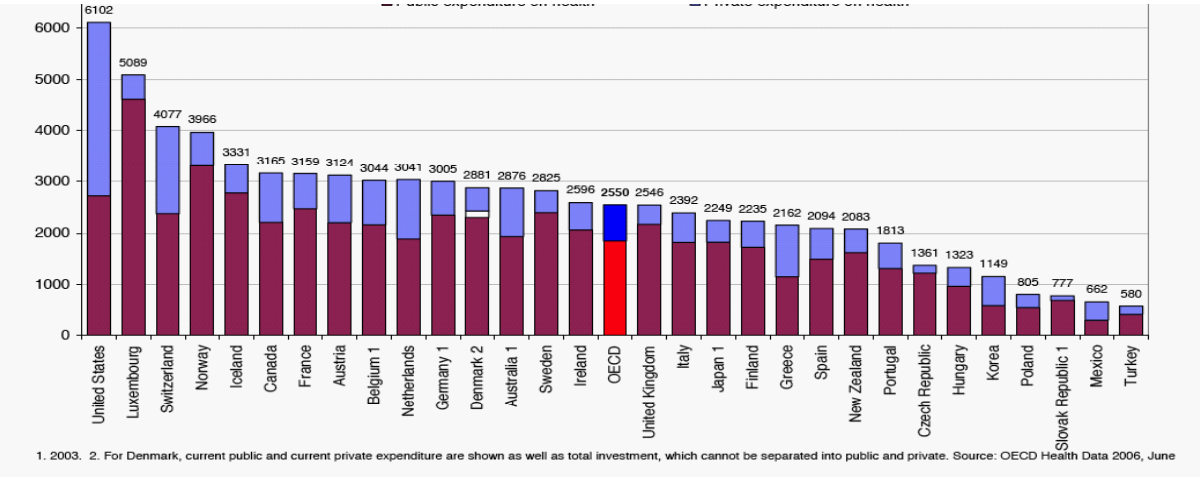
- there is a close relation between income levels of countries, access to health services and mortality;
- limited financial protection leads to high levels of OOP and consequential health-related poverty;
- limited solidarity in financing expressed by the lack of risk pooling;
- low share of social health protection expenditure at GDP and at total health expenditure;
- a large private share of health financing shifts the burden of health protection to households;
- low share of public financing at total health expenditure.

While access to adequate and affordable health care for all remains a key problem for many poor countries, it is increasingly becoming a challenge for high-income countries where rising costs, financial constraints of public budgets and economic considerations concerning international competitiveness are calling for reforms in social health protection as a political priority.

In almost all OECD countries public spending on health is by far the most relevant source for providing social health protection to citizens (figure 9). In Europe, government and social security spending together account for an average of about 70 per cent of total expenditure for health care and the share of population covered by public social protection

mechanisms is close to 100 per cent, except in those countries where private health insurance is mandatory for some population groups (OECD 2006). [7]

Figure 9. Health expenditure per capita, public and private expenditure, OECD countries, 2004



Public expenditure: dark red

Private expenditure: light blue

Source: OECD (2006) (https://www.oecd.org/dataoecd/5/27/36984860.pdf).

Challenges faced by the population in high-income countries include demographic ageing and related changes in disease and disability patterns. Issues such as disability due to chronic diseases are partly linked to ageing and often require expensive and labour-intensive long-term care. Data for Germany indicate that in 2002 about 2.5 per cent of the total population was dependent on long-term care, and the figure is expected to rise to 3.4 per cent by 2020. [8] While most high-income countries provide for some kind of professional long-term care services, this often covers only a small percentage of the nursing care required. Given the cost of long-term care, many elderly dependants are not able to access services considered necessary.

In OECD countries the average health expenditure per capita for persons 65 and older is estimated to be about three times higher than that for younger persons. [9] It is projected that due to demographic ageing total health spending in OECD countries might increase by about 3 per cent of GDP over the period 2000-2050. [10]

According to OECD, total expenditure for long-term care ranges between 0.2 per cent and 3 per cent of GDP in OECD countries. [11] Public revenues are the main source of funding.

[7] This refers to the Netherlands and Switzerland, where health insurance is mandatory. People can choose between various insurance providers, and flat-rate contributions are independent of their ability to pay.

[8] Statistisches Bundesamt (2003).

[9] OECD, 2005a.

[10] OECD, 2004.

[11] OECD, 2005b.

Nursing care in institutions accounts for 82.8 per cent of total expenditure on long-term care in Canada, for example, and for 54.7 per cent in Germany.

The expected development of cost of health care at higher ages and for long-term care embodies a formidable challenge to industrialized countries' health systems. New ways to invest in preventing long-term dependency on chronic care and financing of care need to be devised to avoid the re-emergence of old-age poverty or the dependency on charity in old age in industrialized countries. At the same time, the meaning of solidarity in financing long-term care needs to be redefined in order to avoid solidaristic financing of individual care leading solely to the protection of inheritable estates for the next generation.

The above findings indicate that national patterns of health financing have an impact not only on the health status of the population but also on their income levels and income security. The experience of many industrialized countries shows that social health protection can raise enough funds to achieve universal access while protecting the individual against the risk of high health-care costs in case of sickness.

4. Coverage of social health protection and access to health services

a. ILO concepts and definitions of coverage and access

The ILO's ultimate objective in the field of social health protection is:

> *To achieve universal social health protection coverage defined as effective access to affordable health care of adequate quality and financial protection in case of sickness* [12] .

This definition of coverage refers to the extension of social health protection in respect of the size of the population that can access health services and the extent to which costs of the defined services are covered so that the amount of health-care cost borne out of pocket does not pose a barrier to access or lead to service of limited quality.

To be effective, *universal coverage* needs to ensure access to care for all residents of a country, regardless of the financing subsystem to which they belong. This does not exclude national health policies from focusing at least temporarily on priority groups such as women or the poor when setting up or extending social health protection

Coverage relates to effective *access* to health services that medically match the morbidity structure of the covered population. Compared to legal coverage describing rights and formal entitlements, effective coverage refers to the physical, financial and geographical availability of services.

The ILO advocates that benefit packages (i.e. packages of health services that are made available to the covered population) should be defined with a view to maintaining, restoring or improving health, the ability to work and to meet personal health-care needs. Key criteria for establishing benefit packages include the structure and volume of the burden of disease, the effectiveness of interventions, the demand and the capacity to pay.

Effective access thus includes both access to health services and financial protection. Financial protection is crucial to avoid health-related impoverishment. Financial protection includes the avoidance of out-of-pocket payments that reduce the affordability of services.

Affordability or non-affordability of services refers to the non-existence or existence of financial barriers of access for individuals, groups of individuals and societies as a whole.

[12] This was first formulated in the Medical Care Recommendation, 1944 (No. 69), which in its paragraph 8 provides that "[t]he medical care service should cover all members of the community, whether or not they are gainfully occupied". The universality of the right to health care is also formulated in the Declaration concerning the aims and purposes of the International Labour Organization (Declaration of Philadelphia), 1944, which states as follows: "The Conference recognizes the solemn obligation of the International Labour Organization to further among the nations of the world programmes which will achieve: …. (f) the extension of social security measures to provide a basic income to all in need of such protection and comprehensive medical care;…". In addition, the 1948 Universal Declaration of Human Rights provides in its Article 25 (1) that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control".

Affordability for *particular groups* concerns first of all the poor and aims at avoiding health-related poverty. It should be defined in relation to the maximum share of cost for necessary health care at total household income net of the cost of subsistence; for example, health-care costs could be considered affordable if they amount to less than 40 per cent of the household income net of the cost of subsistence.[13] The WHO considers health-care costs below that share to be non-catastrophic for the normal household. Universal coverage is thus associated with equity in financing, implying that households should only be asked to contribute in relation to their ability to pay.[14] Since the ILO has not defined a relative benchmark for affordability, it is suggested here to use the WHO benchmark for the time being.

Macroeconomic affordability relates to the fiscal space that can be made available to finance a level of expenditure that ensures universal access to services of adequate quality without jeopardizing economic performance or crowding out other essential national services (such as social cash transfers or education, internal security, etc.). Necessary expenditure levels depend on a population's health status, the availability of infrastructure, the price level of services and the efficiency of service delivery. While the ILO does not advocate specific benchmarks on public spending on health, it recognizes that several benchmarks for affordable spending on health have been set by other international organizations and commissions, e.g. US$12 per capita for low-income countries as set by the World Bank and US$34 per capita suggested by the Macroeconomic Commission established by WHO.

The notion of quality refers to various dimensions. They include *quality of medical interventions*, e.g. compliance with medical guidelines or protocols as developed by WHO or other institutions. The *quality of services* also includes ethical dimensions such as dignity, confidentiality, respect of gender and culture, and issues such as choice of provider and waiting times.

Compared to the definition of coverage in other areas of social protection, the concept of social health protection coverage is therefore rather complex and multidimensional. Hence, when quantifying the share of the population covered by social health protection the various dimensions of coverage need to be taken into account. Due to the complexity of the subject matter, no statistical measurement of coverage can be perfect. A set of – always imperfect – indicators is all we can hope for. The following section of this chapter provides information on the present level of and trends in social health protection coverage that could be compiled from existing information.

b. Trends and data on formal social health protection coverage

The history of social health protection is characterized by a gradual increase in risk pooling: some two hundred years ago, private – out-of-pocket – spending was the only financing mechanism available. Later on smaller risk pools developed, but a robust notion of social protection in health did not emerge before the concepts of social health insurance and national health service were put into practice by Bismarck, respectively Beveridge. Today the pioneer countries of social health protection such as Germany, Luxembourg, Belgium, France and the United Kingdom are high-income countries with universal formal coverage and effective access to health services, the main health financing mechanisms used still being contribution-based social health insurance, respectively the tax-based

[13] This definition refers to the WHO definition of "catastrophic health expenditure".

[14] Evans (2007), p. 9.

National Health Service. These countries show only a small share of health expenditure by private for-profit insurance companies, and OOP amounts to about 10 per cent of total health expenditure (Annex II, Table 1b).

The trends in formal *social health protection coverage* that can be delineated on the basis of existing sources of information suggest a link[15] between rising income levels of countries and the use of health financing mechanisms based on risk pooling and prepayment. However, it is also important to note that levels of health expenditure and levels of formal social health protection coverage vary greatly at each national level of income. This indicates that there is considerable policy space for countries wishing to introduce social protection financing of health-care risks.

In many low-income countries OOP serves as the key financing mechanism for health care – up to 80 per cent of total health expenditure in countries such as Myanmar, the Democratic Republic of the Congo, Guinea and Tajikistan. Remaining expenditures are usually financed by taxes and to a small extent by social and community-based health insurance schemes (Annex II, Table 1b). In middle-income countries, such as Lebanon and Guatemala, private for-profit insurance is reducing the share of OOP. However, OOP often remains the principal financing mechanism, followed by government budgets and social health insurance (Annex II, Table 1b). In at least 22 countries (China and India among them, see Annex II, Table 1b), 50 per cent and more of total health expenditure is borne out of pocket.

Accordingly, in low- and middle-income countries formal social health protection coverage often remains far below universal coverage, even decades after the first public insurance scheme was introduced (e.g. in Latin America). In El Salvador, for instance, formal coverage of public and private schemes together concerns only about half of the population (table 1).

In tables 1 and 2, "coverage" is measured in terms of population that is *formally* covered by social health protection, e.g. through legislation, without referring to effective access to health services, quality of services or other dimensions of coverage discussed below.

Table 1. Formal social health protection coverage in % of population in selected Latin American countries and selected years between 1995-2004

Country	Public scheme	Social insurance	Private insurance	Other	Total (%)
Argentina	37.4	57.6	4.6	1.4	100
Bolivia	30.0	25.8	10.5	0.0	66.3
Colombia	46.7	53.3			100
Ecuador	28.0	18.0	20.0	7.0	73
El Salvador	40.0	15.8	1.5		57.3
Haiti	21.0		38.0		60.0
Honduras	52.0	11.7	1.5		65.2
Nicaragua	60.0	7.9		0.5	68.4

Source: Mesa-Lago (2007).

Formal social health *insurance* coverage, including community-based schemes in low-income countries of Africa and Asia, ranges from the exceptional coverage rate of 78 per

[15] World Bank, 2006b.

cent of the total population in Mongolia to 5 per cent of the total population in Lao People's Democratic Republic and 7 per cent in Kenya (table 2).

Table 2. Formal coverage in social health insurance protection in selected countries of Africa and Asia

Country	Insurance schemes	Estimated formal coverage in % of total population
China	– Urban workers – Basic insurance – RCMS (new)	10
India	– EISIS – CGHS – CBHI	20
Indonesia	– ASKES – JAMSOSTEK – CBHI	20
Kenya	– NHIF	7
Lao People's Democratic Republic	– CCS – SSO – CBHI	5
Mongolia	– National scheme	78
Philippines	– Phil Health – CBHI	55
Senegal	– IMPs – MOH	11.4

Source: WHO (2005); Scheil-Adlung et al. (2006).

As mentioned earlier, while in some cases there may be linkages between increasing levels of national income and the use of prepayment and risk pooling mechanisms in health care, in a significant number of countries a stringent link cannot be identified. Data presented in Annex II, Table 1b suggest that the extension of social health protection is not necessarily directly linked to a country's income level:

- Burundi and the United Republic of Tanzania – countries with GDP per capita of US$100, respectively US$90 – formally cover about 13 and 14.5 per cent of their respective population while the Democratic Republic of the Congo – with a similar GDP per capita – provides coverage at a rate of only 0.2 per cent.
- In Ghana (per capita GDP US$320), 18.7 per cent of the population is formally covered by a health protection scheme, while corresponding rates are significantly lower in Togo (0.3 per cent, GDP per capita US$310) and Burkina Faso (0.2 per cent, GDP per capita US$300).
- A country with a slightly higher GDP per capita like Kenya (US$390) offers formal social health protection to a quarter of its population, and Haiti with no more than US$380 per capita to as much as 60 per cent. Countries with a higher level of GDP like Bolivia (US$890, coverage rate 66 per cent) and Guinea-Bissau (US$920, coverage rate 1.6 per cent) also show very different rates of formal coverage.

This confirms that, depending on a country's specific situation, including strong political will to set priorities, extending social health protection is a possible option for many more countries than commonly assumed, and that population coverage is to some extent independent of their income levels.

The historical development of national coverage rates in countries with high coverage also supports this argument. In some cases it takes many decades to achieve high levels of coverage while in others, starting from similarly low levels of GDP per capita, full coverage is achieved within only a few decades or even years.

The following figures compare the cases of Austria, Canada, France, Germany, Japan, the Republic of Korea, Luxembourg and Norway (see table 3): in the 1920s, countries such as Austria and Germany formally covered some 30 per cent of their total population while others (e.g. France and Norway) – had formal coverage rates of around 20 per cent, and Japan only 3.3 per cent. In 1970 the situation had changed considerably: all countries – except the Republic of Korea – had achieved between 90 per cent and 100 per cent coverage; the related GDP per capita ranged between US$1,997 in Austria and US$3,985 in Canada. In 1980 the Republic of Korea covered some 30 per cent of the total population based on a GDP per capita of US$1,632; in 2000 it achieved 100 per cent formal coverage, with a GDP per capita of US$9,671. This coverage rate was thus achieved with a per capita GDP of less than one-third of the other countries compared.

Table 3. Historical development of formal health protection coverage

Country	Year	Total number of insured as a % of total population	GDP per capita / US$ exchange rate
	1920	18.3	
	1923	32.7	
	1924	34	
	1925	34.3	
Austria			
	1970	91	1 997
	1980	99	10 530
	2000	99	23167
	-	-	
	1970	100	3 985
Canada	1980	100	10 843
	2000	100	22 708
France / Alsace-Lorraine	1921	22.9	
	1970	95.7	2 884
France	1980	99.3	12 742
	2000	99.8	21 884
	1920	31.7	
	1925	32	
Germany			
	1970	88	3 044
	1980	91	13 145
	2000	-	22 814
	1921	35.2	
	1922	35	
	1925	35	
Great Britain / United Kingdom			
	1970	100	2 205
	1980	100	9 524
	2000	100	23 954
	1927	3.3	
Japan	1970	100	1 971
	1980	100	9 164
	2000	100	37 544
	-	-	
Republic of Korea	1970	-	272
	1980	29.8	1 632
	2000	100	9 671
	1922	16,6	
Luxembourg	1970	100	3 728
	1980	100	14 433
	2000	-	43 083
	1920	21.3	
	1925	21.6	
Norway			
	1970	100	3 285
	1980	100	15 519
	2000	100	36 028

Sources: ILO, Compulsory Sickness Insurance, Geneva, 1927 (for years 1920 to 1925); OECD Health Data, 2005 (for years 1970 to 2000).

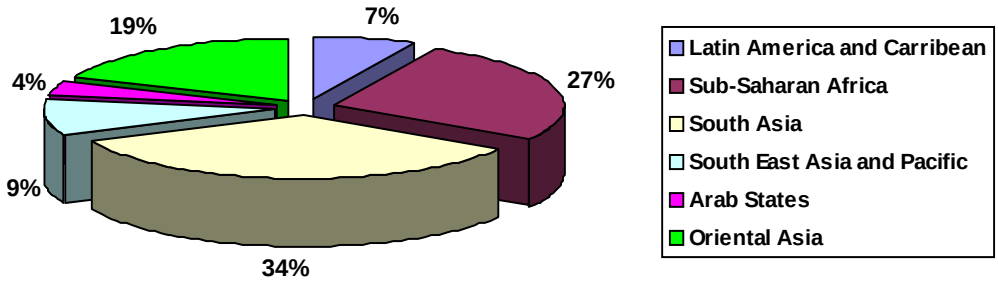
c. The global access deficit: An attempt to estimate its dimension

Unfortunately, globally comparable data on *access to health services* are rather weak and incomplete for use in international comparisons.

Available WHO data indicate that, worldwide, about 1.3 billion people are not in a position to access effective and affordable health care if needed, while 170 million people are forced to spend more than 40 per cent of their household income on medical treatment. [16]

The 1997 UN Development Report estimates that most of the poor that lack access to health services live in developing countries: 34 per cent in South Asia, 27 per cent in sub-Saharan Africa and 19 per cent in South-East Asia and the Pacific (figure 10).

