Social Health Insurance –
Systems of Solidarity

Experiences from German development cooperation
We who live in affluent societies, who can obtain medical treatment whenever illness strikes, can barely begin to imagine how it feels to have no access to medical care and no way of obtaining medicines. Though it affronts human dignity, this is a daily reality for almost half the world’s population. The problems are especially severe for poorer segments of the population in developing countries. Appropriate health care is something they cannot afford. Most of all, it is women and children who suffer.

Developing countries face colossal challenges, in the form of infectious diseases – particularly HIV/AIDS, malaria and tuberculosis, – a lack of access to health services, and insufficient social protection for their people. The poor become ill more frequently than the better-off, and their illnesses are likely to be more severe and more prolonged. It is not unusual for a serious illness to plunge whole families into poverty.

This situation cannot leave a single one of us unmoved. Moreover, in our globalized world where risks and threats to health can spread like wildfire, it also affects us. So it is in our own interests to help where we can.

In the year 2000, the international community set itself the target of halving the proportion of people living in extreme poverty by the year 2015. This is ambitious, but not utopian. The German federal government has made a commitment to this goal. In its “Program of Action 2015” it has created a framework for the active pursuit of German development policy. “Guaranteeing basic social services – strengthening social protection” is one of ten priorities addressed by the Program of Action 2015. We are working towards it, both in bilateral cooperation and through our input at European and international levels. One vitally important aspect is the establishment and expansion of social health insurance systems. I am convinced that the global health targets can only be achieved by working to create sustainable systems for financing health care.

In the fight against poverty, many developing and transition countries are seeking new and more effective ways of organizing health care for their populations. We have responded to the need for advisory services by commissioning the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ, German Technical Cooperation) to set up a supraregional sector project for the “Elaboration and Introduction of Social Health Insurance Systems in Developing Countries”. In cooperation with national and international partners, our experts are supporting countries in Africa, Asia and Latin America as they set up solidarity-based health care and health insurance systems. The following pages provide information on the experience of German development cooperation in this field.

Heidemarie Wieczorek-Zeul
Federal Minister for Economic Cooperation and Development
Contents

The Project

FOREWORD: Worldwide partnership against poverty
by Heidemarie Wieczorek-Zeul ................................................. 3

EDITORIAL
by Bernd Eisenblätter ............................................................. 5

THE SECTOR PROJECT: Social health insurance – better health ensured
by Bernd Schramm and Jürgen Hohmann .............................. 6

INTERVIEW: Interest is mounting
with Assia Brandrup-Lukanow .............................................. 7

PARTNERSHIP WITH THE AOK: Strengthening social safety nets together
by Rainer Eikel ................................................................. 10

Africa

KENYA: Health care for all
by Ulrike Koltermann ........................................................... 12

KENYA: A national act of courage
by Evert-Jan van Lente ........................................................ 16

ZAMBIA: Freed from the daily struggle for survival
by Beatrice Wolter .............................................................. 19

TANZANIA: Ever been to CHICeria?
by David Kyungu and Bernd Schramm ................................. 20

NIGERIA: Competence centre supports insurance start-ups
by Bettina Nellen ............................................................... 23

WEST AFRICA: La Concertation: A network of partners
by Jürgen Hohmann and Marion Baak ................................. 24

AFRICA: REPORTS IN BRIEF ................................................. 26

Latin America

CHILE: Solidarity between the healthy and the sick
by Camilo Cid and Nicola Wiebe .......................................... 28

PARAGUAY: New hope vested in cooperatives
by Jens Holst ........................................................................ 31

LATIN AMERICA: REPORTS IN BRIEF ................................. 32

Asia

THE PHILIPPINES: One health plan for all
by Matthew Jowett .............................................................. 34

INDIA: High confidence in low-cost insurance
by Gabriele Ramm, Hannes Leist and Ralf Radermacher ........ 38

VIETNAM: Workable new ways out of poverty
by Hans Gsänger and Bettina Nellen ................................. 41

ASIA: REPORTS IN BRIEF .................................................... 42

Partners

INTERVIEW: “Too many people lack access to health services”
with Tim Evans (WHO) .......................................................... 44

INTERNATIONAL COOPERATION: Working towards a common goal
by Ole Doetinchem ............................................................. 47

DEVELOPMENT COOPERATION ORGANIZATIONS .................. 48

RESOURCES ...................................................................... 50
It is always worth reminding ourselves of the conventions and treaties on which international cooperation is based. For example, Article 25 of the Universal Declaration of Human Rights states that:

“Everyone 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.”

Guided by this premise, the GTZ project for the “Elaboration and Introduction of Social Health Insurance Systems in Developing Countries” has been advising our partner countries since 1997, on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ). The principle of financing social services through an insurance scheme on the basis of solidarity was developed in Germany 120 years ago. The same fundamental values of solidarity, subsidiarity, sustainability and pluralism underpin not only the continental European model of social market economics, but also the German vision of development cooperation. Protection against poverty, rather than the provision of social services, is the overriding concern. Even when budgets are tight, safeguarding such basic rights is a prime concern of ours, both nationally and internationally.

The role of the health sector in poverty alleviation is a crucial one. Health care bills can put catastrophic financial pressure on families. Savings built up to provide for the future have to be cashed in. Other resources on which livelihoods depend, like land, have to be sold to meet the costs of treatment. A health insurance scheme combats the risk of poverty, because any investment in health is an investment in human capital. This is good for overall economic growth, and a substantial share of it accrues to the staff-intensive health sector.

Health care provision must be geared towards the needs of the population. Above all, this means ensuring access to health services of an appropriate quality for all. Social health insurance provides a framework within which one can strike a balance between public and private responsibility, and between competition among providers and universal access. International cooperation is entering new territory: the United Nations Millennium Declaration, the German federal government’s “Program of Action 2015”, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the World Health Organization’s “3 by 5” initiative to tackle HIV/AIDS are setting ambitious targets. The efforts of all must be systematically consolidated: whatever is achieved must also be sustained. Setting up a social health insurance system is one way of helping to do so. This is a field in which the GTZ can draw on a wealth of experience. Our aim is to share our findings with our national and international partners; to pool our experience and, together, put it to work.

Dr Bernd Eisenblätter
Managing Director of the GTZ
Improving the provision of health care is one of the classic tasks of development work. But one out of every two people in the world today still lacks access to adequate health care. Even where health centres and medical staff are available, many people do not have the money to pay for treatment. Often, only public employees or permanent staff in the private sector have any health insurance. And local health insurance schemes generally cater for a small section of the population only.

Because poverty is one of the greatest risks to health, most nations have committed themselves to the goal of setting up high quality yet affordable health care provision for all segments of the population. But given the limited financial resources of state health services, and the commercial calculations of private providers, it seldom becomes a reality. A possible solution for many developing countries and countries in transition is to set up a health insurance scheme financed on the principle of solidarity.

In 1997, the German Federal Ministry for Economic Cooperation and Development (BMZ) responded to this growing need by setting up a supraregional sector project for the “Elaboration and Introduction of Social Health Insurance Systems in Developing Countries”. The Ministry contracted Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH – German Technical Cooperation to implement the project. Its stated objective is to support partner countries in Africa, Asia and Latin America in constructing socially balanced health care systems. As a result, all sections of the population, particularly poor and disadvantaged groups, should have better access to appropriate health services.