Figure 10. Poor people lacking access to health services (in % of total number of poor in developing countries)



Source: UNDP (1997).

Despite significant efforts of many national and international institutions to develop and provide data on access to health services – particularly by the poor – the information available remains fragmented and is often not comparable. Nevertheless, the availability of such data is vital when developing and advocating strategies for universal coverage, given the close link between access to health services and lack of coverage in social health protection.

Numerous conceptual and methodological issues come into play in the provision of data on coverage and access; in addition, often only very specific and non-comparable national data are available at national and international levels, data that do not allow assessments of effective coverage and access. Ideally, the most useful approach to measure social health protection coverage would be a combined indicator of various indicators reflecting the situation in a country, including:

- the number of people formally/legally covered by social health protection;
- the costs that legally covered individuals face to obtain needed care, e.g. OOP;
- the cost of public and private health expenditure not financed by private households' out-of-pocket payments;

[16] WHO (2004b), p. 2.

- total public expenditure on health benefits as a percentage of GDP,
- physical access to health services.

Such a combined indicator does not exist and more research is needed to combine fragmented national data in a meaningful way. Among these indicators, physical access to health services in particular is relatively difficult to measure and yet it is the factual basis for all concepts of coverage. Legal coverage, for example, is meaningless if the necessary physical health-care infrastructure and the necessary health-care staff are not available. Access to health services does not vary only among countries and regions, but also within countries. Attempts to describe and quantify access to health care often refer to access to hospital beds. However, this indicator tends to overweigh hospital care if used as a co-indicator for social health protection coverage.

Indicators on the outputs of health policies with respect to maternal and child health might provide a first approach to measure effective access to health services. Until more reliable data become available, the following indicators might serve as a proxy for estimating access to health care, even if this exhibits some inconsistencies:

- The benchmarking of the density of health professionals, and
- The proportion of deliveries attended by skilled personnel.

Thus, it is suggested that the parallel use of the number of health professionals per population and of the proportion of professionally attended births opens up a range of relative values that might serve as a crude indicator for access or non-access to health services. The range of values can also be used to establish an indicator for the estimated access deficit in a country. This is estimated on the one hand by the proxy indicator of women giving birth without the presence of skilled health personnel; on the other hand, it is measured by comparing a country's density of qualified health professionals (population per health professional, i.e. physicians, nurses and midwives) to the density level of Thailand (313 persons per health professional in 2004). Countries like Algeria, Ecuador, the Republic of Korea, Mexico, Namibia, the Syrian Arab Republic and Turkey show similar densities (i.e. between 280 and 330 persons per health professional).

Table 4. Density of health professionals

Country	Population per health professional
Algeria	297
Bolivia	262
Burkina Faso	129
Chad	3113
Egypt	388
France	92
Ghana	932
Mexico	348
United Kingdom	66

Source: ILO calculations (2007).

While the births attendance based indicator simply transposes the lack of access to qualified health care from pregnant women to the total population, the density-based access deficit indicator uses another methodology. The access deficit is measured as the relative difference of the national density levels from the Thailand benchmark. This measurement is obviously a conservative minimum estimate of the access deficit. If, for example, health professionals are very unevenly spread in a country then the de facto

deficit can be much bigger than the estimate based on national averages. But if this rather "optimistic" indicator signals a national or regional problem then one can safely assume that the real problem is even bigger than the one indicated by national averages.

Tables 1a and 1b of Annex II provide a profile – albeit imperfect – of our present knowledge of national coverage statistics. They mirror the two deficit indicators on a country-by-country basis with further information such as population, GDP, Human Poverty Index, Gini index, formal coverage, OOP, and total expenditure on health. It should be stressed that the suggested indicators only allow to estimate the global national access deficit and provide insight into the gap of effective social health protection coverage in connection with the other coverage-related variables. However, the tables make it possible to run interesting regression analyses.

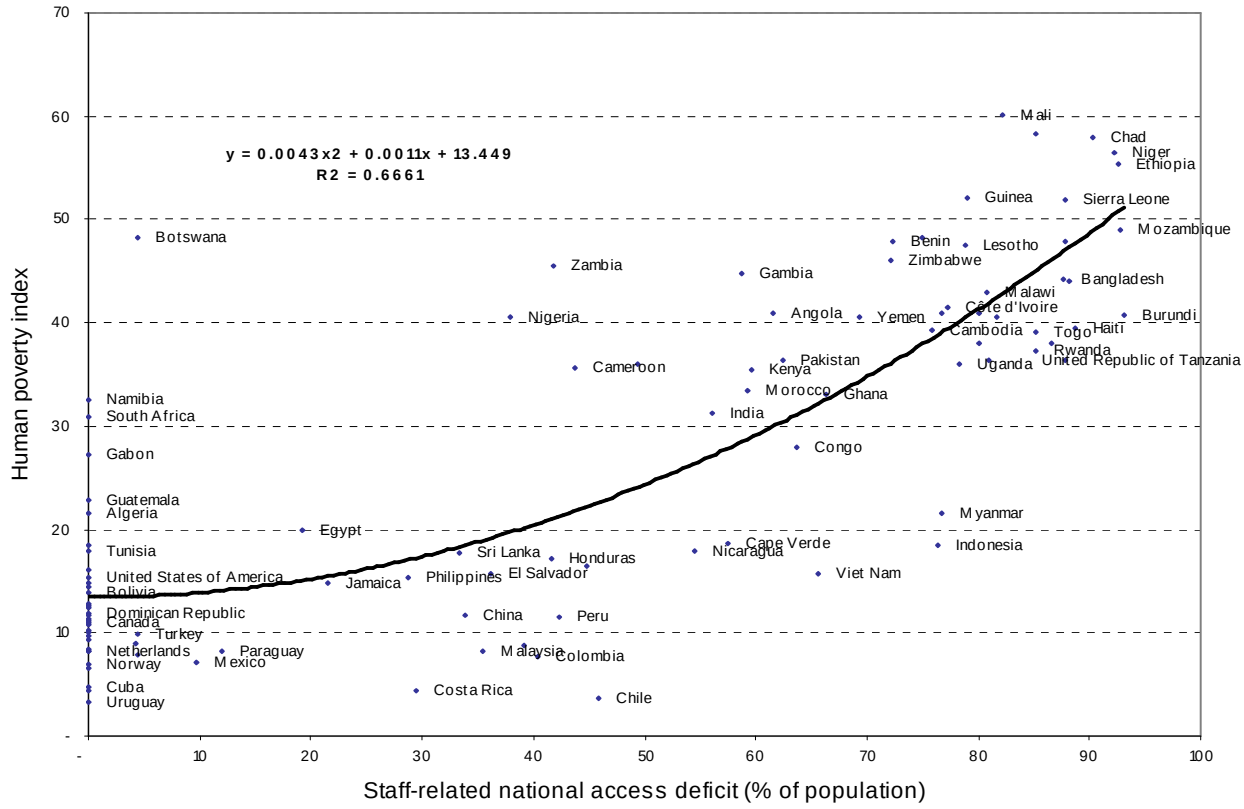
Figure 11 shows the correlation between staff-related national access deficit and the Human Poverty Index (HPI). It is worth mentioning that the HPI, an indication of the standard of living in a country, is based on four components, namely the probability at birth of not surviving to age 60, people lacking functional literacy skills, long-term unemployment and population below 50 per cent of median adjusted household disposable income.

Countries with a low HPI tend to have small staff-related national access deficit. Therefore, it is not surprising to observe that most of the developed countries are in the lower-left part of the figure. Conversely, a high poverty level is correlated with high access deficit. Countries such as Chad, Ethiopia and Bangladesh characterize this correlation well.

However, some countries show significant variation from the general trend. Botswana, for instance, has a relatively low access deficit given its poverty level. Assuming data are accurate, one can conclude that Botswana, like other countries in the upper left part of the figure, enjoys a relatively better health access than its poverty level would suggest. The opposite statement is true for countries in the lower right part.

Correlation between access deficit and Human Poverty Index does not prove that low global national access deficit reduces poverty but rather illustrate that they usually coexist together.

Figure 11. Regression between access deficit and Human Poverty Index



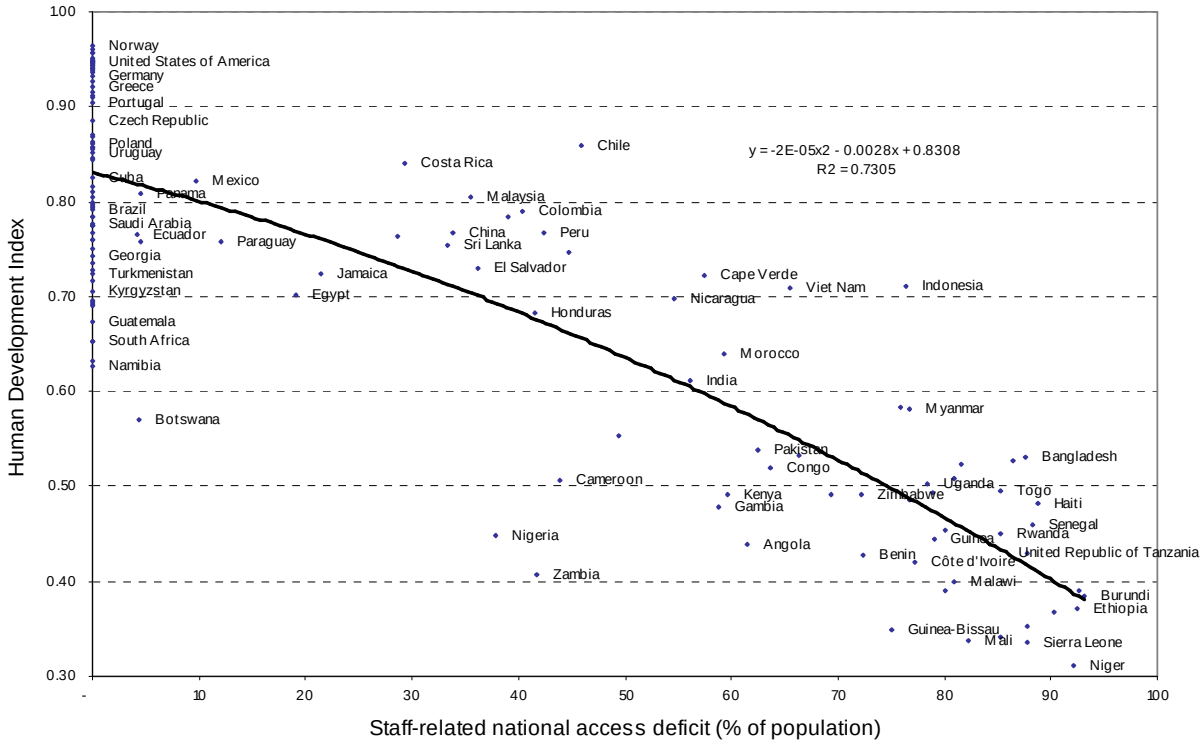
A similar analysis can be made with the Human Development Index (HDI). This index is a comparative measure of life expectancy, literacy, education, and standard of living for countries worldwide. To some extent the HDI covers many components of the HPI. Thus, it is normal to observe comparable trends in figure 6 despite the fact that some countries have significant different interrelations.

Nevertheless, the correlation shown in figure 12 is slightly stronger than with the HPI. This means that on average the development level is a better indicator of the staff-related national access deficit than the poverty level.

In the same way, regressions between GDP per capita and global national access deficit provide interesting information. A high GDP per capita level is correlated with a low health-care deficit.

Regression with the Gini coefficient, which is a measure of inequality of income distribution, is less conclusive. We observe that the correlation is weaker even though the calculations show that a greater inequality is correlated with a greater health access deficit.

Figure 12. Regression between access deficit and Human Development Index



While the above Access Deficit Indicator has the potential to provide globally comparable data, it certainly does not provide fully consistent data and reveals some divergence if compared to survey data from countries. This is due to a number of reasons, including the fact that it does not take into account:

- The differentiation according to scope and depths of coverage such as varying benefit packages and quality
- The diversity of definitions applied in various statistics used, e.g. regarding social security, social health protection and other relevant terminology
- Geographical, socio-economic and socio-cultural differences within and between countries
- The difficulty of assessing small-scale community-based health benefit schemes in terms of quantity and coverage. Most of the available evidence focuses on the number of such schemes and the average or range of membership, but does not contain any concrete data on the number of affiliates and beneficiaries. Mainly in African countries, community-based health benefit schemes cover formal sector workers as well as beneficiaries who belong to the country's informal economy.

While being conscious of its limitations, the ACCESS DEFICIT INDICATOR has been calculated for the first time for a significant number of countries. The estimated size of the global access deficit lies between 30 and 36 per cent, based on the benchmark of Thailand. That means that more than one-third of the global population are not receiving the quality of health care that could be provided to them by an adequately staffed network of health professionals. If countries such as Ireland serve as a reference, then the global access deficit amounts to more than two-thirds of the global population.

Country-specific access deficits reveal high related gaps even if Thailand is chosen as the benchmark: in China, the estimated staff-related access deficit indicates that the equivalent of 34 per cent of the population has no access to health services. In Colombia, the staff-related access deficit is 40 per cent. This is comparable to the staff-related access deficit of 42 per cent in the Philippines.

Table 5. Estimated access deficit in selected countries

	Estimated access deficit	
	Staff-related in % of population	**Births attended** in % of live births
Burkina Faso	85	43
China	34	17
Colombia	40	9
Ghana	66	53
Philippines	29	40
Uganda	78	61

Source: Annex II, Tables 1a and 1b.

d. The global access deficit: Some detailed observations

Despite evident gaps in data availability and reliability as well as the given methodological limitations, the approach to estimate worldwide access deficits to health services has revealed a series of interesting and challenging developments in a series of countries around the globe.

The *effect of social health protection coverage on out-of-pocket payments* is very heterogeneous. For instance, there is only a relatively small difference of the share of OOP between Tunisia, which has almost universal legal coverage, Nicaragua where almost 70 per cent of the population has formal health protection and Niger, where less than 1 per cent of the population is formally covered. At the same time, OOP represents only around 10 per cent in Slovenia and South Africa, while it rises to 26.8 per cent in Ukraine and to 45.1 per cent in Tunisia although all these countries have achieved universal legal coverage. And the burden of OOP on practically unprotected households in Uganda is only slightly higher than in Turkmenistan, where over 80 per cent of the population is covered.

These findings clearly indicate that the *scope of benefit packages including financial protection* and the quality of services provided have a higher impact on private health expenditure than the number of persons or households covered by any kind of prepayment system for health. In other words, social health protection should provide a reasonable level of financial protection in order to shield the population from high private expenditures and impoverishment.

Despite the existence of public health systems, a growing number of countries plan to introduce or have recently embraced universal *social health insurance*. They include countries such as Egypt, Ghana and Kenya. Many of these countries also have public health services which, although narrowing and deteriorating as a result of structural adjustment policies, public expenditure cuts and privatizations, still play an important role. For example, formal coverage amounts to 47.6 per cent in Egypt and 25 per cent in Kenya, and staff-related access deficit to 19 per cent in Egypt and 60 per cent in Kenya.

Many *community-based schemes* suffer from a high fluctuation rate and enrolment is often relatively unstable. In Senegal, the variation of affiliation was more than 20 per cent in three out of five community-based health insurance schemes, and four out of every five

beneficiaries had not paid their contribution on time. Data from India indicate that the share of informal economy workers (unorganized workers) covered by social security arrangements both in public and private not-for-profit schemes is in the order of 8 per cent. Out of the total number of 370 million workers in the Indian informal economy, around 30 million are covered by social protection including health. [17]

Only information for a certain cut-off date or average data are available, and a more in-depth analysis reveals that quite a large quantity of data regarding coverage rates of existing social health protection schemes rely on surveys that have only limited value for estimating the total number of beneficiaries. All in all, the statistical figures on population coverage of health benefit schemes should be interpreted carefully and taking into account the diversity behind them.

Employer-facilitated insurance systems are not very frequent in most developing countries although they are relatively common in the Arab world. Enterprise-based health plans usually provide care directly through employer-owned, on-site health facilities or rely on contracts with outside providers and facilities. Employer-driven insurance schemes are highly exclusive since only stable workers and in some cases their families are covered. The concept is often closely related to the existing labour legislation regarding work accidents and professional diseases.

In the Syrian Arab Republic, for example, practically all public companies and most larger private enterprises offer relatively comprehensive health benefit packages free of charge to their staff; dependants are sometimes covered by the scheme itself, or otherwise through contribution-borne schemes implemented by trade unions. (Schwefel 2006b) In Yemen, a number of public, private and mixed companies offer various types of health benefit schemes ranging from relatively low flat-rate reimbursement to comprehensive coverage packages, and average per capita expenditure varies between €10 and €450. [18]

Examples from Africa include employer-provided medical care in Zambia and Nigeria, as well as in the rubber forests in Liberia and the Democratic Republic of the Congo. [19] Company health benefit schemes often reflect a paternalistic relationship between employer and employees, relying partly on individual, case-to-case decisions rather than on vested rights. Even more important is the fact that the size of the schemes is in many cases too small to provide an effective coverage of catastrophic diseases.

Trade union related health insurance systems may be found in Zimbabwe, South Africa, Mauritius, Burkina Faso, Guatemala and Argentina, among others. Some foster dual membership and automatically insure all trade union members through the insurance plan, while others develop mutual insurance systems that are relatively autonomous of the union and are open to members and non-members alike. [20]

The above examples also show the wide heterogeneity of national health protection policies and the way in which they approach the extension of coverage and improvement of access. Any meaningful further development of national and internationally recommended health coverage strategies has to incorporate – to the extent possible – such national, regional and community-based initiatives. New strategies should build on existing foundations rather than destroy them. Too much effort was put into the building of existing schemes, and the effort would be wasted if new policies were to destroy such

[17] Kannan (2006).

[18] Schwefel et al. 2005, p. 66 f.