From the outset, the longstanding project coordinator, Jürgen Hohmann, sought to collaborate with fellow experts in Germany and elsewhere in Europe on the project implementation. In 1998, the GTZ entered into a cooperation agreement with the Federal Association of the AOK (the umbrella organization of the AOK network of German statutory health insurance funds) and its in-house consultancy company, AOK Consult GmbH. The GTZ contributed its experience in the field of development cooperation while the AOK, as Germany’s largest statutory health insurance fund, could offer insurance-specific knowledge as well as experience in setting up social health insurance schemes in Eastern Europe. This is not a simple matter of transferring continental European health care systems, which have taken shape over more than a hundred years, to other countries. Experience shows that participation, through self-governance, autonomy and trust, is indispensable for making social insurance systems sustainable.

Ambitious goals. Since November 1997, the sector project has supported developing countries and countries in transition in setting up solidarity-based health insurance systems. Special attention was and still is devoted to people in the informal sectors in urban and rural areas. These groups are exposed to higher risks of ill health and poverty because of their low incomes, bad living conditions, and environmental factors. Health insurance systems that enable these sections of the population to access health care services are a key component of poverty reduction.

Continued on page 8.
Interest is mounting

For a long time, setting up social health insurance schemes in developing countries was considered a thankless task. But, more recently, efforts by the GTZ and other organizations in this field are beginning to generate positive feedback. Assia Brandrup-Lukanow explains why this is so.

Health, education and social protection are fundamental human rights. As development in Europe has shown, a region whose people are healthy, educated and socially protected can achieve substantially better economic development. Those are also basic prerequisites for people in the world's poorer countries to increase their prosperity. Germany, with its long tradition as a social state, has a valuable contribution to make.

What is your team’s approach when supporting health insurance schemes in developing countries?

Initially we are guided by the values of European health insurance schemes: the principles of solidarity, subsidiarity and self-governance or at least participation of insured members. We always look for a solution that is adapted to local circumstances. However, what solidarity means to us is socially equitable membership criteria for health insurance schemes. Contributions should be collected without reference to the health status of individuals. No insurer must take advantage by insuring young and healthy people whilst perhaps excluding the chronically ill because they are “expensive risks”.

It is often claimed that social health insurance schemes can only work in medium- to high-income countries. What do you say to that?

International findings on this issue vary considerably. In Kenya the government, with support from the GTZ, the World Health Organization (WHO) and other international organizations, is working on a national health insurance system for the entire population. Besides solidarity-based financing, the government plans to subsidize the contributions of the very poor. In this way, even people who could not afford to contribute themselves will be able to obtain insurance. Also, mainly in Africa and Asia, there are promising approaches where community-based health insurance systems are successfully forging networks with one another and with state systems. Here GTZ is supporting the establishment of regional networks and competence centres for health insurers, for instance those in Tanzania and Nigeria. So, even people in the informal sector are getting access to health services.

What are the basic benefits that every health insurance scheme in Africa, Asia or Latin America should provide?

The international community has attempted to define these “essential packages”. The result is a schedule of basic medical benefits for the most common diagnoses. The recommended benefits are selected on the basis of their cost-effectiveness. The package aims to help with a more effective deployment of limited health sector resources. Some examples of the most elementary benefits of a health insurance scheme are mother-and-baby care, combating major infectious illnesses like HIV/AIDS, tuberculosis and malaria, and promoting reproductive health. The WHO has also defined some essential drugs for the treatment of commonly occurring or life-threatening illnesses, which no health insurance scheme should fail to include in its benefits package.

What can employers do for their employees?

Nowadays, many international companies are keen to profess their Corporate Social Responsibility (CSR). CSR is a kind of code of conduct that firms can follow voluntarily. By integrating social and environmental concerns into their corporate activities, they also ensure their long-term economic success. In countries without compulsory employers’ contributions to social insurance, corporate social benefits for employees and their families can provide some level of security.

What priority does social health insurance have at the international level?

Within development policy, interest in solidarity-based health insurance schemes – as opposed to purely market-driven systems – has grown enormously in the last few years. Now the theme is increasingly being taken up in the programmes of multilateral organizations such as the WHO, the International Labour Organization (ILO), the World Bank and the European Union. The GTZ works closely in this area with all the organizations mentioned. There is also a lively exchange of experience with numerous sectoral institutions, nationally and internationally: e.g. the Federal Association of the AOK, private health insurers, the international alliance of mutual insurers AIM, or the Belgian health insurance alliance ANMC.

Dr Assia Brandrup-Lukanow
is Director of the Health, Education and Social Protection Division of the “Planning and Development” Department of the GTZ
To date, the sector project has been through three implementation phases. In the first phase of BMZ promotion (1997 to 1999), the objective was to support health care sector reforms in developing countries and to work towards the introduction of solidarity-based financing systems. For example, GTZ experts analysed community-based health insurance systems (the Philippines, India, Guinea and Senegal), evaluated international experience and utilized these findings for effective policy advice. Moreover, the sector project participated in workshops and seminars on health care financing around the world.

In the second implementation phase (2000 to 2002), the sector project geared its objectives more closely towards policy advice, (further) development and application of an evaluation methodology for health insurance systems (InfoSure), and analysis of interaction between public and private institutions in the health care sector. The experts analysed the national framework conditions for the introduction of new health insurance systems and the reform of existing schemes in numerous countries. In many cases they employed the InfoSure method. This Internet-based information and evaluation tool for health insurance systems includes 18 thematic areas covering the key aspects of any health insurance scheme, and is available from the project as a CD-ROM in three languages (English, French and Spanish). Questionnaires and case studies can be downloaded from the Internet (www.infosure.org).

The objective of the third implementation phase (2003 to 2004) is to strengthen the competence of decision-makers and managers to establish solidarity-based systems of health insurance. Findings and results from the various projects are systematically evaluated and documented, for use in policy advice. Project staff also work on the developmental significance of social health insurance in the international context, and make recommendations for implementation. With a series of short-term missions like the ones to Kenya (see the article “A national act of courage” on pages 16 to 18), the sector project is stepping up advisory work to governments, and supporting processes of political reform in the countries concerned.

Management training with CHIC. The GTZ has taken a major step forward with the development and introduction of the “CHIC approach”. CHIC stands for Centre of Health Insurance Competence. This type of competence centre for health insurance schemes supports insurance providers with management and organizational tasks. The first CHIC came into being in Tanzania and is part of a national network of community-based health insurance schemes (see the article “Ever been to CHICeria?” on pages 20 to 22). One of this competence centre’s products is the CHIC Management Seminar for health insurers. So far it has been held in five African countries (Cameroon, Congo, Senegal, Nigeria and

Better health for all: No time to lose

“The World Bank is pursuing a double strategy with its approach on poverty reduction: it aims to strengthen people’s capacity and improve the investment climate in the countries of the South. The World Development Report 2004, the political credo of the World Bank, took as its title “Making services work for poor people”. It turned a spotlight on the customer-focused nature of services such as education, health, water, electricity, etc. In the year 2000, development goals were agreed, which should halve poverty by the year 2015. The World Bank believes that to achieve them, access to health services for the poor will play a critical role. Three out of a total of eight Millennium Development Goals mention health objectives specifically: to improve maternal health, to lower the rate of infant mortality, and to fight serious diseases such as HIV/AIDS, tuberculosis and malaria.