[19] Develtere and Fonteneau (2001), p. 29.

[20] Idem, p. 30.

initiatives. “Build up, don’t destroy” is the credo of the ILO-recommended health system policy that is spelled out in the next chapter.

5. Rationalizing the use of pluralistic financing mechanisms: An ILO strategy for achieving universal coverage in social health protection

a. Overall concept of the ILO strategy on rationalizing the use of pluralistic financing mechanisms

Worldwide experience and evidence show that there is no single right model for providing social health protection or one single pathway towards achieving universal coverage. In most cases, social protection evolves over many years and often decades according to historical and economic developments, social and cultural values, institutional settings and political willingness and stewardship. However, the way in which countries combine the various functions of resource generating, risk pooling, health care delivery and financing is not neutral regarding efficiency and equity of health systems. Furthermore, most national health financing systems are based on multiple financing options that cover disjunct or even overlapping subgroups of the population while others remain uncovered.

The overall objective of national policies in social health protection should be to develop a pragmatic strategy aimed at rationalizing the use of various health financing mechanisms with a view to achieving universal coverage and equal access for all.

It is suggested here that countries develop their strategies towards universal coverage by:

- first, taking stock of all existing financing mechanisms in a given country;
- next, assessing the remaining access deficits, and
- last, developing a coverage plan which fills gaps in an efficient and effective way.

The State should play a pivotal, active role as facilitator and promoter in this context and define the operational space for each subsystem. This entails developing an inclusive legal framework and ensuring adequate funding and comprehensive benefits.

The framework should also regulate voluntary private health insurance, including community-based schemes and consider regulations to ascertain good governance and effective protection. This framework establishes *a rights-based approach* to social health protection that refers in particular to the objective to include the uncovered part of the population in line with their needs and capacity to pay. The ILO also advocates a strong role for the social partners, particularly through social dialogue and *broad participation* in policy processes and governance of schemes including the social partners, civil society, the insured and other stakeholders in social health protection.

When developing the coverage plan *all options of financing mechanisms* – including all forms of compulsory and voluntary schemes, for-profit and non-profit schemes, public and private schemes ranging from national health services to community-based schemes – should be considered *if* they contribute in the given national context to achieving universal coverage and equal access to essential services for the whole population.

The coverage plan aims to provide a coherent design of pluralistic national health financing coverage and delivery systems consisting of subsystems such as national and social health insurance schemes, private insurance schemes, tax-based benefits, etc. for universal coverage that operate within a clearly defined scope of competence and cover defined subsections of the population. The objectives of the coverage plan thus comprise:

- determining a covering subsystem for all population subgroups;
- determining the rules governing the financing mechanisms for each subsystem and the financial linkages between them (also as financial risk equalization between different subsystems, if any);
- developing adequate benefit packages and related financial protection in each subsystem;
- maximizing institutional and administrative efficiency in each subsystem and the system as a whole,
- determining the time frame in which universal coverage will be reached.

The coverage plan should be accompanied by or include an overall *national health budget* making it possible to establish and project, on the basis of a National Health Account, the total resources such as taxes, contributions and premiums available to finance health care, and estimating the expenditure of the different subsystems in such a way that the process of achieving affordable universal coverage and access can be accelerated and build on a realistic and sustainable plan.

Annex I describes the national health-care system in Thailand as an example of the rational use of pluralistic financing mechanisms. The system consists of social health insurance, major occupational systems, a tax-based system and private health insurance schemes, and combines the various mechanisms through legal benefit entitlements.

An approach to apply pluralistic financing mechanisms simultaneously to achieve the stepwise extension of effective social health protection coverage through national health services, social health insurance, community-based insurance and mandated private health insurance is the most promising strategy for attaining universal coverage. It represents an integrated approach, respects existing coverage and financing arrangements, and can be adjusted to the specific social and economic context of each country.

b. Core elements of the ILO strategy on rationalizing the use of pluralistic financing mechanisms

When applying the suggested ILO strategy on rationalizing the use of pluralistic financing mechanisms on a national basis it will be necessary to follow a certain sequence of steps which include:

- assessing the coverage gap and the access deficit;
- developing a national coverage plan,
- strengthening national capacities for implementation.

i. Assessing the coverage gap and the access deficit

The ILO is suggesting that access deficits be established by detailed national health surveys as well as regional disaggregated analyses of formal legal coverage by each health financing subsystem.

ii. Developing a national coverage plan

The development of a national coverage plan involves a number of activities that are briefly described here.

Development of a coverage map

The coverage plan aims to close the coverage gap and the access deficit by the rational use of existing health financing mechanisms in a given country. The national coverage plan should thus first establish a coverage and access map that could look as follows:

Figure 13. Health care coverage and access map

Health care coverage and access map - Specimen

Population group	Proportion of the group that can access: Government health servies	Private sector health services	TOTAL	Proportion of the group whose services are: General revenues	Social security	Community based inititiaves	Employer based initiatives	private insurance	out of pocket	subtracting double counting	TOTAL
Public employees											
Private employees											
workers											
dependents											
Self employed outside agriculture											
workers											
dependents											
Self employed in agriculture											
workers											
dependents											
Unemployed persons of active age											
Children not covered elsewhere											
Persons in pension age not covered elsewhere											
Total											

That map could then be used to project intended progress on coverage on an annual basis within the framework of a multi-annual coverage plan.

Development of a national health budget

In order to be able to build the coverage plan one should take stock of the funds available for social health protection. This requires *developing a national health budget* which assesses the financial status and development of national health-care schemes. A health budget first compiles the status quo of all expenditures and revenues in the health sector in the form of a national health account that could be structured in tables similar to the one above for a given start year and used for the coverage map. A generic health budget model is available from the ILO Tool Box in Annex III to this paper. The following box describes the methodology and results of an abridged health budgeting exercise that the ILO undertook in collaboration with the Thai International Health Policy Programme in 2004.

A health budget for Thailand

The basic structure of the model is mapped out in figure B.1 below. The basic modelling philosophy follows the pragmatic modelling philosophy of ILO's genuine social budgeting models. Instead of building a complete national social budget encompassing all social transfer schemes in Thailand, the non-health parts of a social budget were excluded and the budgetary analysis was limited to the health sector and its impact on the government budget.

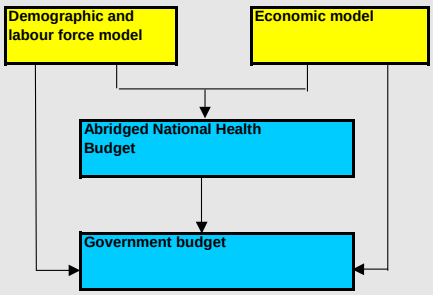
The model provides classical and pragmatic "if–then" projections, i.e. it depends on exogenous demographic and economic assumptions and then simulates their impact on health expenditure and revenues and the government budget. Observation years are 2002 and 2003 and projection years are 2004 to 2020.

The model consists of four deterministic sub-models that are driven by a set of exogenous assumptions:

- This first sub-model is a demographic model that projects the population and the labour force on the basis of assumptions on future developments of fertility, mortality and labour force participation rates.
- The second sub-model is an economic model that derives employment and wage data from exogenous assumptions on growth, labour productivity and the wage share at GDP.
- The third sub-model is a health budget model which projects health expenditure of the four major financing schemes (UC, SSO, CSMBS and privately funded health care) and the health resources (contributions to SSO and WCS, out-of-pocket and other private outlays, and general taxation). The two central result variables are overall national health expenditure and the resource requirement from general revenues.
- The last sub-model, the government model, links public health expenditure and the general revenue resource requirement to government budget projections. The central result variable is the government annual budget deficit.

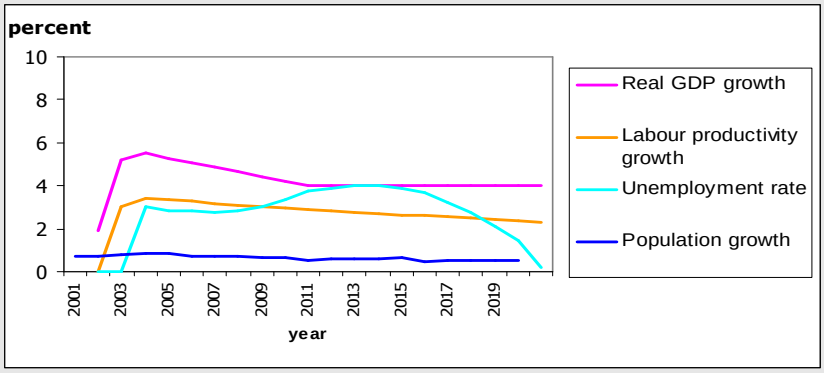
This (abridged) health budget model thus allows tracing the effects of changes in the health delivery and financing system to overall national health expenditure and the government's budgetary balance, i.e. to one global health system performance indicator and a public finance performance indicator. Two model scenarios were developed: the first (status quo scenario or variant) reflects the legal status quo; the second scenario (reform or UC scenario or variant) uses identical demographic and economic assumptions and differs only in the health budget sub-model which simulates the introduction of the UC Fund and the implementation of the two major cost-reducing measures in the perspective of NHSO (extension of SSO coverage and CSMBS contributions) after 2005.

Figure B.1. Structure of the first version of the National Health Budget Model for Thailand



The key demographic and economic assumptions are provided figure B2.

Figure B2. The assumed development of key economic variables for Thailand, 2002-2020



The projections for the government budget use the growth rate of nominal GDP as the main driver for all income and revenue items of the central government accounts that are not driven by wages (such as income tax) and are not imported from the abridged health budget sub-model. Further assumptions are documented in the model itself.

The central results of the projections are summarized in the following figures. The model estimates show that the overall health-care expenditure in the country – measured as a percentage of GDP – will rise by about 0.3 per cent of GDP over the next half-decade, starting from an initial level of around 3.5 per cent of GDP. This is largely an effect of two factors: the assumed substantial real GDP growth rates over the next decade and the fact that the cost development of the major share of public health expenditure is contained through the use of the capitation mechanism which is exercising an overall cost-containment effect on the health financing system as a whole. Total national expenditure is expected to slowly increase back to the original level until 2020 as the GDP growth rates decline.

For the *status quo*, the general revenue share at financing total health expenditure stagnates throughout the period at a level of 1.98 to 2.17 per cent of GDP. This would not pose a major problem if the overall budgetary balance were projected to remain positive throughout the projection period. However, the model (prudently) suggests that the government budget remains negative throughout the projection period, minimum level of deficit of 1.19 per cent of GDP in 2020. The Ministry of Finance assumes – more optimistically – that the budget will turn positive over the years but in this model it reaches the minimum deficit at the end of considering period. It could well be that this health budget model is too pessimistic. In any case, it can safely be assumed that the trend towards tighter budgetary situations will recommence at the end of the decade if all our assumptions – cum granu salis – hold true.

The first scenario simulates the effects of the suggested revenue increases and cost reductions for the government and the introduction of a special UC fund that would generate earmarked income for the UC scheme from taxes on alcohol and cigarettes. The effects are that the general revenue share at overall health-care financing declines over the next two decades to a level of 1.5 per cent of GDP in 2020 and the overall government deficit shifts up by about 1.5 per cent of GDP and remains at slightly negative level till the end of the projection period at 0.55 per cent of GDP. The second scenario was produced based on assumptions that SSO expand coverage to non-working spouses and dependants (estimate of 6 million beneficiaries) in 2005. When SSO expand their coverage without increasing any contributions and the government does not introduce any additional taxes, the effects are that the government reduces the health-care budget subsidy from 2.17 to 1.99 per cent of GDP by the end of the projection. The first and second scenarios were combined together into the third scenario. The government decreases the budget for health-care financing from 2.17 per cent to 1.35 per cent of GDP by the end of projection if SSO expand their coverage to spouses and dependants and introduce additional taxes.

Figure B3.

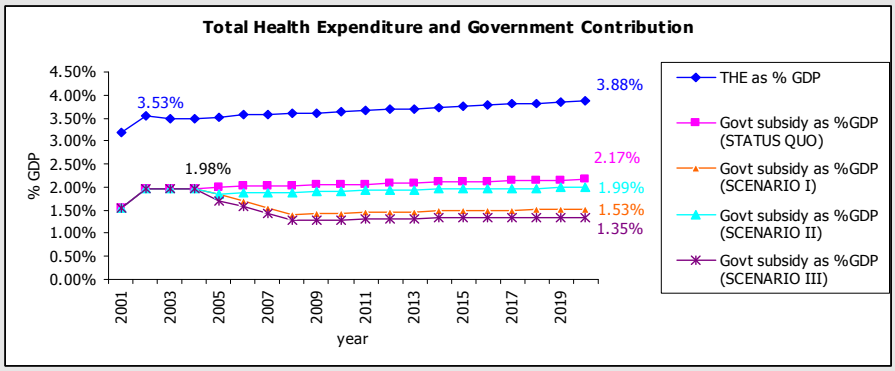
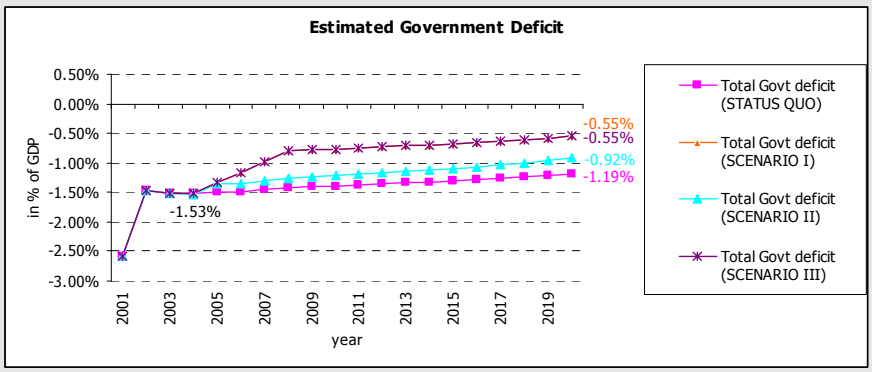


Figure B4.



Improving health financing mechanisms

Further, it is important for countries to develop policies *for improving health financing mechanisms, designing adequate benefit packages – including financial protection – and creating institutional and administrative efficiency*.

Based on the results of the national health budget, issues related to improving health financing mechanisms and conceiving linkages need to be addressed. There are essentially five ways to improve health financing mechanisms with a view to extending social security coverage, namely:

- implementing and expanding the existing social insurance schemes;
- introducing universal benefits or services financed from general state revenues ;
- establishing or extending means-tested benefits or services (social assistance) financed from general state revenues;
- encouraging microinsurance schemes,
- Mandating private health insurance.

At the country level, the pros and cons of each of these options need to be discussed carefully in the context of the above. The applicability and performance of the different mechanisms need to be judged on their:

- capacity to mobilize funds;
- efficiency in targeting public funds to the poor;
- ability to shift funds and power from the supply to the demand side in order to improve efficiency and quality,
- level of accountability and the quality of budgeting.

Criteria for the choice of mechanisms for particular sub-groups of the population include the number, structure and performance of existing schemes, the political and cultural context, the size of the tax base, the size of the informal economy, the disease burden, the availability of infrastructure, the capacity to collect taxes / contributions / premiums, managerial capacity, possibilities to enforce legislation, and regulation and related impacts on equity.

A summary of the pros and cons of various financing mechanisms is presented in the following overview.

Overview : Pros and cons of key financing mechanisms for social health protection

Tax-based health protection		Social health insurance		Micro-insurance and community-based schemes		Private health insurance	
Pro	**Con**	**Pro**	**Con**	**Pro**	**Con**	**Pro**	**Con**
Pools risks for whole population	Risk of unstable funding and often under-funding due to competing public expenditure	Generates stable revenues	Poor are excluded unless subsidized by government	Can reach out to the informal sector	Poor may be excluded unless subsidized	Preferable to out-of-pocket ex-penditure	High administrative costs
Potential for administrative efficiency and cost control	Inefficient due to lack of incentives and effective public supervision	Often strong support from population	Payroll contributions can reduce competitiveness and lead to higher unemployment	Can reach the close-to-poor segments of the population	May be financially vulnerable if not supported by national subsidies	Increases financial protection and access to health services for those able to pay	Ineffective in reducing cost pressures on public health financing systems
Redistributes between high and low risk and high and low income groups in the covered population		Provides access to a broad package of services	Complex to manage Governance and accountability can be problematic	Strong social control limits abuse and fraud and contributes to confidence in the scheme	Coverage usually remains a small percentage of the population	Encourages better quality and cost-efficiency of health care	Inequitable without subsidized premiums or regulated insurance content and price
		Involvement of social partners	Can lead to cost escalation unless effective contracting mechanisms are in place		Strong incentive to adverse selection		Requires administrative and financial infrastructure and capacity
		Redistributes between high and low risk and high and low income groups in the covered population			May be associated with lack of professionalism in governance and administration		

Generally, taxes are considered to be an efficient and equitable source of revenue for the health sector. They can be considered as resources leading to national risk pooling for the whole population and redistributing between high and low risks and high and low income groups. The civil service has the potential to be administratively efficient and control costs.

However, their potential to contribute to health-care financing depends largely on national macroeconomic performance and competing demands from other sectors, the quality of governance, the size of the tax base and the government's human and institutional capacity to collect taxes and supervise the system. In practice, government schemes often tend to be underfunded, which might lead to a shortage of goods and services and to under-the-table payments and lack of efficient governance.

The success of *social health insurance schemes* depends on the generation of stable resources, the often strong support of the population, the provision of a broad package of services, the involvement of social partners and the redistribution between risk and income groups. However, schemes are administratively complex and governance and accountability can be problematic. Also, from a macroeconomic point of view, payroll contributions can reduce competitiveness and lead to higher unemployment.

Furthermore, if coverage is not universal, social health insurance might have an impact on equity in countries with sizeable informal economies. It should be emphasized that health care for the workforce is not free and that enterprises and the economy have to bear a respective share of the financial burden. In case of social health insurance schemes, funding should consist of shared financial resources from both employers and employees. For specific benefits such as maternity benefits specific rules might apply, e.g. full coverage through public funds, in order to avoid disadvantages for particular groups protected.