However, the World Bank report also underlines the fact that the world is still far from achieving these health targets. Remediying this will call for social protection systems that prevent people and their families from sliding into absolute poverty in crisis situations. Governments must shoulder their share of this responsibility, as must citizens and service providers. Demand-side subsidies may help to enable the poor to gain access to social protection. However, it is just as important to strengthen the countries’ political and administrative capacities so as to enable the implementation of such programmes. Appropriate institutional capacities must be built up, integrating a cost control of the systems in order to ensure that low-income population groups are not excluded from services.

The global community has just eleven years to show how seriously it takes the development goals. Thankfully, developing countries have felt a growing need to invest in social protection systems.

Against this backdrop, it is commendable that support from the German Federal Ministry for Economic Cooperation and Development (BMZ) is being channelled, through the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), into the introduction of social health insurance systems in developing countries and countries in transition.”

Dr Eckhard Deutscher is the German Executive Director at the World Bank.
Tanzania). The seminar makes use of the CEFE method (Competency-based Economics through Formation of Enterprise) developed by the GTZ to boost entrepreneurial skills. Other products made available to the competence centres by the sector project are InfoSure and SimIns. SimIns is a newly developed simulation tool used to forecast the trends in an insurance scheme’s income and outgoings over a period of several years. The tool was developed jointly with the World Health Organization (WHO) and deployed in the context of advisory work to the government of Kenya.

International network. An increasingly high priority is placed on national and international cooperation links. The sector project maintains a large and constantly growing network of institutions and experts. This makes for intensive collaboration, with the other German organizations involved in development cooperation. These include KfW Entwicklungsbank (the German development bank), InWEnt gGmbH (Capacity Building International), non-governmental organizations and political foundations. Partnerships are maintained with specialist institutions in the fields of health insurance and public health. These include the contract partner AOK, other German health insurance funds, the Association Internationale de la Mutualité (AIM) in Brussels, the Belgian health insurance group Alliance Nationale des Mutualités Chrétienennes de Belgique (ANMC) and the Heidelberg and Antwerp Institutes of Tropical Medicine. Internationally and at country level the GTZ cooperates on social health insurance with the World Health Organization (WHO), the International Labour Organization (ILO), and other bilateral organizations of development cooperation. Furthermore, regular dialogue takes place with experts from the World Bank, the European Union, and regional UN organizations. In West Africa, the GTZ is the co-founder of Action Concertation, a concerted campaign to strengthen health insurance in that region (see the article “La Concertation: A network of partners” on pages 24 and 25. Internet: www.concertation.org).

Educating, consulting and motivating
The sector project gears its services to the demand from the partner and priority partner countries involved in development cooperation with Germany.

Policy advice
- Advising governments on the introduction or reform of health insurance systems: the Philippines, India, Indonesia, Vietnam, Cambodia, Côte d’Ivoire, Oman, Uganda, and Kenya

Expert consultancy
- Introducing community-based health insurance schemes in West Africa and Asia: Guinea, Côte d’Ivoire, Senegal, Togo, the Philippines and India
- Advisory work on the establishment of competence centres for health insurance (CHIC approach): Tanzania, Nigeria and Ghana
- Legal advisory work: the Philippines, China, Ghana, Kenya and Chile
- Function of risk structure equalization: Chile
- Importance of health insurance in the fight against AIDS: South Africa

Basic and advanced training
- CHIC Management Seminars on health care financing and health insurance (for examples of countries involved, see above)

Studies
- Feasibility studies: Côte d’Ivoire, Senegal, Uganda, Chile, El Salvador, Paraguay, India, Indonesia, the Philippines, Cambodia, Vietnam and Laos
- Evaluating health insurance schemes using InfoSure: India, Indonesia, the Philippines, Peru, Bolivia, Paraguay, El Salvador, Togo and Senegal

Continued on page 11.
What do the Philippines, Guinea, Senegal, Kenya, Chile and Indonesia have in common? In these and several other countries, AOK experts have helped to set up social health insurance systems over the past six years. Coordinated and organized by AOK Consult – the in-house consultancy company of the AOK – experts from AOK health insurance funds have been supporting the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) as it responds to the complex issues relating to health insurance.

And these are numerous: contracts with service providers, calculation of contributions, risk structure equalization, quality assurance, data processing, administrative organization, membership rights – virtually no aspect has escaped the attention of AOK staff on short-term assignments. Until now, GTZ sector project staff have had offices in the AOK building, which contributed to the rapid exchange of expertise.

As a result of the international activities they have collaborated in, the Federal Association of the AOK and AOK Consult have acquired new skills. Foreign assignments and international exchange of ideas open up new ways of thinking for the staff involved. Meanwhile, short-term assignments abroad have been incorporated into the AOK personnel development concept. Anyone who travels abroad as an expert must meet rigorous demands in terms of their flexibility, powers of analysis, and linguistic and intercultural skills.

With the help of the AOK-GTZ cooperation, the AOK has successfully built up international advisory competence. With support from the European Union (EU), this has also been deployed in countries of Central and Eastern Europe. Among other work, the Federal Association of the AOK took on a two-year EU project to support the Romanian health insurance scheme. It then kept up intensive exchange with health insurance systems in Central and Eastern Europe during the EU enlargement process. In this respect, cooperation also helps to boost acceptance of social insurance solutions around the world. What Europe can offer is a positive alternative to solutions influenced by private sector interests. In many countries, the AOK, with its 120-year history, is seen as synonymous with a model social system.

The GTZ and AOK intend to continue to work together and to focus on new areas of cooperation. A joint seminar on current developments in German health care policy and international experience has already been added to the range of training courses offered by the GTZ.

Rainer Eikel is Public Relations Officer at the Federal Association of the AOK.

Looking beyond the national horizon

Dr Hans Jürgen Ahrens is Chairman of the Board of Managers of the Federal Association of the AOK.

Why is the AOK working with the GTZ?

Our cooperation is a clear sign that sustainable social development is moving to the foreground of development policy. Especially in the age of globalization, development cooperation is more and more concerned with setting up systems for social protection. A key component of these systems is social health insurance. The AOK provides know-how, which developing countries and countries in transition find extremely useful.

What do you hope this cooperation will achieve?

We must begin to think and act more internationally. That is what the enlarged European Union is demonstrating to us right now. I can see a positive example of transnational cooperation in a development project that is currently underway. Under contract to the GTZ, AOK has short-term experts in Indonesia coordinated by a Polish team leader, advising on how to set up a social health insurance scheme. On foreign missions like that, we Europeans certainly learn how to work together closely.

What else does the AOK hope to gain from this cooperation?

Foreign assignments are an element of AOK personnel development. We want our staff to be familiar with the international as well as the national perspective.
Full marks. The sector project turns out to have got its priorities absolutely right. This was the verdict of the two appraisers, Hans Gsänger and Monika Gabanyi, who carried out a project progress review in summer 2002. The quality of services is praised by partners and users in equal measure. The sector project was also adjudged to have contributed to the creation and ongoing development of national and international network structures. It was found to have achieved its stated objectives in every respect, even though it was too early for all services to have brought demonstrable benefits to population groups without adequate health care provision. Nevertheless, according to the two appraisers, “The sector project, particularly in selected countries in West Africa and Southeast Asia, made a relevant contribution to the establishment and development of solidarity-based social health insurance schemes, or to improving the framework conditions for their introduction”. They also recommended systematic and region-specific documentation of the experience gained in promoting social health insurance. They said that more publicity work should be done in order to raise levels of awareness about the project. In the current phase, the project is implementing their recommendations to extend in-service training and continuing education for experts and decision-makers, and to concentrate more on knowledge management, policy advice and strategic cooperation links with international organizations.