Specific schemes such as private community health insurance schemes can be efficient to collect non-salary-related contributions and reduce costs for the poorest at the point of delivery. However, they often experience problems of coverage and therefore of achieving sufficient pooling, difficulties to organize membership across different ethnic groups, management capacity and inadequacy of resources.

A current trend in low-income countries includes increasing the role of mutual health organizations and social health insurance when mainstreaming pro-poor policies in social health protection and addressing issues of high user fees. Voluntary and community-based schemes are also gaining support in many low-income countries. Their success and sustainability depends highly on the attractiveness of benefit packages and related financial protection as well as the quality of services. Increased interest in these schemes is related to coverage of workers in the informal economy and their families. Key issues for sustainability, e.g. with regard to the capacity to pay and adverse selection are currently addressed in creating financial and administrative linkages among schemes at various levels based on different ownerships. Current country examples point to the fact that schemes can work successfully, one of them being the Yeshasvini scheme in India covering some two million workers and their families. In other countries, however, for the time being coverage often remains limited.

Private for-profit health insurance schemes are also found in many countries, ranging from OECD countries to developing countries such as Peru and the Philippines (Annex II, Table 1b). If not subsidized, they cover the wealthier part of population based on risk-related premiums. The exclusive character and high administrative costs are often criticized, whereas the better quality of services is appreciated.

The pros and cons of the various financing mechanisms can be overcome by improving and linking the different approaches. In the context of the development of a coverage plan, an evaluation should be undertaken that identifies mechanisms best suited with regard to raising sufficient and sustainable revenues in an equitable manner for the provision of adequate benefit packages and financial protection to the whole population.

Given the country-specific nature of the evaluation, there is no general rule on an optimal composition of the portfolio of national health financing subsystems that a country should build up. However, it is suggested that a set of guiding principles be applied during the system building, including:

- equity and solidarity in financing according to capacity to pay and equity in access to all health services. This includes risk pooling and sharing contributions payments in social health insurance between employees and employers;

- inclusiveness of all citizens without discrimination on the basis of gender, ethnicity, religion, etc.

A health financing policy checklist is provided in the following box.

Checklist: Key policies on health care financing

- Mobilizing sufficient resources to achieve policy objectives;
- improving equity and solidarity in financing through burden sharing by income level;
- setting up risk equalization and solidarity funds where appropriate;
- maximizing risk pooling and reducing fragmentation;
- in insurance schemes: introducing government subsidies for the poor and for informal sector workers and their families (either direct or for contributions/premiums);
- minimizing out-of-pocket payments;
- setting user charges according to capacity to pay;
- increasing financial sustainability;
- using a mix of health financing mechanisms to accelerate achievement of universal coverage and balance equity, efficiency, and quality of care,
- ensuring efficient and effective use of resources.

Usually, extending social health protection requires increasing funds, particularly in public spending on health. However, in many middle- and high-income countries, revenue collection based on public funds and payroll taxes often encounters perceived limits. The spending on health is perceived as unproductive cost that hampers economic development. In many low-income countries fiscal space and domestic revenues are considered too limited to ensure access to health services for the majority of the population.

Furthermore, mobilizing additional government resources usually requires a functioning formal economy whereas many low-income countries have large informal economies. Over the past years, the share of total labour supply in the informal economy has been constantly growing, particularly in Asia.[21] This applies even in countries with high rates of economic growth in the formal sector.

Increasing fiscal space is essential for increased sustainability of social health protection. It often involves changes in governments' policies and – for countries relying on international aid – more sustainable support from donors. Most successful methods to increase fiscal space through government policies include:

- more efficient use of public expenditure;
- strengthened efficiency in public institutions and service delivery;
- budgetary reallocations;
- increased efforts to collect taxes and contributions,
- introducing new sources of funding for the national health budget.

These approaches require strong political commitment, priority setting towards extending social health protection and addressing issues of transparency and accountability. In this context, it is crucial that a democratic management is established and based on tripartite

[21] ADB (2006).

governance. This also refers to a participatory approach of scheme management and governance based on social and national dialogue between policy makers, social partners, civil society groups, public and private insurers, health-care providers, and others.

Building rational linkages between subsystems

Another approach to improve health financing mechanisms consists of creating financial linkages between various schemes. Linkages can achieve redistributive effects, e.g. by means of subsidies and financial consolidation (through reinsurance and guarantee funds, for example).

Further administrative and governance linkages include sharing management functions, mutual support regarding registration and collection of contributions/premiums, mutual audits and control, co-contracting of providers and sharing of information.

When conceiving new linkages between different health financing mechanisms, testing, evaluating and monitoring of integrated approaches linking the schemes are the key to achieving sustainable solutions.

Checklist: Policies on building rational linkages between different health financing mechanisms

- Introducing subsidies;
- developing common national fee schedules;
- setting up risk equalization and solidarity funds where appropriate;
- maximising risk pooling through increasing membership;
- in insurance schemes: introducing government subsidies for the poor and informal sector workers and their families (either direct or for contributions/premiums);
- mandating private insurances, hospitals and facilities to cover (for example in part) the health care services for the poor;
- facilitating reinsurance and guarantee funds;
- establishing joint management functions;
- introducing mutual support in registration and collection of contributions/premiums;
- co-contracting health service delivery networks,
- establishing mutual audit and control.

Designing adequate benefit packages

In addition to improving health financing mechanisms, the coverage plan should develop *policies on adequate benefit packages, including protection against catastrophic spending*.

Generally, health challenges to be addressed in benefit packages of social health protection vary in low, middle and high-income countries:

- in low-income countries the main health challenges to be addressed include infectious diseases such as HIV/AIDS, TBC and malaria, and challenges related to care during maternity;
- in middle-income countries often health issues include partly those in low-income countries, but also cardio-vascular diseases, drug and tobacco abuse,
- in high-income countries the list of challenges refers partly to the above but also includes stress-related syndromes and long-term care of the elderly.

Services covered in the benefit package and financial protection should be based on consensus deriving from broad consultations of all stakeholders involved in social health protection given the diverging views of the medical profession, various groups in the population – e.g. the poor, the old, the minorities – and others. Therefore, the policy mechanism to define health care needs should be national dialogue including social dialogue on health care priorities.

While the size of the benefit package involves a balance between cost and risk protection, it is recommended to define benefit packages – including financial protection – with a view to provide equitable access to a comprehensive range of services as outlined in ILO Conventions and Recommendations, including primary health care, inpatient care, prevention and maternity care, rather than defining a "minimum benefit package".

This refers to a general policy of the ILO to ensure universal access at all times and at all facilities and that nobody should be denied care because of its cost or because of his/her place of residence. Care should be provided without discrimination and in conditions of dignity ensuring that consideration is given to local traditions and preferences.

Checklist: Key policies on adequate benefit package and protecting from catastrophic spending

- Introducing comprehensive and complementary benefit packages of various schemes providing for an adequate level of services and income protection;
- ensuring acceptability of the protected, professionals and politicians;
- balancing the trade-off between equity and quality in broad consultations with all actors;
- addressing health-related poverty by covering catastrophic health expenditure (> 40 per cent of a households' income net of subsistence);
- covering out-of-pocket payments / user fees etc in order to ensure equal access;
- ensuring adequacy through focus on patients needs regarding quantity, adequacy and quality of services;
- minimizing out-of-pocket payments;
- providing access to primary, secondary and tertiary care (through referral systems), including maternity care, preventive care and care in relation to HIV/AIDS;
- providing for transportation costs, e.g. for groups living in remote areas;
- addressing loss of income through adequate cash benefit.

Under ILO Convention 102 the following benefits in case of sickness are foreseen: general practitioner care, including domiciliary visiting, specialist care, pharmaceutical supplies, and hospitalization where necessary.

Convention 102 / Article 10

The benefit shall include at least:

a. in case of a morbid condition:

(i) general practitioner care, including domiciliary visiting;

(ii) specialist care at hospitals for in-patients and out-patients, and such specialist care as may be available outside hospitals;

(iii) the essential pharmaceutical supplies as prescribed by medical or other qualified practitioners; and

(iv) hospitalisation where necessary; and

b. in case of pregnancy and confinement and their consequences:

(i) pre-natal, confinement and post-natal care either by medical practitioners or by qualified midwives; and

(ii) hospitalisation where necessary.

Applying ILO Conventions and Recommendations avoids inequities in access to health services between formal and informal economy workers, between the rich and the poor. However, when implementing and extending social health protection systems it is in some cases necessary to take deficiencies in infrastructure or the non-availability of certain services into account. Against this background, it is possible to limit access at an initial stage of extending social health protection, for example to services available, and include full access at a later stage.

Given the fact that private health expenditures are a primary cause of impoverishment, benefit packages should be designed with a view to minimizing out-of-pocket payments. This also applies to high-income countries where long-term care expenditure accounts for a significant proportion of out-of-pocket payments. In this context, ILO policies aimed at achieving equity in access to health services refer to the adequacy and comprehensiveness of health services covered under the benefit package and includes financial protection against impoverishment, particularly due to catastrophic health expenditure. [22]

When choosing appropriate mechanisms to promote equity and access to health services, alleviate poverty and improve health, countries should take the following into account:

- the actual level of spending on benefits matters more than the choice of funds (e.g. taxes, contributions or premiums) for achieving equity, poverty reduction and a positive impact on health;
- universal benefits and targeted benefits have a different impact on equity: whereas universal benefits contribute more to achieving equity than to reducing poverty, targeted benefits impact more significantly on poverty reduction than on equity.

Creating institutional and administrative efficiency

The coverage plan for the extension of social health protection also requires creating institutional and administrative efficiency.

[22] Defined as health care costs exceeding a household's capacity to pay.

The ILO aims to achieve institutional and administrative efficiency through emphasizing *"Good governance"*. It defines good governance in social health protection referring to decision-making based on:

- existing legal frameworks;
- accountability;
- transparency;
- effectiveness and efficiency;
- equity and inclusiveness;
- participation and consensus.

ILO tools for participatory and inclusive decision making include ILO Conventions and national and social dialogue. In this context, ILO stresses particularly the importance of tripartite governance and participation of stakeholder such as involvement of the insured where applicable and the civil society, government supervision of related administrations, funds and private insurances and government responsibility for covering deficits in social health protection schemes.

ILO quantitative tools for financial governance (ILO Tool Box, Annex III) aim at achieving quality assurance and monitoring progress and outcome: They include:

- Social budgeting;
- Social Protection Expenditure and Performance Reviews;
- Social Security Inquiry;
- STEP tools on community-based insurances.

In order to fulfil the criteria of good governance, the *financial and administrative separation* of health insurance funds from Ministries of Health and Labour is essential. Generally, revenues earmarked for social health protection should be separated from government budgets and it should be ensured that contributions are used only for health-care benefits and administration of the scheme and not in support of Ministry of Health functions; it is particularly important to ensure that health-care contributions are not used for other contingencies.

A recent trend in organizing social health protection with a view to efficiency includes various forms of *decentralization* of responsibilities from the national to local governments or other sub-national institutions. However, the related shift of financial burden to the local level is often problematic, since transfers of funds from the national level may be insufficient and result in increasing inequities in access, for example of the poor. [23] Another form of decentralization of social health protection concerns community-based schemes. They mobilize additional funds at local levels and provide financial protection of out-of-pocket payments particularly for informal sector workers and their families. [24]

Creating efficiency also relates to *purchasing services*. Generally, the provision of services can be organized through public or private providers. The most efficient mechanisms to purchase services are:

[23] OECD (2006a).

[24] ILO (2006d).

- budgeting, such as setting caps on annual expenditure;
- contracting and accreditation of providers based on performance, and
- provider payment methods such as salary, capitation, case-based payments and fee-for-service.

Further, funds – e.g. social health insurance – may act as purchasers. By doing so, insurance funds shift (financial) power from the supply to the demand side, which might result in important changes in the availability and affordability of services, particularly for poor segments of the population.

Checklist: Key policies on creating institutional and organizational efficiency

- Ensuring good governance based on efficient management, transparency and accountability;
- designing insurance schemes based on tripartite governance of independent, quasi-autonomous health insurance funds ruled by public law, governments, social partners, and others;
- minimizing administrative costs;
- introducing participatory decision-making regarding policy formulation and implementation of social health protection, involving key actors in social health protection such as government, social partners, representatives of the insured and civil society at national, district and/or local levels;
- decentralizing organizational structures with a view to reducing the burden of governments and improving responsiveness;
- introducing referral systems acting as gatekeepers;
- developing adequate purchaser methods using incentives to improve quality and reduce oversupply;
- using public and private purchasing;
- introducing regulations for private insurers including voluntary health insurance,
- enforcing regulations.

Strengthening national capacities for implementation

Besides the two elements discussed above, namely assessing the coverage gap and the access deficit and the development of a coverage plan, another core element of the new *ILO strategy on rationalizing the use of pluralistic financing mechanisms for achieving universal coverage in social health protection consists* of strengthening national capacities for extending social health protection.

Capacity building in this context consists particularly of training, upgrading capacities in designing, implementing and monitoring and knowledge development, e.g. through research and exchange of experiences.

Building administrative capabilities through training and the establishment of efficient structures and procedures is one of the key preparatory activities for a sustainable social health protection. The successful implementation of a reform, along with effective monitoring, good governance and reliable delivery of service are dependent on well-trained, effective and committed staff.

Moreover, strengthening institutional technical and administrative capacity is essential for ensuring that the necessary conditions are in place to guarantee responsiveness to members' needs and the viability of national security schemes. It will further contribute towards the design, implementation and testing of national health protection to ensure its viability.

Currently, however, many developing countries lack sufficiently trained staff to ensure successful extension in social health protection. It is particularly important to train administrators who are expected to implement related reforms.

In addition, enhancing technical capacities of public authorities, social partners and other stakeholders is crucial for the overall governance and supervision. Evidence from many countries proves that successfully extending social health protection to the poor requires consensus of various levels and entities of government, social partners, civil society and others. Given the diverse interests of stakeholders, obtaining the necessary support is a highly complex and difficult task. Problems often arise when stakeholders and social partners feel that they have been ignored in the process involved in the design and provision of social health protection, that concerns have been misunderstood or that the quality and depth of participatory decision-making was limited.[25] This might result in a lack of support in implementation, enforcement, funding, and compliance with new laws and regulations and thus lead to complete failure of important reform activities, sometimes even after parliamentarian hurdles have been cleared.

Against this background, it is important to enhance technical capacities of public authorities, social partners and other stakeholders and improve their participation in the social and national dialogue. This can be achieved through appropriate training on a tripartite or even broader level.

[25] An example might be seen in the recent experience with social health insurance in Kenya: "Ngilu's fit of fury", The Standard (Kenya), 16 Nov. 2004.

6. Conclusion

The ILO strategy on *rationalizing the use of pluralistic financing mechanisms for achieving universal coverage in social health protection* is aimed at accelerating the achievement of universal coverage, promoting equity and supporting global international efforts to alleviate poverty and improve health. The strategy is built on the central credo of incorporating all existing coverage and financing subsystems in a country into one pragmatic pluralistic national system as long as the existing subsystems and the system as a whole meet a number of outcome and process criteria.

The system should provide for:

- the achievement of universal coverage of the population within a realistic time frame;
- the effective and efficient provision of adequate benefit packages including financial protection for all, but not necessarily uniform benefit packages;
- the existence of a governance system that confirms the overall responsibility of the government for the functioning of the system as a whole but also involves covered persons, financiers (contributors and taxpayers, including employers and workers in the formal and informal economy) and providers of care,
- fiscal and economic affordability.

The strategy is part of the ILO decent work strategy and the Global Campaign on Social Security and Coverage for All. It builds on in-depth analyses of the extent of social health protection coverage and the gaps in access to health services. The ILO, in cooperation with other agencies (notably within the ILO-WHO-GTZ Consortium on social health protection), recommends to governments and other actors in the field of social health protection a comprehensive tool box and information base on social health protection and offers support in closing gaps and addressing limitations. We believe that the suggested strategy has the potential to achieve universal coverage in health.

Annex I

Country experiences: A brief overview

This section provides a selection of recent national experience on extending social health protection in countries in Africa, Asia and Latin America.

a. Africa

Benin [26]

According to an ILO study on social protection expenditures (SPER) in Benin, 6.21 per cent of the country's active population benefits from an old-age pension and 5.15 per cent has health-care coverage.

State employees are covered for 80 per cent of their health-care costs, with the exception of pharmaceutical costs, old-age pensions from the National Retirement Fund of Benin (FNRB) and family benefits, considered to be accessory to salaries.

Social security for salaried workers in the semi-public and private sectors is managed by the National Social Security Fund (CNSS) and covers old-age and invalidity pensions, family benefits, work accidents and illness, maternity, and survivors' benefits.

In parallel, assistance is increasingly given to develop initiatives by the population of rural and peri-urban areas, who organize collectively to face financial risks linked to poor health. To date, over one hundred health microinsurance schemes covering an estimated 100,000 people, administered by their members and functioning on the basis of solidarity, have been set up.

Burkina Faso [27]

Formal social security schemes in Burkina Faso cover less than 10 per cent of the total population and are limited in scope to old-age pensions, work accidents and maternity.

Since the 1990s, many new initiatives have emerged under such names as *mutuelles de santé, caisses de solidarité, systèmes de prépaiement, couplage assurance santé-crédit*. In 2003, over a hundred mutual health organizations, microinsurance schemes and other schemes operated in the country. These initiatives are closely supervised and supported by the State with the establishment of the *Direction for the mutual benefit associations* within the Ministry of Employment, Labour and Social Security.

In 2006, the Government launched a national campaign on social protection and risk management which confirmed the role of microinsurance and its extension to the population of the informal economy within the national strategy. This strategy consists of an in-depth reform of the existing mechanisms of formal social security with a view to improving their management. Further, strong support is provided to the microinsurance schemes in order to increase coverage rates. This support will be made available through the implementation of pilot projects in rural and urban areas for farmers and informal economy workers.

[26] Source: ILO/STEP (2006e).

[27] Source: ILO/STEP (2006e).