The way forward. In the development policy debate, it is now widely acknowledged that to overcome poverty, it is essential to create structures for social protection. Increasingly, developing countries are requesting support with the introduction of health insurance schemes. However, major efforts are still required to draw more attention to this issue in the international debate. Therefore, the GTZ team works in alliance with the WHO, the ILO and other bilateral and multilateral organizations to establish social health insurance as a firm component of the development policy agenda – not just in Germany but worldwide. In this sense, technical cooperation is increasingly becoming international cooperation (see the News Flash on page 47). In the medium term, efforts are in hand to tie in the health insurance theme with other measures for social protection in the development arena. This is currently being discussed in relation to income security, basic pensions, disability assistance and microinsurance schemes. Starting in 2005, a sector project on social protection will integrate these key themes. The extensive experience gained from the health insurance project will be highly significant to that endeavour.

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Dr Bernd Schramm has led the project since April 2004, having previously worked for the sector project since June 2002 as Project Manager. (Bernd.Schramm@gtz.de)

Millennium Development Goals: At the United Nations Millennium Summit held in September 2000 in New York, the world’s heads of state adopted eight development goals. Known as the Millennium Development Goals, they mark the beginning of a global partnership for development. It involves not only the 191 member states of the United Nations but also international organizations and companies. The goals: fighting extreme poverty and hunger, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, combatting serious diseases like HIV/AIDS and malaria, ensuring environmental sustainability and forging a global partnership for development. Extreme poverty is defined as having to survive on less than one dollar a day, a reality for 1.2 billion people.

Social health insurance: A general term for health insurance systems financed through solidarity-based mechanisms. They protect against the risk of poverty resulting from accident or illness. Social health insurance schemes relieve the financial burdens of sickness and disability, and help to improve the health status of the population as a whole. In a wider sense, they promote social justice and stability within a society.

Program of Action 2015: In the year 2001, the German federal government passed the Program of Action. It sets out the German government’s contribution to the goal of halving the proportion of people in the world living in extreme poverty by the year 2015 (Millennium Development Goal 1; see above). The programme contains ten priority areas for intervention, which include improving economic opportunities for the poor, boosting their political participation and establishing social protection. These measures tackle issues at the international and multilateral levels, involving both Germany and its partner countries.

BMZ: The German Federal Ministry for Economic Cooperation and Development (BMZ) plans the federal government’s development policy and puts it into practice. It does not implement the actual projects and programmes itself, but contracts independent organizations to carry out this work.

GTZ: Deutsche Gesellschaft für Technische Zusammenarbeit GmbH is a service company for development cooperation with worldwide operations. The principal client of the enterprise, which was established in 1975, is the German Federal Ministry for Economic Cooperation and Development (BMZ). In a General Agreement, the BMZ assigned the implementation of technical development work to the GTZ. The GTZ pursues the aim of bringing about sustainable improvement in people’s living conditions in developing countries and countries in transition. It is concerned with encouraging the initiative of people living in partner countries, and promoting self-help mechanisms. Its work areas include the stimulation of economic activity and employment, state modernization and the promotion of democracy, health, education and social protection, environmental protection and the conservation of natural resources, and rural regional development.
The image of the Kenyan health sector has long been marred by mismanagement and gaps in provision. But not for much longer. Now Nairobi is backing a reliable health insurance fund for the whole population. By Ulrike Koltermann

Boniface hides behind the curtain which screens off the bed from the other living space in the small corrugated-iron shack. From there he has a good view of the visitors perched on the shaky bench. Only the five-year-old’s dry cough is an occasional reminder of his presence. His mother holds his little brother Michael on her lap. The baby also seems poorly. When he starts to whimper, his mother quickly puts him to the breast. Ruth Muhonja knows all about clinic fees. Like most Kenyans, she has no health insurance and has to pay for each visit to the doctor out of her own pocket. “Boniface has asthma. He needs to see the doctor every month and then he gets tablets,” the 26-year-old explains. Each course of treatment costs the equivalent of six euros. She also had to pay for both her sons’ births. “Boniface cost us 3,000 shillings (36 euros). It was a difficult birth. Michael’s only cost 2,000 shillings (24 euros),” she says. Her husband works...
as a caretaker in a monastery and earns around 42 euros a month.

Ruth lives in Kangemi, a slum on the outskirts of the Kenyan capital. The corrugated metal roofs glisten in the sun. Between the shacks the place teems with people. Women carry water canisters on their heads and infants in cloths on their backs. There are communal water taps but nobody knows exactly when the water will be turned on. People who go to work in the city leave a canister with their neighbours, just in case. The place is littered with torn plastic bags, fibrous mango stones and rags, covered in red dust. In the rainy season, the dirt tracks become deep and muddy.

The expense of seeing the doctor is a worry for Ruth. “Sometimes I have no money and then Boniface can’t get his tablets,” she says, humiliates. When the small boy hears his name, curiosity makes him peek out from behind the curtain and he can’t help coughing violently. “The doctor has even sent us home before to fetch money. But what can I do if I have none?” Transport to the hospital is also far from easy. If someone is too ill to use a communal taxi, the trip costs about six euros. “We hope that the new hospital is also far from easy. If someone is too ill to use a communal taxi, the trip costs about six euros. “We hope that the new government can do something for us,” says Ruth.

**Corruption kept in check.** By now, Kenya’s new government is no longer all that new. January 2004 marked the end of President Mwai Kibaki’s first year in office. Compared with the 20-year rule of the previous corrupt regime under Daniel arap Moi, Kibaki’s Rainbow Coalition with its enthusiasm for reform has not yet lost its novelty. The mood of the population has shifted considerably within the past year. Posters hang in public offices with the slogan “Do not pay bribes – it is your right to be served here!” A study by Transparency International, the organization dedicated to the fight against corruption, noted significant improvements. It found that in 2003, Kenyan men and women had only spent an average of 17 dollars on routine bribery. The previous year the figure had been 52 dollars. Less than one-third of those surveyed had bribed a police officer in 2003. Under Moi the figure was 70 percent.

Among the most corrupt in the old system were the judges. To address this, Kibaki took drastic action. A government commission conducted covert investigations for months, until one morning the names and photos of half of all senior judges were published in the newspaper – in a “List of Shame”. Some immediately stepped down. The others will be dealt with by a special tribunal. Price lists for legal favours were also published. They ranged from around 250 dollars for an acquittal in a rape trial to 190,000 dollars to manipulate a judgement in a court of appeal. Some judges had also accepted sexual favours in lieu of payment.

The winds of change are blowing through the education system as well. Kibaki fulfilled one of his most important manifestos promises and abolished primary school fees. The number of children starting school rose drastically. The schools were more or less unprepared for the surge in numbers, and financing was not really secured – but Kenya was thrilled. Even some adults whose parents had been too poor to send them to school now decided to catch up with their schooling. One of them is 84-year-old Kimani Maruge, once a fighter for independence and now a grandfather to thirty grandchildren. He wanted to be able to read the Bible for himself, he said on his first day at school. Infant mortality is high. The next step planned by the government is to set up a national health insurance scheme – an immense task in view of the present state of the health service. Under the portrait of Kibaki that hangs in all government offices in Kenya sits Tom Mboya Okeyo, a moustached man in his mid-forties with a mauve shirt and a winning smile. The insurance expert in the Ministry of Health is convinced he is right. “Health means wealth,” he says. “Kenya can only grow if we improve access to medical care for all.” With passion, he explains how dysfunctional the Kenyan health service has become. “The worst thing is that so many children are dying of illnesses which cost very little to cure, problems like diarrhoea, malaria or fevers,” says Mboya. Infant mortality is high: out of every 1,000 children, close to 80 die before their first birthday. This despite the fact that the vital medications normally cost only a few euros. “Millions of people in Kenya have just enough to survive on. How can they be expected to pay a doctor?”

In the course of his research, Mboya has made some alarming discoveries. Six thousand identity cards turned up in a hospital in Embu in the centre of the country. They belong to patients who had left them as security for bills that they couldn’t pay. “Many of them could never afford to redeem them, and simply reported them lost,” says Mboya. Some doctors held their patients virtually hostage until relatives scraped together their fees. In March 2004 a case came to light in which 40 mothers had to stay in hospital for almost two months with their new-borns, because they were unable to pay for their deliveries. They were kept locked in a single dormitory where they had to sleep five to a bed. When the Minister for Local Government, Karisa Maitha, found out about it, he ordered the immediate release of the women and paid the hospital bill out of his own pocket.

“The health care system in Kenya is riddled with inequality,” sums up Mboya. People who can afford private health insurance can still obtain good services. Many white people who work in Nairobi for international organizations are very satisfied with the medical care they receive. But for them, the cost of childbirth followed by a one-week hospital stay will be as high as 6,000 euros.
“For the poor, on the other hand, there are not even qualified staff on duty,” says Mboya. This is precisely the sort of inequality the Kenyan government now wants to eliminate, with the help of universal social health insurance. One foundation for this is firmly in place: Kenya can boast the oldest compulsory insurance scheme in the whole of Africa. Ever since 1966, all employees earning at least 15 dollars a month have had to contribute. The level of contributions is set at two percent of income, to a maximum of five dollars a year. In return, the National Hospital Insurance Fund pays a fixed amount for the hospital bed, treatment and drugs. This is deducted from the hospital bill.

But that is just the theory. Often, the finance applies to board and lodging only – the patients have to meet all the other costs of treatment themselves. The National Hospital Insurance Fund is known as one of the most corrupt institutions in the country. Many members complain that they only ever pay in, but never receive any benefits. Instead of financing the hospital stays of contributing members, the fund apparently chose to invest in property deals and dubious banking ventures.

Its Nairobi headquarters is an opulent new building with steel columns and a glass facade. “In 2002/2003 the budget was close to three billion shillings (36 million euros). More than half of it was being spent on administrative costs. Substantially less than one-third was paid out to members in the form of benefits,” Mboya calculates. In the past, its approximately 1,400 employees also primarily looked out for their own interests, and invested members’ money for their own advantage wherever possible.

Kenya can boast the oldest compulsory insurance scheme in the whole of Africa. Ever since 1966, all employees earning at least 15 dollars a month have had to pay contributions – at least in theory.

Health care for all. But this is the very institution the government wants to make the centrepiece of a new social health insurance scheme, once its management has been replaced. The principle of solidarity will take pride of place in this scheme. So it is no mere chance that the German model is an especially important influence on the African country’s plans. “There are many aspects of German social insurance that we would like to adopt,” says Mboya. The Kenyan government has requested German support for the consolidation phase. Consequently, the World Health Organization (WHO) and the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) have already accepted several
advisory assignments in Kenya. Many important questions remained to be answered. Who is actually able to pay contributions? What benefits should the insurance scheme cover? Who will support those who cannot afford to pay contributions? Henri van den Hombergh, the GTZ Health Sector Coordinator in Nairobi, has worked alongside Mboya to provide in-process support since the project began. “The greatest challenge is to prevent the new insurance scheme from becoming just as corrupt as the present Hospital Insurance Fund,” he says.

Joint strategy. Four months after Kibaki took up office, the Kenyan Ministry of Health, the WHO and the GTZ agreed to assist with further development of the concept prepared by a Kenyan working group, and the draft legislation. The goal was a good system of health care, which should be “accessible, acceptable and affordable” for all. Several groups of experts analysed individual aspects of the new insurance scheme and, following consultations with stakeholders, came up with recommendations.

The model is easy to understand, even for non-experts. Under the chosen approach, every Kenyan man and woman will have compulsory insurance. “First, permanent employees will become compulsory members and pay their contributions,” explains van den Hombergh. The scheme must also include the self-employed, for instance the Jua Kali artisans and traders. Jua Kali is a Kiswahili expression meaning “hot sun” – a metaphor for their small stalls and makeshift workshops seen in the open air all over Kenya. “Furthermore, the really poor need to be integrated,” says van den Hombergh. An estimated nine million Kenyans are too poor to afford medical treatment.

To ensure sufficient funding for all, the make-up of the membership must be maintained at a certain ratio: around 30 percent of poor people, who pay nothing, around 20 percent of regular employees, who pay contributions from their own salaries with half contributed by the employer, and the remainder, insured members who pay a flat-rate contribution. The money is administered by a national council, made up of elected representatives from all regions. Mboya is optimistic that the total income will suffice in the long term even to insure treatment of AIDS patients with life-prolonging drugs. “Basically, generic [non-branded] medicines are getting cheaper and cheaper,” he believes. In Kenya, some ten percent of the population is infected with HIV. Until now, AIDS sufferers have had to bear the costs themselves.

But Mboya and van den Hombergh also appreciate the difficulties of this model. For one thing, contribution-free membership for the poor has to be financed somehow. The government is planning to spend five percent of value-added tax on this in future. Whether this contribution will be sufficient in the long term depends principally on whether economic growth rises in line with expectations. “If there is no other way, we will just have to put up with a temporary health insurance deficit,” says Mboya. “Health comes first!” The planning groups had also suggested making the mobile phone operators contribute, and raising airport tax by five dollars.

It is equally important to gain the confidence of those paying contributions. “This time, people must not have the impression that they only pay in but never receive any benefits,” says van den Hombergh. To achieve this, access to decent medical care must be assured for all. The GTZ expert is working on the assumption that it could take 15 or 20 years for the insurance scheme to cover a significant proportion of the population.

Expectations are high. For the Health Minister, Charity Kaluki Ngilu, things cannot happen quickly enough. “That woman is a human dynamo,” says van den Hombergh, grinning. But it will be a while before the first inhabitants of the slums take delivery of their insurance cards. Ruth, the mother of Boniface and Michael, finds it a marvellous idea that a time will come when she no longer has to pay doctor’s fees. “If the government managed that, it would be wonderful!”