The health-care system in Egypt is mainly tax funded and publicly provided, with a small but long-established social insurance sector and some private funding and provision.

Some health protection coverage is available to the whole population through the public system. Social insurance grants a higher level of provision to 8.4 per cent of the population (ranging from only 3.4 per cent in the area with the lowest coverage to 12.7 per cent in the one with the highest).

The benefit package covers primary care, outpatient hospital services, dental care, pharmaceuticals, medical appliances, hospital care and even evacuation for specialized surgery. Dependants are generally not covered.

Services are provided by a mixture of public and private providers. Most outpatient care is given by private practitioners working in their own facilities, in public or private clinics under contract to social insurance. Hospital care is provided mainly in hospitals owned by the Health Insurance Organization (HIO).

Hospitals are owned primarily by the HIO and are funded directly. Contracts for care by private providers are mainly on a fee-for-service basis.

Social health insurance is funded by contributions of 4 per cent of earnings, of which 75 per cent is paid by employers and 25 per cent by employees. Pensioners pay 1 per cent and widows 2 per cent of their income. For government employees, the contribution rates are 1.5 per cent for the government and 0.5 per cent for the employee. There is a ceiling on the level of income used to calculate contributions and there are small co-payments for the use of services. The HIO is subsidized by the Employment Injury Scheme.

Benefits under social insurance are six to seven times greater than those offered by the state health services. Half of HIO spending goes to drugs and around one-third to its own facilities.

There are plans to extend the scheme to cover more occupations, dependants and some self-employed people, bringing coverage to around 35 per cent. The main constraint is the lack of administrative capacity to develop the scheme in these more difficult areas.

Egypt [28]

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The benefit package covers primary care, outpatient hospital services, dental care, pharmaceuticals, medical appliances, hospital care and even evacuation for specialized surgery. It does not generally cover dependants.

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[28] Source: Weber and Normand (2007).

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Ghana [29]

Ghana is divided into ten regions with 110 decentralized districts which constitute the lowest level of political administration. In effect, the districts or district assemblies are autonomous agencies responsible for the implementation of public service functions and governance at the local level.

Ghana's economy is predominantly agrarian, with agriculture dominating in terms of employment, revenue and export earnings. It accounts for 50 per cent of the labour force and 42 per cent of GDP. Other major exports are minerals (notably gold, diamonds, bauxite and manganese). The tourism industry is becoming an important foreign exchange earner as well.

In 2005 Ghana’s real GDP growth was both broad-based and robust, at 5.9 per cent. The 2005 budget deficit has been estimated at 2 per cent of GDP. In the past few years the national currency has seriously depreciated and inflation has spiralled, although more recently both have stabilized somewhat, and inflation in particular has been falling steadily.

Despite some improvements in many health indicators, including mortality and morbidity, crude indicators still demonstrate the need for further major improvements. Life expectancy at birth in 2004 was 56 years for males and 58 years for females, and healthy life expectancy 49.2 and 50.3 years respectively (2002 figures).

[29] ILO (2005b).

Health indicators

Indicator	Value (year)
Life expectancy at birth (years) males	56.0 (2004)
Life expectancy at birth (years) females	58.0 (2004)
Healthy life expectancy (HALE) at birth (years) males	49.2 (2002)
Healthy life expectancy (HALE) at birth (years) females	50.3 (2002)

Source: WHO, National Health Data, 2006.

While the impact of HIV/AIDS is less severe than in some other African countries, recent developments show a steady increase in prevalence. Under-five mortality is high: 118 per 1,000 for males and 109 per 1,000 for females.

Total health expenditure as a percentage of GDP in 2003 was 4.5 per cent, and about 68 per cent of this expenditure was constituted by private out-of-pocket payments. Total health expenditure per capita amounted to US$98.

Health financing indicators for Ghana, 2003

Indicator	Value (year)
Total expenditure on health as percentage of gross domestic product	4.5
General government expenditure on health as percentage of total expenditure on health	31.8
Private expenditure on health as percentage of total expenditure on health	68.2
General government expenditure on health as percentage of total government expenditure	5.0
External resources for health as percentage of total expenditure on health	15.8
Out-of-pocket expenditure as percentage of private expenditure on health	100.00
Per capita total expenditure on health at international dollar rate	98
Per capita government expenditure on health at average exchange rate (US$)	5

Source: WHO, National Health Data, 2006.

Access to and use of health facilities have been low. A survey conducted by the Ghana Statistical Service revealed that 42.5 per cent of the urban population and 54.7 per cent of the rural population did not consult medical personnel in 1992 in times of illness or injury. Medical consultation increased to 46.6 per cent (urban) and 69.2 per cent (rural) in 1998. This trend may probably be linked to increasing health-care user fees over recent years.

The Government of Ghana has a clear understanding of the problems associated with the out-of-pocket health financing system ("cash and carry"). Consequently, it has decided to abolish this financing mechanism and replace it with health insurance. The objective is to pool risks, reduce individual burden and achieve better utilization rates, as patients do not have to pay cash at the point of delivery. The declared objective is for at least 50-60 per cent of Ghana's residents to belong to the new health insurance system within the next five to ten years.

The new National Health Insurance System (NHIS) is at an early stage of implementation, following the adoption of legislation in August 2003.[30] The system will consist of more than one hundred District Mutual Health Insurance Schemes financed by a combination of personal contributions from persons in the informal economy, a social insurance

[30] National Health Insurance Act 2003 (Act 650).

contribution of 2.5 per cent for all members of the Social Security National Insurance Trust (SSNIT), and a 2.5 per cent health levy (i.e. a VAT-type indirect tax).

The system replaces the user fee-based ("cash and carry") scheme that excluded many of the poor from access to health care. Young children and the elderly are exempted from contributions.

The system is coordinated and supervised by the National Health Insurance Council which manages, inter alia, the National Health Insurance Fund. The Fund receives the proceeds from the contributions and the levy and subsequently allocates it to the District Mutuals.

Despite its commitment and the measures initiated, Ghana faces tremendous challenges in extending social health protection to the informal economy and in rural areas. Aside from financial constraints, there are insufficient linkages between national and community-based health-care schemes.

Ghana is progressively implementing concrete measures to respond to these challenges based on different strategies, reflecting and building on distinct experiences on extending social security. The establishment of the NHIS is a key point of departure of the strategy for extension and interventions at provincial and district levels.

Furthermore, the Ghana Poverty Reduction Strategy (GPRS) highlights the Government's commitment to ensuring access to health care through the improvement of basic health care for the poor. The strategies include "bridging gaps in access to health, nutrition, and family planning services, ensuring sustainable financing arrangement that protects the poor, and enhancing efficiency in service delivery". [31]

Kenya [32]

Historically, Kenya's health system has been financed from government revenue. Kenya was the first country in Africa to introduce compulsory health insurance, in 1966. However, the insurance is limited to workers, employees and their families, who account for no more than 20 per cent of the population. Contributions to the "hospital insurance fund" are deducted from salaries and membership is compulsory. The hospital fund covers inpatient services, to which members still have to contribute out of pocket.

In 2004, legislation for the national social health insurance fund (NSHIF) was submitted to parliament. It is conceived as a compulsory insurance scheme with solidarity-based, income-related contributions, and aims to cover the entire population. The new scheme is to take over the infrastructure of the existing insurance. The underlying aim of the proposed reform is to achieve universal coverage and thus appropriate health care at an affordable cost for all. By accrediting and remunerating private service providers it should also bring the public and private sectors under one financing umbrella. However, the social health insurance law has not been approved yet, and it is still an open question how soon this can be achieved.

The existing National Hospital Insurance Fund (NHIF) as the future carrier of the NSHIF has already made far-reaching improvements to the current system. This includes the accreditation of private and public providers and the introduction of financial incentives to promote quality improvements.

[31] Ghana (2003).

[32] WHO/GTZ/ILO/KfW/DFID (2004).

Senegal [33]

In Senegal only some 12-17 per cent of the population is covered by statutory social security schemes, namely salaried staff from the private sector as well as civil servants and their dependants. Rural and informal economy workers (70-80 per cent of the population) do not enjoy any kind of organized social protection, except for those who are members of mutual benefit associations (health coverage). The indigent population (representing 10-20 per cent of the total population) is also excluded since social assistance programmes provide only scarce and erratic benefits.

Extending social protection to the uncovered population is a high priority for the Senegalese Government and various initiatives have been taken at political level to this end:

- In 2003, the National Commission on Social Dialogue (Comité national du dialogue social) was set up to develop a strategy to specifically address issues on extending social security.
- In April 2004, Senegal launched the Global Campaign on Social Security and Coverage for All.
- In December 2004, the transport operators' trade union Syndicat National des Travailleurs des Transports Routiers du Sénégal (SNTTRS) included in its demands the question of social protection.
- Senegal also hosted the ILO Conference on "Organizing for Decent Work in the Informal Economy: The Way out of Poverty" in Dakar (25-27 Oct. 2005) that brought together representatives from African trade unions to discuss the extension of social security to the informal economy.
- This priority has also been translated into the new Agricultural Law adopted in June 2004 (Loi d'Orientation Agro-Sylvo Pastorale), which specifies that the Government should design and implement a social security scheme for the rural population which represents more than 50 per cent of the country's population (5 million people).
- As part of its Poverty Reduction Strategy Paper (PRSP) process, Senegal has revised its social protection strategy and policy to address coverage for the formal and informal economy, notably the extension of social security to those currently excluded. The new National Social Protection Strategy is the third pillar of the PRSP, which was presented and adopted at the World Bank/African Development Bank regional meeting on PRSP (Tunis, July 2005). The objective is to increase health insurance coverage rate from 20 per cent of the total population to 50 per cent by 2015.

In line with these initiatives, various projects aimed at extending social security to rural and informal economy workers are being conducted, based on a new type of scheme including a centralized structure at the national level and relying on community-based sections (either area- or occupation-based) at the local level. However, extending coverage to the population in the informal economy remains a significant challenge.

[33] Sources: Asfaw (2004), Wade (2007).

Tunisia [34]

Since the end of the 1950s, two out of three Tunisians have been insured through two schemes that offer social security for civil servants and for workers in public as well as private enterprises. In addition, the Government provides free health-care services for the poor and low-income population in public facilities run by the Ministry of Health. Also, some private societies or public bodies offer private health insurance for their employees, covering the same package as the public insurance.

In the 1990s, the Tunisian health insurance system faced a series of problems and difficulties regarding efficiency, quality, equity, and satisfaction of stakeholders and users. The burden of contribution payments of employers and employees was unequally distributed.

The current health insurance reform pursues two major goals. The benefits of the different health insurance regimes should be harmonized and a sole mandatory health insurance body, the *Caisse Nationale d'Assurance Maladie* (CNAM), be put into operation. Secondly, optional complementary regimes should be created in order to cover OOP that currently remains uncovered.

At present the national debate is focusing on issues such as the coverage of the benefit package, cost containment (including provider payment methods), quality assurance, management procedures, regulation and guidelines.

b. Asia

China [35]

China is enjoying impressive and sustained economic growth, and since the early 1980s the living conditions of the vast majority of its population have improved significantly. The world's most populated country is currently experiencing major social and economic changes, but the social agenda is still incomplete, since inequity in health remains a major concern. Until the 1970s China enjoyed a relatively well functioning health system, with about 90 per cent of the population covered by health insurance. However, since the 1980s both the quality of health services and the proportion of the population insured have declined dramatically, and health indicators have deteriorated accordingly. The collapse of cooperative medical schemes in rural areas and the crippling of the public insurance schemes produced serious problems in health financing and access. Out-of-pocket payments have increased from 20 per cent in 1978 to 60 per cent in the early 2000s. At the same time public funding for the health sector has been reduced while health expenditure has continued to rise.

The Chinese Government is currently focusing on building a "moderate welfare state" and has defined the improvement of health care as an essential element of economic growth. The central Government has increased public health spending as well as social cash transfers. Based on high economic growth, some communities have set up local health insurance schemes.

In urban areas, Government Employment Schemes (GIS) and Labour Insurance Schemes (LIS) covering public servants and workers in state enterprises were replaced in 1998 by an insurance system for all employees that is open to smaller companies and the self-

[34] Sources: Achouri (2007) and Asfaw (2004).

[35] Sources: Tang et al. (2007); Hu (2007); Drouin and Thompson (2006).

employed. The GIS and LIS reforms are local initiatives comprising the introduction of cost sharing to the beneficiaries, the establishment of catastrophic disease insurance and the application of capitation payment in some cities. In 2005, the Basic Medical Insurance (BMI) covered more than 130 million beneficiaries in various Chinese cities.

In rural areas, the Rural Community Medical Insurance schemes (RCMI) were replaced by mainly private insurance schemes after the dismantling of the agrarian collectives. As a result, most farmers could not afford private insurance and were thus subject to high out-of-pocket payments. In 2002, the Government issued a "Decision on Strengthening Rural Health Works" and decided to reintroduce RCMI as voluntary local health insurance for self-employed farmers. The organization and financing are fostered and backed by the central Government and coverage was expected to be extended to 179 million beneficiaries by the end of 2005.

Republic of Korea [36]

The Republic of Korea is an outstanding example of the successful introduction of a universal health insurance system. It took just 26 years, once the country had passed its Health Insurance Act in 1963, to achieve universal insurance coverage. It should be stressed that the country's GDP per capita in real terms was still under US$1,600 in other words, only two-thirds of that of the Philippines and around the same level as that of countries such as Mozambique, Niger, Sri Lanka, and Cameroon.

For the first 14 years there was more emphasis on building functional structures than on providing coverage for a significant proportion of the population. With strong stewardship by President Park Jung-Hee, the introduction of compulsory health insurance began in 1977 with the Employee Scheme for formal sector employees. SHI coverage progressed according to the principle of workplace size: insurance was initially compulsory for companies with more than 500 staff and then stepwise expanded to smaller firms of 300, 100 and finally 16 employees. SHI schemes for civil servants and educational staff started in 1981 and became important promoters of extending social protection. When the uncovered population became aware of the substantial financial protection benefits provided by the existing schemes, the motivation to join SHI increased significantly.

Universal social health insurance ranked very high on the political agenda for many years. The introduction and extension of social health insurance coverage was of course bound up with competition with neighbouring Democratic Republic of Korea and the political legitimacy of the authoritarian military regime of the Republic of Korea. Enrolment in social welfare programmes was a central issue in the 1988 presidential election campaign. Mr. Noh Tae-woo, the then candidate of the ruling party, promised to cover the self-employed by the SHI scheme by 1991. Therefore, the major hurdle of contribution collection from informal sector beneficiaries with irregular incomes had to be overcome. This goal was reached full two years before the actual target date, however, and since 1989 health insurance has been compulsory for all groups within the population. Certainly, the burgeoning economic development in the late 1980s played a substantial part in the rapid expansion of the country's social security systems.

The SHI health system was encumbered with many problems, mainly regarding fairness and efficiency of financing. For many years, beneficiaries had to assume high co-payments and co-insurance rates, and a series of benefits were expressly excluded from SHI coverage. The share of out-of-pocket payments was an important cause of the low level of equity in insurance financing and proved to be highly regressive. A lack of horizontal

[36] Sources: Kwon (2002), Yang and Holst (2007).

equity and chronic shortages of funding finally led recently to the standardization of health insurance and the implementation of a single-payer system.

India [37]

The Indian health-care sector is growing rapidly, following on the country's general economic and social development. However, at just 1 per cent, the share of GNP spent on health care remains very low.

All health financing mechanisms coexist in India: OOP constitutes the main form of financing (87 per cent of total health expenditure).[38] Social health protection is available through social health insurance: Employees State Insurance Scheme (ESIS) providing for compulsory coverage of government employees and staff in larger companies, Central Government Health Scheme (CGHS), employer-based schemes, voluntary (commercial) health insurance and community health insurance.

Despite the Government's initiatives to support health insurance schemes, only some 10 per cent of the population enrolled for health insurance. Indeed, the majority of the population cannot afford premium and contribution payments.

Shortfalls in provision, high contributions, drastic co-payments and poor quality of providers have led to the emergence of microinsurance schemes in rural areas as well as in major cities. Microinsurers often purchase products from state insurance companies. For the population in the informal economy, coverage of outpatient services, medicines and the indirect costs of illness (e.g. transport costs and loss of earnings) are crucial. Against this background, some community-based and commercial health insurance schemes offer related benefits.

Thailand [39]

In October 2001 Thailand took a historical step towards achieving full population coverage in health care by introducing a universal health-care scheme called "UC scheme" (also commonly known as the "30 baht" scheme). The scheme offers any Thai citizen not affiliated to the Social Security Health insurance scheme (SSO scheme) or the Civil Servants' Medical Benefit Scheme (CSMBS) full access to health services provided by designated district-based networks of providers (consisting of health centers, district hospitals and cooperating provincial hospitals). Eligible persons have to register with the networks, obtain a free insurance card and pay a nominal co-payment of 30 baht (approximately US$0.75 [40]) for each outpatient visit or hospital admission. Drugs on prescription are free of charge. The scheme has been remarkably successful with respect to population coverage in the first two years of its existence. However, its long-term fiscal sustainability is as yet unclear.

Thailand's national health-care financing system now has five major components:

- the SSO scheme covering presently about 7.4 million card holders who are eligible for health-care benefits;

[37] Sources: Gupta (2007), ILO (2003b), van Ginneken (2000).

[38] WHO (2000), p. 193.

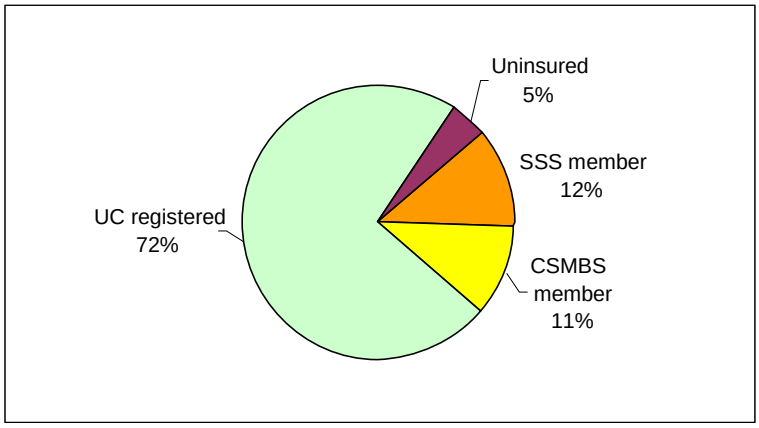
[39] Source: ILO (2004c).