Ulrike Koltermann works as a press correspondent for the dpa in Nairobi.
A national act of courage

The Kenyan government has set itself a Herculean task: in future, all citizens of the East African country should be able to afford medical care. “Harambee” – meaning solidarity – is the watchword.
By Evert-Jan van Lente

When the joint project team of the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) and the World Health Organization (WHO) first met with the new Kenyan health minister, Charity Kaluki Ngilu, in 2003, the politician told the advisors why they would often see bicycles and cows around the back of her country’s hospitals. Unfortunately, she explained, many patients were not in a position to pay the high co-payments in cash. Instead, they would hand over a bicycle or a cow to the clinic. This is a situation that jeopardizes the livelihoods of poor families.

Following independence in 1963, early progress in improving the general health situation of the Kenyan population was good. Training for doctors and nurses is second to none, and the Kenyatta National Hospital, Nairobi’s university hospital, is a beacon of quality for the whole region.

However, for some years problems have been growing more acute again, mainly because of the HIV/AIDS epidemic. Public spending on the health care sector amounts to 80 billion Kenyan shillings, which is about 880 million euros. In 2001, patients paid 53 percent of these costs out of their own pockets.

Structurally, the East African country’s health care system is characterized by parallel public and private systems. A British-style state health care system was adopted in the pre-independence era, and this – despite all its failings – forms the basis of provision for many people. One drawback is that since the introduction of a cost-sharing system in 1989, patients have had to pay towards their treatment and medicines. Only those who are too poor are not charged. However, there are no clear criteria and ultimately, the costs become a burden on the public clinics.

The well-off choose private doctors. The public health infrastructure is supplemented by private and church-run institutions. The church institutions suffer as much as the public ones from underfunding and difficulties in finding qualified staff. Well-off Kenyans turn to private health care providers. These range from very good treatment offered at the Aga-Khan Hospital, to self-styled healers. Health Maintenance Organizations (HMOs) on the American model provide insurance to high earners. However, after some of them were found to be covering up financial irregularities they have a bad reputation and will only be allowed to act as health care providers in future.

For those in regular employment, there is also a social health insurance scheme: the National Hospital Insurance Fund (NHIF). In principle, this provides for the compulsory insurance of all employees and their family members. In practice, though, only about seven percent of Kenya’s population are members. Moreover, its set-rate reimbursement system only covers part of the costs of treatment. So, those insured by NHIF must also make substantial co-payments.

The previous government under Daniel arap Moi had already commissioned an analysis of the health care systems in several countries around the world. The conclusion was that Kenya’s health care system should be based on a social health insurance scheme in future, with contributions from employers and employees. The solidarity-based funding of this system is a crucial point for the new leadership. In Kenya, solidarity has special significance: “Harambee”, meaning “solidarity”, is incorporated into Kenya’s national emblem. Inspired by the principle of mutual assistance, the government appointed a Special Commission to formulate a national social health insurance scheme involving employers, employees, and representatives of the medical profession, ministries and private insurers.

Their common goal is to include the entire population in a compulsory social health insurance scheme. It is specifically intended to cover not only privileged groups like civil servants and employees, but also the many people who are self-employed or out of work.

The name of the new Kenyan health insurance scheme is the National Social Health Insurance Fund (NSHIF). Those responsible are quite deliberately building on the existing structures of the National Hospital Insurance Fund (NHIF).

From policy decision to advisory follow through. Once the direction of Kenyan policy was clear, the Ministry of Health began to look around for technical support and policy advice – and found it in the GTZ and the WHO. Aside from several short-term missions by experts, it was also
agreed that a specialist should be sent to Nairobi on a longer-term assignment, to provide ongoing support for the process. It was apparent from the moment GTZ and WHO specialists were first deployed – partly supported by the International Labour Organization (ILO), the Kfw Development Bank and the British Department for International Development – that successful reform would require precisely defined steps. Since a Ministry of Health strategy paper had defined the individual components by this time, the main technical and political priorities for advisory work were also clear.

**The legislative process.** In parallel with the Ministry of Health’s strategy paper, draft legislation for the social health insurance scheme, the “National Social Health Insurance Fund Act”, was drawn up. Manfred Zipperer, former head of the Health Insurance department of the German Ministry of Health, collaborated with Kenyan legal experts to formulate a parliamentary bill out of the existing health policy strategy.

**The benefits package.** The entire population is to receive comprehensive insurance protection. But what does that mean in real terms? And how much do particular benefits packages cost? As part of their technical advisory work, the WHO and the GTZ had to ascertain the costs of the services in order to determine how much money needs to be found to achieve particular health care goals. This was not an easy task: with the Ministry of Health subsidizing services on a number of different levels, donations coming from foreign aid organizations and governments, varying co-payment regimes, and only the most basic charts of costs (usually not even computerized), only a very approximate idea of the real costs of particular services could be sifted out. The experts also supported a Kenyan working group drawing up a proposal for the future benefits package.

Of key importance in Kenya is the cost of care for people with HIV/AIDS. The debate on this issue centres on antiretroviral drug therapy, which enables those affected to live a halfway normal life. The cost is around 13.50 euros per person per month, if generics are used. The new health insurance scheme is expected to meet this category of expenditure out of special international programmes to combat AIDS.

**Funding.** The Ministry of Health strategy paper envisages that NSHIF expenditure will be funded by contributions from employers and employees. This can be put into practice in the formal economy. It is more difficult in the informal sector, with millions of workers in (small-scale) self-employment. They are to be charged a standard contribution of around 4.50 euros per person per year. Contributions for the poor are to be subsidized, using five percent of value-added tax revenues.

But what total amounts will have to be found? And what sources of revenue will offset the costs? The GTZ and WHO specialists employed to a simulation tool, and played out several scenarios: the estimated costs of the benefits package, the growing number of people covered by insurance, and the expected revenues from contributions and taxes. There is one particularly challenging variable: how will Kenyans respond in future to having

In Kenya 2.2 million people are living with HIV, one million have died of AIDS, one million children are AIDS orphans. Up to 50 percent of hospital beds are occupied by patients suffering from HIV/AIDS and related infections. The impact of AIDS on the health care system is devastating.

To address this situation, I have put in place a major policy reform to make health the engine for economic development and, therefore, increase resource allocation to the health sector. The National Health Insurance scheme will guarantee every Kenyan, poor, unemployed or self-employed access to a basic health care package. This package will include clinic-based prevention services like immunizations for every child, prevention of mother-to-child HIV infection, prevention of malaria in pregnancy. The benefits will also include treatment for common diseases like malaria, diarrhoea and acute respiratory infections, which are responsible for most deaths of children in my country.

We need to learn from our on-going experience in providing free universal primary education. Through this scheme, the Kenyan government has placed an additional three million children in primary schools and initiated a programme that will eradicate illiteracy from the country. Since good health is a high priority component of the basic social infrastructure, universal free primary health care should also be provided and coupled with development of environmental health to make Kenya also a healthy working nation.”

„**We have to make health the engine for economic development“**

**Charity Kaluki Ngilu** has been Kenya’s Minister for Health since 2002.

„**Maintenance and promotion of good health** is one of the primary responsibilities of a modern state and cannot be left to market forces. Thousands of Kenyans do not dare to seek treatment in clinics, health centres and hospitals as they are well aware that they cannot raise the monies for meeting the costs of treatment. How do the poor share the costs of treatment when they cannot even afford food?”

Statement

17

Social Health Insurance
“Achieving reform by their own efforts”

Turning outline policy ideas into finished legislation is always a lengthy process, and Kenya is no exception. Manfred Zipperer on the legal pitfalls, and his commitment to health reform “Made in Nairobi”.

When was your first contact with the GTZ?
It was in 1975. At the time, the GTZ contacted the German Federal Labour Ministry, looking for an English-speaking social insurance expert. So, I went to Iran for four weeks to advise the government of the then Shah regime on pension issues.

Since this first posting, you have often worked for the GTZ overseas. Latterly this has often been in Kenya. What has been your brief?
The Kenyans prepared draft legislation for a national health insurance scheme. My job was to examine it and, in collaboration with Kenyan colleagues, to polish certain parts of it from a legal point of view.

What is special about the Kenyan government’s health insurance plans?
What is happening in Kenya at the moment is not typical of the rest of Africa. The Kenyans are enshrining in legislation their own clear vision of a future system of national health insurance. Other developing countries prefer to have draft legislation drawn up by advisors. The Kenyans want to bring about progress in their country by their own efforts, and they are tackling this with enormous commitment.

What is your assessment of the draft legislation?
The text is sound and carefully worked out. The democratic organizational and decision-making structures for the planned national health insurance fund are particularly striking. In one or two places, there are still unresolved issues. When they are resolved, the draft legislation will be ready to put before parliament.

What has yet to be resolved?
The legal nature of the National Social Health Insurance Fund (NSHIF), for example. It will probably be a public-law corporation, but this kind of set-up is still unfamiliar in Kenya. Legal supervision of the self-governing fund also remains to be settled. And funding streams still need to be more clearly defined.

Where do you see the most pressing need for action?
So far the government has not done enough consultation on the draft legislation with those affected by it. Many more discussions on this need to take place: first of all with each individual Member of Parliament, but then also with freelancers, doctors, provincial governments and parastate insurance funds, which do already exist – basically, consultations with everyone involved.

Dr Manfred Zipperer, lawyer and retired Director-General was for many years head of the Health Insurance Department of the Federal Ministry of Health. He regularly travels overseas to carry out advisory work on behalf of the GTZ.

Interview

Management. Since the beginning of 2004, each of the four working groups of the former NHIF – which is to become the new NSHIF – has been working on a specific brief: “Quality Assurance and Contract Design”, “Public Relations Work”, “Further Training and Management” and “Monitoring and Evaluation”. The new system will be launched in three regions on July 1, 2004.

One question that will rear its head during the trials is how contributions should practicably be collected in the informal sector. Following intensive discussion of this question, the Special Commission has suggested using the good social networks that exist throughout Kenyan society. These could be occupational organizations like the matatu drivers’ associations (matatus are small buses which most people use for transport) or fishing cooperatives, but also church organizations and village communities. The setting up of the new NSHIF will remain the focus of advisory work in Kenya.

Evert-Jan van Lente is a project leader in the Federal Association of the AOK. He has worked in Kenya on several occasions as a short-term expert for the GTZ.

easier access to medical services? According to information contained in a government paper, about 40 percent of people claim no health care benefits, even when ill, because they cannot pay for the treatment.

Fees. How can medical staff and hospitals be paid appropriately? The pros and cons of various methods were debated in the course of the advisory work. The outcome favored fixed rates per treatment for the outpatient sector, and fixed rates per day for the inpatient sector. The advantage of flat-rate systems is that from an administrative point of view, they are simple to implement and make corruption difficult.

Along with fees, another topic of health reform in Kenya is the quality of medical provision. The new NSHIF health insurance scheme will only enter into contracts with hospitals and medical practices that meet specified quality standards. The Ministry of Health has developed the Kenya Quality Model (KQM) specifically for this purpose. One problem, however, is the infrastructure in sparsely populated rural areas. For this reason, the medical care of the population cannot be left to market forces. National framework planning is needed urgently.
Zambia is one of the least developed countries in the world. According to official estimates, more than 73 percent of the population live in poverty. Added to that, the dramatic spread of HIV presents a huge problem. Official estimates indicate that one-tenth of Zambian men and women are infected with HIV. Moreover, according to WHO estimates, over 20 percent of the economically productive 15- to 49-year-old age group are HIV-positive.

The resulting illness and death leaves behind children in need of support, who are often sick themselves. The number of AIDS orphans is estimated at 600,000. In a total population of barely ten million, this places an unbearable strain on the traditional kinship networks. Social cohesion is under threat. Where they exist at all, social institutions like church halls or neighbourhood clubs are in a desolate state. So, caring for the needy becomes the responsibility of extended families or village and district communities. It is not unusual for these networks to be totally overwhelmed. When this happens, those in need of help frequently have to be turned away, or even ignored and neglected. This is starting to undermine the cohesion of traditional communities. Against this backdrop, the German Federal Ministry for Economic Cooperation and Development (BMZ), through the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), is supporting the Zambian Ministry of Social Affairs in setting up an income security scheme for households struggling with life-threatening poverty levels.

**Combining modern with traditional.** Studies have shown that distributing small sums of money is more effective than handing out foodstuffs and coupons. Plus, it has a less disruptive effect on the sensitive economic cycle. In a southern Zambian district, which is home to around 12,000 households, the GTZ is piloting an income security project with participation from village health committees, parents’ groups, non-governmental organizations, churches and traditional authorities.

This provides the poorest families with a regular basic income, which frees them from the daily struggle for survival. The village community decides which families should benefit from the scheme. The GTZ simply stipulates the number of families.

At the same time, the scheme is mobilizing traditional forms of support. The relief provided by the assured basic income enables the community to help its poorest members again. People assist one another with working the land, and help out during illnesses and emergencies. The result is a complementary blend of modern and traditional forms of social protection.

But what does income security mean for the poor? A study by the Food and Agriculture Organization (FAO) in Zambia has shown that the poorest twelve percent of households can only eat one meal a day, even in good times. The income security model developed by the Zambian Ministry of Social Affairs with German support will pay for a second meal each day. All this will take is a monthly payment of five to six euros for each family. What is critical is that the recipients can rely on it, come what may. But how could such a system be financed sustainably? Scaling up the pilot project to the rest of Zambia, that is to 200,000 households living in extreme poverty, would cost approximately 16 million euros. This kind of sum is unlikely to be available from the Zambian national budget without external assistance. Therefore as well as resolving purely technical concerns – such as the distribution of payments to the needy families – it is also necessary to secure sustainable funding for such systems.

**Funds from the global community.** The international donor community has recognized that dependable, long-term funding of this kind can bring about development policy aims very effectively. At any rate the World Bank, the “Global Fund to Fight AIDS, Tuberculosis and Malaria” (GFATM), the International Labour Organization (ILO) and a number of bilateral donors are open to such approaches.

The GTZ project in Zambia shows that, even in extremely poor rural societies and with relatively manageable sums of money, basic social protection is feasible and makes a significant contribution to poverty reduction.

Dr Beatrice Wolter works as an editor for the publisher KomPart-Verlag.