[40] Exchange rate: 40 baht = US$1.

- the non-contributory civil servants medical benefit scheme (CSMBS) covering roughly 7 million eligible people (some 3 million civil servants themselves as well as about 4 million eligible dependants, i.e. children, spouses and parents);
- the UC scheme with a registered total membership of 46.5 million; UC beneficiaries fall into two groups: 24.3 million beneficiaries who are exempted from a co-payment of 30 baht (US$0.75) per episode (or UCE), and 22.2 million beneficiaries who must contribute a co-payment of 30 baht at point of service (or UCP);
- a self-payer/non-covered group (i.e. people in remote areas) of about 3 million people,
- voluntary private health insurance covering about 5 million people. [41]

Figures 14 and 15 show the estimated composition of population coverage and of the national health-care budget in Thailand in 2003. Population coverage with respect to access to health care can be considered as virtually complete.

Figure 14. Estimated structure of health care coverage - Thailand 2003

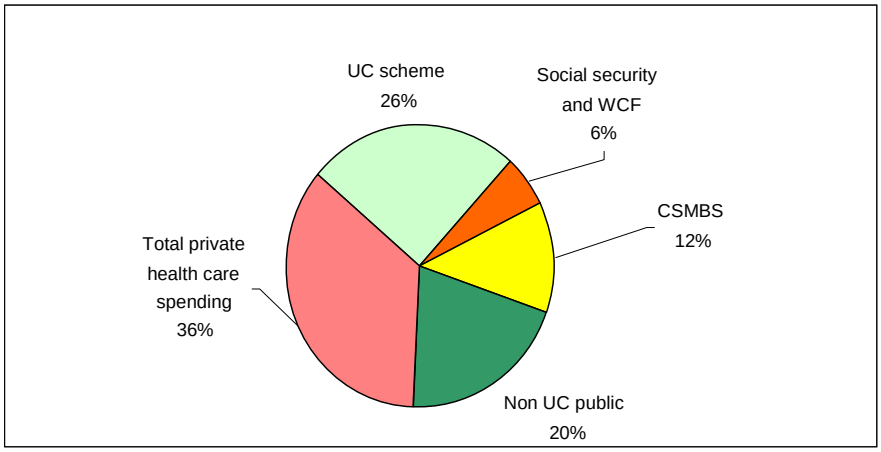


Source: ILO and IHPP mission estimates, 15-20 May 2004 at Geneva.

The UC scheme is new in that it establishes a specific legal entitlement for all people to access health services and abolishes virtually all financial barriers to access as co-payments are small and the needy are even exempted from them. That entitlement is backed up by a new allocation mechanism for public sector health-care resources, i.e. the capitation payment, which should ensure that all provider networks receive a fixed budget for each person to whom they provide care. In its present state the UC scheme is clearly not a fully fledged health insurance scheme as it is not financed by contribution income. It is rather a variant of a National Health Service type of health-care financing system that combines insurance elements (through legal benefit entitlements) and public service elements (through general revenue financing).

[41] Surasinangsang (2004).

Figure 15. Estimated composition of the National Health Budget – Thailand 2003



Source: ILO and IHPP mission estimates, 15-20 May 2004 at GVA.

In theory, the UC scheme presently permits access to health care for about 70 per cent of the population. The proportion of the population it really caters for is probably smaller, however, as not all people eligible and/or holding a UC card may actually take up the service. In fact, the 2003 Health and Welfare Survey conducted by the Thai National Statistical Office (NSO) shows that only about 57 per cent of registered members used the outpatient services in public health centres and hospitals financed by the scheme, whereas 81 per cent of registered members used the inpatient service offered by the scheme. The take-up rate varies greatly according to income groups and is significantly higher in the lower income groups. It appears that about one-third of the population in higher income groups tends to use the UC scheme as a fall-back scheme.

It is obvious that the change to the UC system in 2001 has increased government spending on health care. The actual amount is difficult to determine as the counterfactual (i.e. government spending on health in the absence of the new UC scheme) is obviously unknown. But from the increase in the spending level between 2000 and 2003 one might conclude that the additional cost of the scheme might be in the order of 25 billion baht per annum. That order of magnitude is confirmed by the IHPP estimates of the extent of household savings of out-of-pocket health expenditure. The amount was estimated at around 10-13 billion baht for all households that were newly covered by the UC third-party arrangement. Due to the differential take-up rates by income strata this is a substantial income transfer to the lower income households and confirms the MOH assessment that the reform has had significant pro-poor effects.

The scheme has not had earmarked resources it could rely on during the first years of its existence. Its resource base had to be renegotiated in an annual government budgeting process. From the point of view of long-term scheme sustainability it is in the interest of the UC scheme to shrink as much as possible by conceding “market share” to the other two or three schemes. At the same time it seemed logical to try to establish earmarked income sources that are protected against annual budgetary competition. This was done in 2005 when a certain proportion of the taxes on tobacco and alcohol was earmarked for the financing of the UC scheme, thus helping to safeguard the resources for health care of the economically weakest sections of the population in times of fiscal difficulties. However, the financial situation of the UC schemes can only be stabilized in the long run if it constantly shrinks at the expense of other players. The most effective way to reduce government expenditure is through the extension of social security (SSO) coverage.

c. Latin America

Chile [42]

Chile's health-care system came to general attention as one of the first market-oriented models with the introduction in 1981 of private health insurance funds aimed at achieving efficiency gains and overcoming bottlenecks in provision and funding. Twenty-five years later, the coexistence of public social health insurance and several for-profit private health insurance companies assures universal coverage. However, the Chilean health system still faces shortcomings in terms of equity and fair financing and is challenged by risk selection.

The National Health Fund (FONASA) currently covers two out of three Chileans, including 3 million people considered to be very poor.

Chile has achieved universal health protection coverage by combining in a single-payer system a Bismarck-type contribution system with a tax-financed health system covering the poor:

- employees in the formal sector and some self-employed pay income-related contributions for a comprehensive benefit package. Indigents are covered by the public health insurance fund, FONSAS, which receives substantial subsidies for this purpose from general taxation,
- exempted enrollees are not entitled to claim for private health services as other beneficiaries may do for paying high co-payments. However, as affiliation to FONASA is free of charge they are protected from discrimination and stigmatization when receiving health care at public providers.

Colombia [43]

Before the Colombian health sector reform of 1993, employment-based social health insurance schemes covered about one-third of the population. Formal sector workers were compulsorily enrolled in closed pools and paid mandatory contributions. While the largest fund, the Instituto de Seguridad Social (ISS), covered private sector workers, public sector workers were enrolled in funds restricted to state-owned enterprises, public universities or government units. Besides two large public sector funds (Cajanal, for central government employees, and Caprecom, where workers in the state-owned telecommunications, television and postal enterprises were enrolled), the overall risk pool was divided into more than a thousand small-scale insurance schemes.

The 1993 reform was inspired by the fundamental changes that Chile had applied to its health system 12 years earlier. However, Colombians tried to avoid the obvious undesired effects that were becoming more and more evident in Chile. By creating a contributory system for all formal sector workers and employees, the previously existing monopolistic funds were exposed to a sort of managed competition, since new insurance companies were allowed to enter the market and citizens had the right to choose their insurer according to their own preference. Financing is based on mandatory payroll contributions of 12 per cent of the salary (employer 8 per cent, employee 4 per cent).

In order to avoid market failure and inefficient competitive behaviour by health insurers (most of them were private, and some for-profit), Colombians tried to implement effective

[42] Source: Holst et al. (2004).

[43] Sources: Castaño and Zambrano (2005).

regulation. In order to prevent competition on prices, contributions within the contributory scheme are pooled in a single equalization fund, which then allocates insurers a risk-adjusted community-rated premium for each enrollee defined by age, gender and geographic location (urban/rural). Thus, enrollees pay according to their ability to pay, but insurers receive contributions according to the individual risk of the insured persons. Furthermore, a standardized benefit package defining covered/excluded services and qualifying periods for full coverage and co-payment rates has been established; insurers are mandated to contract all applicants; enrolment is compulsory for all registered workers; and full portability of benefits is guaranteed.

With regard to the challenge of extending social health protection beyond formal sector employees and workers, the creation of a subsidized system alongside the contributory scheme is especially worth mentioning. Citizens lacking financial means to pay contributions are required to register with the Administrator of the Subsidized System (ARS). However, the number of poor and indigent people affiliated to the subsidized scheme still remains below expectations.

To better target the needy and the poor, Colombia has developed a Beneficiary Identification System (SISBEN) based on comprehensive questionnaires and individual contacts by social workers. Entitlement to the subsidized system is conditioned on an adequate SISBEN qualification. Financing of the subsidized scheme relies on tax revenue and on the solidarity contribution of the better-off who pay 13 per cent instead of 12 per cent for health insurance, the additional 1 per cent contribution being designated to subsidize the poor. The benefit package covered by the solidarity scheme is more limited than the comprehensive one of the contributory system; the main advantage for its beneficiaries lies in co-payment exemptions at public health-care providers.

Costa Rica [44]

The health sector in Costa Rica is mainly funded by social insurance, with preventive services provided by the Ministry of Health (MOH). The Costa Rican Social Security Fund (CCSS) was created in the early 1940s to administer the social security insurance system. The system has been very successful in improving the health status of the population. Costa Rica's health indicators resemble those of Europe, the United States and Canada, rather than those generally exhibited by countries with similar per capita incomes (US$1750). Population coverage has expanded and access to CCSS health services is now more or less universal.

The MOH (17 per cent of total expenditure in 1990) oversees health promotion, disease prevention and environmental health. The CCSS (80 per cent of total expenditure) provides curative and rehabilitative care, individual preventive services (e.g., immunization) and some educational services. The National Insurance Institute (INS) covers the treatment, rehabilitation and compensation of policyholders for occupational illnesses and injuries and automobile-related injuries.

The CCSS owns and operates all of the country's 29 hospitals, providing 95 per cent of hospital services and around 70 per cent of all consultations. Except for three private clinics, virtually all health facilities are operated by the CCSS, the MOH or the INS, and form part of the national health system. While the quality of care for inpatient services is considered to be quite high, dissatisfaction with the quality of care provided in ambulatory settings is increasing.

[44] Source: Weber and Normand (2007).

Health-care providers in the MOH and CCSS are mainly paid in salary, although the CCSS has been experimenting with other options, including the Company Medicine Scheme (where a company pays the physician's salary and provides a clinic for employees) and capitation payments to physicians or cooperative clinics.

Annex II

Table 1a. Estimated access deficit in social health protection

Country	Population		GDP[1]		Human Development Index[2]	Human poverty Index[3]	Gini-Index	Estimated access deficit	
	Total (2003)[4]	Urban population (%) (2004)[5]	Total (in billion US$)	Per capita				Staff-related national access deficit (% of population)	Estimate of access deficit (skilled attended births)
Albania	3	45	6	1 740	0.78		28	-	6
Algeria	32	63	60	1 890	0.73	22	35	-	8
Angola	14	53	10	740	0.44	41		62	53
Argentina	38	90	140	3 650	0.86	4	52	-	1
Armenia	3	64	3	950	0.77		38	-	3
Australia	20	88 0	431	21 650	0.96	13	35	-	1
Austria	8	66	215	26 720	0.94		30	-	-
Azerbaijan	8	52	7	810	0.74		37	-	16
Bangladesh	141	25	55	400	0.53	44	32	88	87
Belarus	10	72	16	1 590	0.79		30	-	-
Belgium	10	97	267	25 820	0.95	12	25	-	-
Benin	7	40	3	440	0.43	48		72	34
Bolivia	9	64	8	890	0.69	14	45	-	39
Bosnia and Herzegovina	4	45	6	1 540	0.80		26	-	-
Botswana	2	57	6	3 430	0.57	48	63	4	6
Brazil	179	84	479	2 710	0.79	10	59	-	50
Bulgaria	8	70	17	2 130	0.82		32	-	1
Burkina Faso	12	18	4	300	0.34	58	48	85	43
Burundi	7	10	1	100	0.38	41	33	93	75
Cambodia	14	19	4	310	0.58	39	40	76	68
Cameroon	16	54	10	640	0.51	36	45	44	38
Canada	32	80	757	23 930	0.95	11	33	-	2
Cape Verde		57			0.72	19		57	11

Country	Population		GDP[1]		Human Development Index[2]	Human poverty Index[3]	Gini-Index	Estimated access deficit	
	Total (2003)[4]	Urban population (%) (2004)[5]	Total (in billion US$)	Per capita				Staff-related national access deficit (% of population)	Estimate of access deficit (skilled attended births)
Central African Republic	4	38	1	260	0.35	48	61	88	56
Chad	9	25	2	250	0.37	58		90	86
Chile	16	87	69	4 390	0.86	4	57	46	-
China	1 297	40	1 417	1 100	0.77	12	45	34	17
Colombia	45	72	80	1 810	0.79	8	58	40	9
Congo	4	60	2	640	0.52	28		64	64
Costa Rica	4	61	17	4 280	0.84	4	47	29	2
Côte d'Ivoire	17	45	11	660	0.42	42	45	77	37
Croatia	5	56	2	5 350	0.85		29	-	-
Cuba	10	76			0.83	5		-	-
Czech Republic	10	74	69	6 740	0.89		25	-	-
Dem. Rep. of the Congo	55	32	5	100	0.39	41		80	39
Denmark	5	86	182	33 750	0.94	8	25	-	-
Dominican Republic	9	66	18	2 070	0.75	12	47	-	1
Ecuador	13	62	23	1 790	0.77	9	44	4	31
Egypt	69	43	94	1 390	0.70	20	34	19	31
El Salvador	7	60	14	2 200	0.73	16	53	36	31
Eritrea	5		1	190	0.45	38		80	72
Estonia	1	69	7	4 960	0.86		37	-	-
Ethiopia	70	16	6	90	0.37	55	30	93	94
Finland	5	61	141	27 020	0.95	8	27	-	-
France	60	77	1 523	24 770	0.94	11	33	-	-
Gabon	1	83	4	2 739	0.63	27		-	14
Gambia	1.5	53	12	8	0.48	45		59	45
Georgia	5	53	4	830	0.74		37	-	4
Germany	83	75	2 085	25 250	0.93	10	28	-	-

Country	Population		GDP[1]		Human Development Index[2]	Human poverty Index[3]	Gini-Index	Estimated access deficit	
	Total (2003)[4]	Urban population (%) (2004)[5]	Total (in billion US$)	Per capita				Staff-related national access deficit (% of population)	Estimate of access deficit (skilled attended births)
Ghana	21	47	7	320	0.53	33	30	66	53
Greece	11	59	147	13 720	0.92		35	-	-
Guatemala	13	47	23	1 910	0.67	23	48	-	59
Guinea	8	33	3	430	0.45	52	40	79	65
Guinea-Bissau	1.5	30	12	960	0.35	48		75	65
Haiti	9	38	3	380	0.48	39		89	76
Honduras	7	46	7	970	0.68	17	55	42	44
Hungary	10	66	64	6 330	0.87		24	-	-
Iceland	0.3	93	858	2 932	0.96			-	-
India	1 080	29	568	530	0.61	31	33	56	57
Indonesia	218	47	173	810	0.71	19	34	76	34
Iran, Islamic Republic	67	66	133	2 000	0.75	16	43	45	10
Ireland	4	60	106	26 960	0.96	16	36	-	-
Israel	7	92	105	16 020	0.93		36	-	-
Italy	58	68	1 243	21 560	0.94		36	-	-
Jamaica	3	53	7	2 760	0.72	15	38	22	5
Japan	128	66	4 390	34 510	0.95	12	25	-	-
Jordan	5	82	10	1 850	0.76		36	-	-
Kazakhstan	15	57	27	1 780	0.77		31	-	1
Kenya	32	21	13	390	0.49	36	45	60	58
Korea, Republic of	48	81	576	12 020	0.91		32	-	-
Kuwait	3	98	38	16 340	0.87			-	-
Kyrgyzstan	5	36	2	330	0.71		29	-	2
Lao People's Dem. Rep.	6	20	2	320	0.55	36	37	49	81
Latvia	2	68	9	4 070	0.85		32	-	-
Lebanon	5	87	18	4 040	0.77	10		-	7

Country	Population		GDP[1]		Human Development Index[2]	Human poverty Index[3]	Gini-Index	Estimated access deficit	
	Total (2003)[4]	Urban population (%) (2004)[5]	Total (in billion US$)	Per capita				Staff-related national access deficit (% of population)	Estimate of access deficit (skilled attended births)
Lesotho	2	19	1	590	0.49	48	63	79	45
Lithuania	3	67	16	4 490	0.86		32	-	-
Luxembourg	1	83	25 664	56 780	0.95	11		-	-
Madagascar	17	27	5	290	0.51	36	48	81	49
Malawi	11	17	2	170	0.40	43	50	81	39
Malaysia	25	66	94	3 780	0.81	8	49	35	3
Mali	12	30	3	290	0.34	60	51	82	59
Mauritania	3	40	1	430	0.49	41	39	77	43
Mexico	104	76	637	6 230	0.82	7	55	10	14
Moldova, Republic of	4	47	2	590	0.69		36	-	1
Mongolia	3	57	1	480	0.69	19	44	-	1
Morocco	31	58	40	1 320	0.64	33	40	59	37
Mozambique	19	34	4	210	0.39	49	40	93	52
Myanmar	49	30	14	270	0.58	22		77	44
Namibia	2	35	4	1 870	0.63	33	71	-	24
Nepal	25	15	6	240	0.53	38	37	87	89
Netherlands	16	80	427	26 310	0.95	8	33	-	-
New Zealand	4	86	64	15 870	0.94		36	-	-
Nicaragua	6	59	4	730	0.70	18	55	55	33
Niger	12	17	2	200	0.31	56	51	92	84
Nigeria	140	47	43	320	0.45	41	51	38	65
Norway	5	77	198	43 350	0.97	7	26	-	-
Oman	3	72			0.81			-	5
Pakistan	152	35	69	470	0.54	36	33	62	77
Panama	3	70	13	4 250	0.81	8	56	4	7
Papua New Guinea	6	13	3	510	0.52	41	51	82	82

Country	Population		GDP[1]		Human Development Index[2]	Human poverty Index[3]	Gini-Index	Estimated access deficit	
	Total (2003)[4]	Urban population (%) (2004)[5]	Total (in billion US$)	Per capita				Staff-related national access deficit (% of population)	Estimate of access deficit (skilled attended births)
Paraguay	6	58	6	1 100	0.76	8	57	12	23
Peru	28	72	58	2 150	0.77	12	50	42	29
Philippines	83	62	88	1 080	0.76	15	46	29	40
Poland	38	62	201	5 270	0.86		32	-	-
Portugal	10	57	124	12 130	0.90		39	-	-
Romania	22	54	51	2 310	0.81		30	-	2
Russian Federation	143	73	375	2 610	0.80		46	-	1
Rwanda	8	19	2	220	0.45	37	29	85	69
Saudi Arabia	23	81	187	8 530	0.78			-	7
Senegal	11	41	6	550	0.46	44	41	88	42
Serbia and Montenegro	8		16	1 910				-	7
Sierra Leone	5	40	1	150	0	52	63	88	58
Singapore	4	100	90	21 230	1		43	-	-
Slovakia	5	56	26	4 920	1		26	-	1
Slovenia	2	51	23	11 830	1		28	-	-
South Africa	46	59	126	2 780	1	31	59	-	16
Spain	41	77	698	16 990	1	13	33	-	-
Sri Lanka	19	15	18	930	1	18	34	33	3
Sweden	9	84	258	28 840	1	7	25	-	-
Switzerland	7	75	293	39 880	1	11	33	-	-
Syrian Arab Republic	18	51	20	1 160	1	14		-	30
Tajikistan	6	25	1	190	1		35	-	29
Tanzania, United Rep. of	37	24	10	290	0	36	38	88	54
Thailand	62	32	136	2 190	1	9	43	-	1
The FYR of Macedonia	2	68	4	1 980	0.80		28	-	2
Togo	5	39	1	310	0	39		85	51

Country	Population		GDP[1]		Human Development Index[2]	Human poverty Index[3]	Gini-Index	Estimated access deficit	
	Total (2003)[4]	Urban population (%) (2004)[5]	Total (in billion US$)	Per capita				Staff-related national access deficit (% of population)	Estimate of access deficit (skilled attended births)
Tunisia	10	65	22	2 240	1	18	40	-	10
Turkey	72	67	197	2 790	1	10	40	4	17
Turkmenistan	5	46	5	1 120	1		41	-	3
Uganda	26	13	6	240	1	36	43	78	61
Ukraine	48	77	47	970	1		29	-	1
United Kingdom	59	90	1 680	28 350	1	15	36	-	1
United States	294	81	10 946	37 610	1	15	41	-	1
Uruguay	3	92	13	3 790	1	3	45	-	1
Uzbekistan	26	37	11	420	1		27	-	4
Venezuela, Boliv. Rep. of	26	93	89	3 490	1	9	49	39	6
Viet Nam	82	26	39	480	1	16	36	66	15
Yemen	20	27	10	520	0	41	33	69	78
Zambia	11	35	4	380	0	46	53	42	57
Zimbabwe	13	35	6	480	0	46	57	72	27

[1] World Bank (2006b), pp, 292-295. [2] Human Development Report 2006 (2006), pp, 283-286. [3] Idem, pp, 292-295. [4] All data from World Bank (2005), pp, 256ff. except for Cuba. [5] Human Development Report 2006 (2006), pp, 297-299.

Table 1 b. Formal coverage in social health protection

Country	Formal coverage							OOP as % of total exp. on health	Total expenditure on health as % of gross domestic product[1]	Social security expenditure on health as % of general government expenditure on health[1]	Out-of-pocket expenditure as % of private expenditure on health[1]
	Total (%)	State (%)[2]	SHI (%)	PHI (%)	Other (%)	Company based/ trade union	MHI Total				
Albania	…							58.2	6.5	25.1	99.8
Algeria	85.0	17[3]	68[4]	0				18.3	4.1	28.4	95.3
Angola	…							15.8	7.1	89.2	71.1
Argentina	99.9	37.3[5]		13.6[6]	0.2[7]	48.8[8]		28.6	2.8	0.0	100
Armenia	100.0	100						64.3	4.5	0.0	100
Australia	100.0	59.7		40.3[9]				22	8.9	56.8	55.6
Austria	98.1	3.8[10]	94.2	0.1[9]				19.2	6.0	0.0	80.6
Azerbaijan	...							73.8	9.5	0.0	67.8
Bangladesh	0.4						0.41	58.9	7.5	65.8	59.2
Belarus	100.0	100[11]						23.2	3.6	0.0	96.8
Belgium	100.0		99	57.5[9]				21.8	9.4	88.4	66.6
Benin	0.5						0.44	51.4	4.4	...	90.3
Bolivia	66.9	30	25.8	10.5			0.6	28.5	6.7	65.0	79.3
Bosnia and Herzegovina	100.0	100						49.3	9.5	77.5	100
Botswana	…							12	5.6	...	28.8
Brazil	85.0	100[12]		24.5				35.1	7.6	0.0	64.2
Bulgaria	100		100[13]					44.8	7.5	51.6	98.4
Burkina Faso	0.2		0[14]				0.2	52.2	5.6	1.0	98.1
Burundi	13		13[15]				0	76.7	3.1	...	100
Cambodia							0.66	69.6	10.9	0.0	86.2
Cameroon	0.1						0.05	69.9	4.2	0.1	98.3
Canada	100.0	35		65[9]			0	14.9	9.9	2.1	49.6
Cape Verde	65.0		26.7[16]				0	26.7	4.6	35.5	99.7
Central African Republic	6.0						6.03	58.5	4.0	...	95.3
Chad	…						0.01	57.9	6.5	...	96.3
Chile	96.0	25[17]	43.8	17.6	9.6		0	23.7	6.1	32.1	46.2

Country	Formal coverage							OOP as % of total exp. on health	Total expenditure on health as % of gross domestic product[1]	Social security expenditure on health as % of general government expenditure on health[1]	Out-of-pocket expenditure as % of private expenditure on health[1]
	Total (%)	State (%)[2]	SHI (%)	PHI (%)	Other (%)	Company based/ trade union	MHI Total				
China	23.9		10.0[18]				13.9	55.9	5.6	53.4	87.6
Colombia	31.3		30.5[19]			0.7[20]	0.13	7.5	4.0	...	95.3
Congo	...						0	35.8	2.0	0.0	100
Costa Rica	100.0		87.8[21]	12.2			0	18.8	7.3	88.6	88.7
Côte d'Ivoire	5.0						5.02	65.5	3.6	...	90.5
Croatia	100.0		100[22]				0	16.4	7.8	96.1	100
Cuba	100.0	100					0	9.9	7.3	0.0	75.2
Czech Republic	100.0	100		0[9]			0	8.4	7.5	85.4	83.9
Dem. Rep. of the Congo	0.2						0.17	81.7	4.0	0.0	100
Denmark	100.0	100					0	15.7	9.0	0.0	92.5
Dominican Republic	84	60	7.0	12.0			0	47.3	7.0	17.4	70.8
Ecuador	73.0	28	18 17.4[23]	20	7		0	54.1	5.1	31.9	88.1
Egypt	47.6	34.3[24]	12.9[25]	0.44			0	53.5	5.8	27.1	93.2
El Salvador	59.6	40	18.1[26]	1.5			0	50.4	8.1	44.1	93.5
Eritrea	…						0	54.5	4.4	0.0	100
Estonia	94.0		94				0	20.2	5.3	84.9	88.3
Ethiopia	…						0	32.7	5.9	0.4	78.7
Finland	100.0		100				0	19.1	1.5	0.0	80.5
France	100.0		99.9	92[27]			0	10	1.5	0.0	80.5
Gabon	55.0	14.4[28]	23[29]	4.7[30]	12.9[31]		0	33.4	4.4	1.7	100
Gambia	99.9						0	40.2	8.1	0.0	67.0
Georgia	55.0		14[32]				0	74.7	4.0	59.2	98.2
Germany	101.6	3.9[33]	85.7[34]	10[35]	2[36]		0	10.4	11.1	87.4	47.9
Ghana	18.7						18.7	68.2	4.5	...	100
Greece	99.5			10[9]			0	46.5	9.9	32.0	95.4
Guatemala	72.6	26	16.6 18.2[37]	30		> 0.008[38]		55.4	5.4	50.5	91.9

Country	Formal coverage							OOP as % of total exp. on health	Total expenditure on health as % of gross domestic product[1]	Social security expenditure on health as % of general government expenditure on health[1]	Out-of-pocket expenditure as % of private expenditure on health[1]
	Total (%)	State (%)[2]	SHI (%)	PHI (%)	Other (%)	Company based/ trade union	MHI Total				
Guinea	1.1						1.09	82.9	5.4	1.5	99.4
Guinea-Bissau	1.6						1.6	43.5	5.6	2.2	80.2
Haiti	60.0	21		38	1			43	7.5	0.0	69.5
Honduras	65.2	52	11.7	1.5				37.3	7.1	11.6	85.8
Hungary	100.0	100		0				24.5	8.4	83.4	88.9
Iceland	100.0	100		0[9]				16.5	10.5	36.5	100
India	5.7		5.2[39]	0.04[40]			0.48	72.9	4.8	4.2	97.0
Indonesia	54.6	16.6[41]	36.1[42]	1.9[43]				47.6	3.1	9.9	74.3
Iran Islamic Republic of	…							50	6.5	30.9	94.8
Ireland	100.0	100		43.8[9]				13.1	7.3	0.8	61.9
Israel	9.0							28.3	8.9	61.9	89.1
Italy	100.0	100		15.6[9]				20.7	8.4	0.2	83.3
Jamaica	…							32	5.3	0.0	64.7
Japan	100.0		100					17.1	7.9	80.5	90.1
Jordan	≈80.0		70	5		3 7		40.6	9.4	0.7	74.0
Kazakhstan	70-80		70-80					42.7	3.5	0.0	100
Kenya	25.0		25[44]				0.015	50.6	4.3	10.0	82.6
Korea, Republic of	94.0		94[27]	n.a.[9]				41.9	5.6	81.7	82.8
Kuwait	0.0							20.5	3.5	0.0	91.2
Kyrgyzstan	...						0	59.2	5.3	15.2	100
Lao People's Dem. Rep.	16.1		15.9[45]				0.15	46.4	3.2	1.0	75.5
Latvia	87.0	87					0	46.9	6.4	82.7	94.3
Lebanon	95.1	45.3[46]	26.1[47]	12.6[48]	11.1[49]		0	56.1	10.2	46.0	79.4
Lesotho	...						0	3.7	5.2	0.0	18.2
Lithuania	...						0	23.2	6.6	74.6	96.6
Luxembourg	99.7	1.44[50]	98.3	2.4			0	7.1	6.8	88.1	77.3
Madagascar	...						0	33.6	2.7	...	91.7

Country	Formal coverage							OOP as % of total exp. on health	Total expenditure on health as % of gross domestic product[1]	Social security expenditure on health as % of general government expenditure on health[1]	Out-of-pocket expenditure as % of private expenditure on health[1]
	Total (%)	State (%)[2]	SHI (%)	PHI (%)	Other (%)	Company based/ trade union	MHI Total				
Malawi	...						0	27.7	9.3	0.0	42.7
Malaysia	…							30.8	3.8	0.8	73.8
Mali	2.0						2.0	38	4.8	26.0	89.3
Mauritania	0.3						0.26	23.2	3.7	8.7	100
Mexico	78.6	28.6[51]	47[52]	3[53]				50.5	6.2	66.9	94.2
Moldova, Republic of	78.6		100[54]					43.7	7.2	1.1	96.1
Mongolia	100	57.6[55]	78.5[56]					33	6.7	37.8	91.1
Morocco	41.2		35[57]	0.4	0.5[58]	5.3[58]		50.9	5.1	0.0	76.1
Mozambique	…							14.9	4.7	0.0	38.8
Myanmar	…							80.4	2.8	1.3	99.7
Namibia	22.5		10[59]	12.5[60]				5.8	6.4	1.9	19.2
Nepal	0.1					0.008[61]	0.13	66.6	5.3	0.0	92.2
Netherlands	100		76.3	28[9]				7.8	9.8	93.0	20.8
New Zealand	100.0	100		35[9]				15.6	8.1	0.0	72.1
Nicaragua	68.5	60	7.9		0.5		0.13	49.4	7.7	26.6	95.7
Niger	0.7						0.7	41.9	4.7	2.2	89.2
Nigeria	…							67.9	5.0	0.0	91.2
Norway	100.0			0[9]				15.6	10.3	17.9	95.4
Oman	100.0							9.5	3.2	0.0	56.1
Pakistan	...							70.9	2.4	53.3	98.0
Panama	100.0	35.4	64.6					27.6	7.6	55.5	82.2
Papua New Guinea	...							9.7	3.4	0.0	87.2
Paraguay	63.7	33.3	14.2[62]	12.4		0.18[63]	3.59	51.1	7.3	39.8	74.6
Peru	71.0	11.7[64]	27.2[65]				0.34	40.8	4.4	42.4	79.0
Philippines		37.7[66]	21.1[67]					44	3.2	21.8	78.2
Poland	…			0[9]			0	26.4	6.5	86.0	87.8
Portugal	100.0	100.0		14.8[9]			0	29	9.6	6.5	95.7

Country	Formal coverage							OOP as % of total exp. on health	Total expenditure on health as % of gross domestic product[1]	Social security expenditure on health as % of general government expenditure on health[1]	Out-of-pocket expenditure as % of private expenditure on health[1]
	Total (%)	State (%)[2]	SHI (%)	PHI (%)	Other (%)	Company based/ trade union	MHI Total				
Romania	100.0		100[68]				0	33.5	6.1	85.8	90.4
Russian Federation	88		88[69]				0	29.2	5.6	43.7	71.1
Rwanda	36.6	2.6[70]	8.9[71]				25.1[72]	23.6	3.7	9.8	41.7
Saudi Arabia	…						0	6.9	4.0	...	28.6
Senegal	11.7		7[73]				4.72	55.5	5.1	15.8	95.3
Serbia and Montenegro	96.2		96.2[74]				0	20.9	9.6	89.8	85.3
Sierra Leone	…						0	41.7	3.5	0.0	100
Singapore	…						0	62	4.5	21.5	97.1
Slovakia	96.2				0[9]		0	11.7	5.9	93.5	100
Slovenia	100.0						0	9.7	8.8	82.6	41.1
South Africa	100.0	83.7[75]		17[76] 15.1[77]			0	10.5	8.4	4.6	17.1
Spain	98.9			2.7[9]			0	23.5	7.7	7.0	82.0
Sri Lanka	0.1						0.12	48.9	3.5	0.3	88.9
Sweden	100.0	100		0			0	13.6	9.4	0.0	92.1
Switzerland	100.0		20	80[9]			0	31.5	11.5	69.3	76.0
Syrian Arab Republic	29.2	100[78]	0	0.005[79]		18[80]	11.2	51.8	5.1	0.0	100
Tajikistan	…						0	79.2	4.4	0.0	100
Tanzania, United Rep. of	14.5		14.5[81]				0.005	36.2	4.3	2.6	81.1
Thailand	97.7	75.3[82]	22.4[83]				0	28.7	3.3	32.0	74.8
The FYR of Macedonia	100.0		100[84]				0	15.5	7.1	97.8	100
Togo	0.4						0.44[85]	66.2	5.6	14.6	88.0
Tunisia	99.0	33[86]	65	1			0	45.1	5.4	23.5	83.0
Turkey	69.2		67.2	<2			0	19.9	7.6	54.6	69.9
Turkmenistan	82.3	82.3					0	32.6	3.9	6.1	100
Uganda	0.1						0.098	36.7	7.3	0.0	52.8
Ukraine	100.0	100[87]					0	26.8	5.7	0.0	78.6

Country	Formal coverage							OOP as % of total exp. on health	Total expenditure on health as % of gross domestic product[1]	Social security expenditure on health as % of general government expenditure on health[1]	Out-of-pocket expenditure as % of private expenditure on health[1]
	Total (%)	State (%)[2]	SHI (%)	PHI (%)	Other (%)	Company based/ trade union	MHI Total				
United Kingdom	100.0	100		10[9]			0	11	8.0	0.0	76.7
United States	100	32.4[88]		71.9[9] 66.4[89]			0	13.5	15.2	28.4	24.3
Uruguay	87.8	27.2	15.8	30.8	13.9		0.13	18.2	9.8	48.5	25.0
Uzbekistan	...						0	54.4	5.5	0.0	95.5
Venezuela, Boliv. Rep. of	100.0	65.6	34.4				0	53.2	4.5	25.2	95.5
Viet Nam	23.4			22.2[90]			1.17	53.6	5.4	16.6	74.2
Yemen	6.3		0	0.03[91]	4.65[92]	1.5[93]	0.1	56.4	5.5	...	95.5
Zambia	…						0	33.1	5.4	0.0	68.2
Zimbabwe	…						0	36.3	7.9	0.0	56.7

[1] World Health Organization (2006), Statistical annex (http://www who int/whr/2006/annex/en). [2] All data regarding OECD countries from OECD Health Data (2006) and for Latin America from Mesa-Lago (2005/2007), except other sources are indicated. [3] The State is paying contributions on behalf of about 8 million handicapped persons and half a million unemployed; calculating an average number of 3 dependants, this ensures access to health care for about 17% of the total population. [4] In 2004, the Caisse Nationale de la Sécurité Sociale des Travailleurs Salariés (CNAS) had 7 750 045 beneficiaries. By Oct. 2006 the number had increased to 9 331 767 beneficiaries (CNAS 2006). For the private sector social insurance scheme Caisse Nationale de Sécurité Sociale des non-salariés (CASNOS) only dated information on beneficiaries was available: in 2000, the CASNOS had 330,863 contributing members; calculating an average of four dependants that would correspond to a total number of 1,654,315 beneficiaries (CASNOS 2001). Furthermore, students, war pensioners, unemployed covered through the unemployment program, and some other groups are covered by the CNAS and thus pay lower contribution rates. [5] Maceira 2005 p.7. [6] 9.8% private health insurance only; 3.8% complementary PHI in addition to employee health plan (Maceira 2005 p.7). [7] Maceira 2005 p.7. [8] Employees health care plans (Maceira 2005, p.7). [9] OECD (2006), except for Germany and the Netherlands. PHI is supplementary (1st number) or complementary (2nd number) to either tax-financed or SHI-borne social protection in health. [10] In 2004, Austria had 170,449 welfare recipients whose SHI contributions are paid by the municipalities from tax money (Statistik Austria 2006); the treasury also finances practically all contributions for the 138,539 retired farmers (Mehl 2005. p.15). [11] Arnaudova (2006), p.33. [12] All citizens are entitled to receive benefits covered by the Unified Health System SUS, but availability varies according to regional and geographic conditions. [13] Arnaudova (2006), p.78. [14] The Caisse Nationale de Sécurité Sociale does not cover health benefits other than some preventive maternal and child health services associated to family allowances and other main benefits and is not considered "health insurance" (CNSS 2007). [15] Direct information from the Département Technique de la Mutuelle de la Fonction Publique, Bujumbura Jan. 2007 Witter (2002, p.21) had mentioned a coverage rate of 10-15%. [16] In 2000, the total number of beneficiaries of the Instituto Nacional de Previdência Social (INPS) was 115,378 out of a total population of 431,989 (Ferreira 2003, p.8). [17] Since FONASA beneficiaries group A (indigents) are exempted from contributions, this group's health care is considered to be financed by the State; all other FONASA affiliates pay contributions and are thus covered by a SHI scheme (FONASA 2006). [18] In 2005, more than 130 million beneficiaries were covered by the Basic Medical Insurance scheme (BMI) (MOLSS, 2005, as cited in Tang et al., 2007, p.32); it should be noted that the BMI is called Basic Health Insurance System (BHIS) (Drouin and Thompson, 2006). [19] According to Castaño and Zambrano (2005), about 13,800,000 Colombians are currently covered by the contributory or the subsidized system. [20] Equidad insurance for work-related accidents and diseases covered 309,790 beneficiaries in 2004 (Almeyda and Jaramillo 2005, p.39). [21] Sáenz/Holst 2007. [22] Arnaudova (2006), p.96f. [23] Statistical data from IESS indicate 1,184,484 contributing affiliates in 2003, 261,715 pensioners, 819,405 (= 31.8 per cent of target group) in the Seguro Social Campesino Ecuatoriano (IESS, 2006; González, 2006). [24] 16,470,022 pupils covered according to Act 99/1992 and 5,525,125 infants and children (Decree 380/1997). [25] 3,629,996 public sector employees covered according to Law 32/1975; 3,121,529 beneficiaries of the government worker programme according to Law 79/1975, plus 1,617,923 pensioners and widows (contributing 1% of their pensions). [26] Including all beneficiaries of the Salvadoran Social Security Institute (ISSS, 2006) and of Teachers Welfare (Bienestar Magisterial) (Holst, 2003c, p.25). [27] OECD (2006); note that PHI in France complements universal statutory SHI providing reimbursement for relevant co-payments: some 60% are *Mutuelles* and the remaining 40% non-for-profit and for-profit PHI. [28] 40,000 public employees plus 160,000 dependants covered through the Ministry of Finance; 300,047 indigents and unstable workers, covered in theory by the Caisse Nationale de Garantie Sociale lack any kind of service (Biyogo Bi-ndong et al., 2005 p.9). [29] 92,739 insured private sector employees and 226,515 dependants (Biyogo Bi-ndong et al., 2004, p.9). [30] 22,000 contributing affiliates and the total number of 65,000 beneficiaries were covered through private

health insurance (Biyogo Bi-ndong et al., 2004, p.11). [31] Remaining percentage according to the total number of people covered (52%) minus those covered by any of the schemes mentioned (Biyogo Bi-ndong et al., 2004, p.3f., 9). [32] Until 2002 the State United Social Insurance Fund (SUSIF) had not enrolled more than 14% of the Georgian population (Witter, 2002 p.22) although the country's employment structure accounts for 35.4% wage employees (besides 35% self-employed and 37.8% unsalaried employed) (Collins, 2006, p.302f). [33] Municipalities pay for health insurance contributions of welfare benefit recipients who numbered 2,910,226 in 2004; Furthermore, the central government finances social insurance contributions for 351,409 retired farmers (Krieger, 2006, p.4; LSV, 2005, p.96). [34] Total SHI coverage comprised 74,051,000 people out of the total population of 82,600,000 citizens which corresponds to 89.65% of the population in Germany. However, SHI beneficiaries for whom central or local governments pay contributions are counted as users of State-borne health care access (OECD, 2006). [35] Substitute for mandatory statutory health insurance for the better off. [36] Busse and Riesberg (2004), p.57. [37] Herrera (2006), p.4. [38] More than 1,000 affiliates of the Servicio Solidario de Salud organized by the mutual of the Central General de Trabajadores (Develtere and Fonteneau, 2001, p.30f). [39] The Employees State Insurance Scheme (ESIS) covers about 7.9 million insured persons and about 30.7 million beneficiaries; the number of cardholders of the Central Government Health Scheme (CGHS) is currently about 1 million with the total number of beneficiaries around 4.3 million; Railways Health Scheme 8; defence employees 6.6; ex-servicemen 7.5; mining and plantations (public sector) 4 million beneficiaries (Gupta, 2007, p.113, 118). [40] Universal Health Insurance Scheme (shared contribution: 416,936 beneficiaries (National Insurance Company). [41] 36,146,700 beneficiaries were expected to enter the extended Askesin system for low income people in Indonesia subsidized by central and local governments (Adang, 2007, p.149f). [42] Since 2005, the new initiative (Askesin) has extended health insurance coverage to an additional 60 million people or 27.6% of the population, including the civil-servant social health insurance scheme Askeswith with about 4.5 million affiliated employees and 9.3 million dependants summing up 13.8 million beneficiaries, or 6.3% of the population. Social health insurance for private employees (Jamsostek) was covering 1.26 million employees and 2.74 million beneficiaries in 2005. About 2 million people were insured by the military health services system covering all armed forces. [43] In 1999 (!), 4 million people were covered by private commercial health insurance. (Adang 2007, p.148). [44] Witter (2002), p.21; National Health Insurance Fund (NHIF) covers 7% of the Kenyan population (Scheil-Adlung et al. 2007, p.133). [45] 875,000 beneficiaries covered by the Public Sector Social Security Scheme, including ≈91,000 civil servants and ≈100,000 members of armed forces and 48,096 beneficiaries of the private sector Social Security Organisation (SSO) (Hohmann et al., 2005). [46] 2,083,662 Lebanese – 1,047,338 male and 1,036,324 female - are eligible for MoPH coverage (MoPH, 2006). [47] Self-reported coverage of the National Social Security Fund was 26.1% in 2001, although household surveys showed a lower rate of 17.8% (Ammar et al., 2000) since in 2003 the NSSF had 386,000 affiliates: 253,000 males (65.54%) and 133,000 females (34.45%) (Papadopoulos 2006, p.4). The average number of dependants would be close to two persons, which appears relatively low for an Arab country. [48] 8% of the population has complete coverage through private insurance, and 4.6% of the population has contracted PHI to complement coverage of other insurance schemes (Ammar et al. 2000, p.24). [49] Beneficiaries covered by any scheme in place for members of the four arms of the security apparatus (Ammar et al. 2000, p.24). [50] Ministère de la Sécurité Sociale (2005). [51] Frenk et al. (2007), p.24; for tax financing please note the yearly expected inclusion of 14.3% of the target group consisting of 11 million families, or 50 million beneficiaries representing 49% of the total population. Estimations for the second year after the implementation of the System for Social Protection in Health (SSPH) in 2004. [52] *Ibid*. [53] *Ibid*. [54] Arnaudova (2006), p.114f. [55] 1,439,544 people were covered by the State in 2002 (Khorolsuren and Tseden, 2005, p.3f). [56] In 2002, the total number of health insurance affiliates was 523,617 corresponding to 1,963,161 beneficiaries (Khorolsuren and Tseden 2005, p.3f). [57] In 2005, the private sector social insurance scheme Caisse Nationale de Sécurité Sociale (CNSS) covered about 6 million beneficiaries, and the public sector employees' health insurance scheme Caisse Nationale des Organismes de Prévoyance Sociale (CNOPS) about 3.2 million beneficiaries. About 4% were covered by employer-based health insurance (Caisse Mutualiste Interprofessionnelle Marocaine) (L'Observatoire de Tanger 2007; Kaddar et al., 1999, p.4f). [58] Direction de la Statistique 2005, p.485. [59] Witter (2002), p.21. [60] Feeley et al.(2006), p.6. [61] The General Federation of Nepalese Trade Unions was covering about 2,000 beneficiaries (ILO, 2003a, pp.8,10). [62] Instituto de Prevision Social (2003); Holst (2003b). [63] Employees of Binational Itaipú Company covered through the Seguro Itaipú (Holst 2003b). [64] Also, the publicly run insurance scheme Seguro Integral de Salud (SIS) counted 11,044,140 affiliated beneficiaries (MINSA, 2006, p.IR-1). Only 3,221,090 beneficiaries enjoyed effective coverage (personal communication by SIS-staff). [65] The total number of formal sector employees and their dependants who are covered by the SHI-scheme EsSalud is 7,500,000 (http://www essalud gob pe). [66] As at 31 Dec., 2004, PhilHealth covered a total number of 31,290,750 beneficiaries through the sponsored (indigent) programme which provides subsidized premiums to indigents (PhilHealth, 2006). [67] The total number of 17,520,000 beneficiaries comprises Government employees (compulsory insurance), private sector employees and workers affiliated so far, plus enrolees of the Individual Paying Program offered to informal sector workers (Basa, 2007). [68] Arnaudova (2006), p.132. [69] Balabanova et al. (2003), p.2126. [70] Beneficiaries of Gacaca (113,770) and prisoners (107,000) are entitled to public sector health benefits free of charge (Musango et al., 2006, p.126). [71] The Rwandaise d'Assurance Maladie (RAMA): 155,394; Fonds d'appui aux rescapés du génocide (FARG): 283,000; Army: 100,000; and private sector health insurance: 213,512 (Musango et al., 2006, p.126). [72] Musango et al. (2006), p.126. [73] Total number of beneficiaries covered by company and inter-company health insurance institutions (IPMs) running the statutory formal sector social health protection scheme (Scheil-Adlung et al., 2007, p.133). [74] Information provided by Prof. Laaser Belgrade. [75] Basic health care offered to the large majority in South Africa through public facilities charging user fees according to region and service (Scheil-Adlung et al., 2007, p.133). [76] Covered through employment-based private health insurance plans (Scheil-Adlung et al., 2007, p.134). [77] Council for Medical Schemes (2006), p.47. [78] In principle, Syrians are entitled to preventive and primary care at public providers. Furthermore, patients with chronic conditions also receive health care free of charge or for reduced tariffs at public health facilities. [79] PHI is emerging in Syria since the first companies got licensed in July 2006 (Holst, 2006). [80] Half of the 3 million public sector employees are estimated to be covered by some kind of insurance scheme, according to the first assessment of company-based health benefit schemes in Syria. About 12-14% of the population is entitled to company-based health benefits. However, corresponding studies did not take into account the fact that trade unions are running additional schemes for their dependants in a number of public companies, resulting in a higher number of people protected by company-based health insurance (Schwefel 2006a, 2006b; Holst, 2006). [81] The total number of social security beneficiaries in Tanzania is 5,319,378: NSSF 400,000 members, 2,360,000 beneficiaries; PPF 60,000 members, 354,000 beneficiaries; PSPF 193,000 members, 1,138,700 beneficiaries; LAPF 40,000 members, 236,000 beneficiaries; NHIF 248,343 members, 1,142,178 beneficiaries; GEPF 15,000 members, 88,500 beneficiaries (Dau, 2005, p.2; Humba, 2005 p.7). [82] In 2002 the UC scheme covered 47 million people in Thailand (Tangcharoensathien et al., 2007, p.127). [83] Civil Servant Medical Benefit Scheme for public sector (6 million or 10% of the population) and the Social Health Insurance for private sector employees (8 million or 13%) are both considered SHI systems (Tangcharoensathien et al., 2007, p.127). [84] Arnaudova (2006), p.197f. [85] Concertation (2004), p.14. [86] Achouri (2007), p.52; it should be noted that the CNSS covers about four out of every five social security beneficiaries. The percentage of people covered through tax-based services includes those entitled to health services free of charge (8%) and to reduced tariffs in public facilities (25% of the population). [87] Arnaudova (2006), p.233f. [88] In 2003, 41.2 million US citizens were enrolled in Medicare and 54 million in Medicaid (US Census Bureau, 2007). [89] Hoffman et al. (2005), p.10. [90] At the end of 2005, the compulsory scheme had affiliated 8,142,000 and the voluntary schemes 6,245,000 Vietnamese citizens, while 3,889,000 poor people were enrolled through subsidies from the Heath Care Fund for the Poor (Tien, 2007, p.64). [91] Estimated number of Yemeni citizens covered through PHI is about 6,000 (Schwefel et al., 2005, p.108ff). [92] Armed forces and police are estimated to have 920,000 personnel who are covered through the military health benefit scheme or the scheme of the Ministry of Interior (Schwefel et al., 2005, p.105). [93] According to estimations, about half of all formal sector workers and employees are entitled to some kind of health benefit scheme (Schwefel et al., 2005, p.105).

Annex III

ILO Tool Box

NATLEX

NATLEX is a database of national labour, social security and related human rights legislation maintained by the International Labour Standards Department. Database records provide abstracts of legislation and relevant citation information indexed by keywords and subjects. NATLEX contains more than 55,000 records covering over 170 countries and territories. Each record in NATLEX appears in only one of the three ILO official languages (either in English, French or Spanish). As far as possible, the full text of the law or a relevant electronic source is linked to the record. The database is usually kept up to date, although some delay between receiving information and updating the records might occur.

Actuarial and financial advisory services

Many countries require neutral, objective advice on strategic or managerial financial and fiscal questions or support in building up national capacities for sound financial design and management of social protection programmes. ILO's International Financial and Actuarial Service (ILO FACTS) assists government agencies and autonomous social protection organisms to develop their own capacity for quantitative planning and improve the management and governance of their social protection schemes. ILO FACTS is a public sector advisory group for the exclusive use of national social protection agencies or social security schemes. It is a service that the ILO provides to its constituents. It is highly specialized in the actuarial, financial and fiscal questions of social protection. ILO FACTS is the consulting group with the longest and most extensive international experience in quantitative aspects of social security in the world.

The ILO model family

Population projections. ILO-POP produces population forecasts that match the standard UN methodology for demographic projections on the basis of an initial population structure combined with mortality, fertility and migration assumptions. This model is also used as a standard input producer for the ILO actuarial pension and social budget models which require long-term population forecasts. Population forecasting models have recently been elaborated to take into account the effects of the HIV/AIDS epidemic on mortality.

Social budgeting. ILO-SOCBUD consists of four sub-models: the labour force sub-model (ILO-LAB) and the economic sub-model (ILO-ECO) together provide data on employment and earnings to the social expenditure sub-model (ILO-SOC), which provides information on functional expenditures (expenditure by function of social protection) for main social security subsystems and schemes, e.g. social health protection and old age protection; the fourth sub-model, ILO-GOV, aggregates data for use in government and institutional accounts of the social security system.

Pension model. ILO-PENS is an actuarial pension model which is traditionally used to undertake stand-alone long-term financial and actuarial projections for national pension schemes. It can also be used as an input to ILO-SOCBUD.

Wage distribution. ILO-DIST is developed to generate data on salary distribution. It is used primarily for pension projections but, as social protection systems are redistributive, it is also necessary to take income distribution into account when providing policy advice on the design and financing of such systems.

Health model. ILO-HEALTH is the latest arrival in the ILO social protection modelling family and is still in the testing process. It is designed as a tool to undertake stand-alone

assessments of the financial status and development of national health-care systems and is also applicable for generating inputs for the health part of ILO-SOCBUD.

Performance indicators

The Social Security Department has developed a preliminary set of quantitative performance indicators which can be used by managers and supervisory bodies to assess the performance of social security schemes.

STEP

In order to address low rates in social protection coverage in developing countries, STEP develops innovative strategies and mechanisms specifically aimed at providing coverage to those who are currently excluded from existing schemes. STEP works on community-based social benefit schemes and in particular on mutual health organizations. STEP works also on the linkages between the various schemes designed and implemented for protecting excluded people.

GIMI

The Global Information on Micro-insurance (GIMI) platform is aimed at improving the knowledge base on social health protection and fostering interaction between actors through modern information and communication technologies. It provides resources and services to support users in the design, implementation and management of social protection schemes, through:

- online library including guides, case studies, articles and presentations;
- bilingual French-English glossary;
- database on microinsurance schemes around the world;
- free management and monitoring software;
- training packages to be used in online or face-to-face sessions; as well as self-learning kits;
- online assistance from experts in the field;
- the e-Gimi discussion forum;
- collaborative websites called “wikis” to explore technical issues or conduct joint projects,
- a collaborative newsletter based on contributions from users.

CIARIS

The Learning and Resources Centre on Social Inclusion (CIARIS) is an Internet platform. It supports organizations and individuals in the conception, planning, implementation, monitoring and evaluation of projects aimed at combating social exclusion at the local level. CIARIS contains a wide range of information and resources available in four languages. It allows users to interact and facilitates mutual assistance through three services:

- CIARISAssist connects people with specialized experts;
- CIARISLearning offers a wide range of distance-learning sessions,
- CIARISFora provides online discussion forums.

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