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**ZAMBIA**

**Freed from the daily struggle for survival**

The poorest of the poor must be freed from the daily struggle for survival – on a dependable basis. Only then can they successfully escape from poverty. A GTZ pilot project in Zambia shows how it can be achieved. By Beatrice Wolter
Let me take you on a virtual journey. We are in an East African country. Its name is CHICeria. It has 100,000 inhabitants. Five percent of the population are so poor that they cannot afford to see the doctor, let alone pay for medicine. About 30 percent of CHICerians can only do so in the harvest season, the one time they have money. This is set to change, because the government has decided to introduce community-based health insurance funds. These will ensure that even the poor can afford medical treatment. You have been called to CHICeria as an advisor to set up appropriate health insurance funds, which will help to overcome these problems. So what recommendations will you make to the government?" These are the opening comments that Katja Bender, facilitator of a CHIC Management Seminar, uses to greet participants and involve them in a simulated planning game. The 30 health experts have three days to develop health insurance funds for CHICeria. They have to define target groups, set contribution levels, arrange benefits packages and manage the costs. At the end of March 2004, they came together in the Tanzanian capital, Dar es Salaam, for a total of five days in order to learn more about health care financing and the management of health insurance schemes. The seminar was hosted by the GTZ in collaboration with the Tanzania Network of Community Health Funds (TNCHF) and the World Health Organization (WHO). To start with, everyone spends three days living in the virtual country of CHICeria. Why?
Sickness increases poverty. In the rural regions of Tanzania, protection against the consequences of illness is unheard of. Many people living there have absolutely no idea what health insurance is. They have difficulties accepting the idea of paying in advance for something that they might only need in the distant future. Illness is equated with fate, and there is no way of insuring against fate, or so popular opinion would have it. On the contrary, insurance could even bring about bad luck. Added to that, the poor cannot afford to pay insurance contributions, any more than they can afford the co-payments for medical treatment, which were introduced in 1993. Often they are forced to sell part of their harvest, livestock or land for less than its value to finance a hospital stay.

51 percent below the poverty line. In these circumstances, it is a courageous step for a country like Tanzania to attempt to insure the entire population against the financial risks of illness. 51 percent of Tanzania’s 34 million inhabitants live below the poverty line, and have to manage on less than 900 Tanzanian shillings (approx. 70 euro cents) per day. Nevertheless, experts are trying various approaches to improve the level of health care provision. For example, cooperatives, non-governmental organizations and churches all over the country have set up more than 150 community-based health insurance schemes. Numerous representatives of these organizations attended the CHIC Management Seminar in Dar es Salaam at the end of March. Government officials and managers from the National Health Insurance Scheme also took part in the seminar. The government is responsible for public health facilities, and finances programmes to provide care for disadvantaged groups. Furthermore, as an employer it pays contributions to the National Health Insurance Fund (NHIF), the compulsory scheme for civil servants and public sector employees. The NHIF came into being in 1999 by resolution of parliament, and has been in operation since July 2001. In 2002, it widened its membership to all employees in the public sector, including local government administrations and parastatals organizations. With more than 242,000 paying members, its coverage now extends to 1.1 million potential claimants (members and their immediate families). Employers and employees pay three percent of gross salary per month into the fund.

Informal sector. However, in Tanzania only a minority of bread-winners are employed in the formal sector. The vast majority of the population has neither a contract of employment nor a regular income. Many people work as day labourers or live from small-scale self-employment. They can voluntarily join the Community Health Funds (CHF) initiated and supported by the

CHIC – CENTRE OF HEALTH INSURANCE COMPETENCE

Know-how for community-based health insurance schemes

Not every local health insurance scheme needs to develop all the financial, technical and managerial capacity of a fully-fledged insurance company. The necessary expertise for running an insurance business can also be acquired from a higher-level institution, known as a Centre of Health Insurance Competence (CHIC). For example, take Tanzania (see the report on page 20) and Nigeria (see the report on page 23); these are countries where competence centres on the CHIC model are currently being established. Under this model, small private and public health insurance schemes come together in a network and establish their own competence centre. Its role is to develop insurance products and quality standards, carry out seminars and training courses, and represent members’ interests on the political level. By pooling resources to accomplish tasks and activities, the member health insurers are in a position to work more professionally. While the CHIC takes charge of technical issues and managerial responsibilities, the associated insurance schemes can concentrate on recruiting members and providing direct services to their clients.

A successful CHIC will cover at least part of its own costs from the sale of its services. This may be done via franchise contracts. The CHIC as a service provider makes (semi-)standardized services available to the individual health insurers in return for a franchise fee. There are clear criteria for joining the CHIC network. Every participating health insurer must present an annual financial and quality report. The level of franchise fees is set according to an organization’s resources and membership structure. Development cooperation may provide start-up assistance to launch the CHIC. In this form, Centres of Health Insurance Competence help to improve access to health care provision, especially for poor segments of the population.

A CHIC not only radiates positive effects in the health care sector, but also plays a part in boosting incomes and employment in a region. Thus it gives important stimulation to the local economy. Transfer of the necessary expert knowledge takes place in special CHIC Management Seminars (see report, page 20), which the GTZ has been carrying out since 2002 with great success in various African countries, most recently in Minna, Nigeria and Dar es Salaam, Tanzania. Interested parties are invited to contact the

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government, or self-organized health insurance funds. The first CHF was created in 1996 in the Igunga district, and today 40 districts have such a fund.

The Tanzanian government would like to set up a Community Health Fund in every one of the 113 districts, because according to Gaspar Mwambezi, CHF Coordinator at the Ministry of Health, the CHF system has compelling advantages. Broad coverage of the population, an attractive package of benefits and contributions that members can afford. However, in many districts, CHF systems can only be introduced with great difficulty. Most systems only reach a fraction of the target group, and there is barely any experience in health insurance management.

In Dar es Salaam, the umbrella organization of entrepreneurs in the informal sector, VIBINDO, is trying to insure its members against the costs of illness. For this purpose it has set up its own microinsurance programme. With ten Micro Health Insurance Schemes (MHIS), they are currently providing cover to 1,000 beneficiaries. But, in a city of over three million inhabitants, most of whom work in the informal sector, this is a negligibly tiny number. The main difficulties of self-organized health insurance schemes, according to Gaston Kikuwi, the general secretary of VIBINDO, are the low business profits made by corporate members, who often have no permanent place of business.

**Great potential.** Despite these difficulties both the Community Health Funds (CHF) and the self-organized Micro Health Insurance Schemes (MHIS) have considerable potential to improve the provision of health care to the poor. This is the goal endorsed by the Tanzania Network of Community Health Funds (TNCHF), an alliance of local health insurers and other organizations. Founded in October 2003, its main interest is securing basic health care for Tanzania’s poor. “As a non-profit network, we offer our members professional, organizational and commercial support,” says Sister Rita, director of the legally registered TNCHF.

These support services are very helpful. As a GTZ study looking into experiences with the introduction of health insurance systems in Africa revealed, mutual insurance schemes can make a vital contribution to improving health care provision. Due to a shortage of experience in health insurance management, however, they often exhibit financial and organizational deficits. Multiple factors are to blame for the shortage of management competence. Too few qualified staff, inadequate data, staff practices primarily geared towards charitable work, and no means of financial controlling. Moreover, the poor population with its meagre and irregular income can only pay low insurance contributions. Catastrophic events such as epidemics or an impending insolvency can rapidly destabilize a system. This makes it all the more important to construct an efficient management system. But there is not the money or the know-how to do so. A competence centre for health insurers can assist its member organizations by offering professional support on insurance issues, financial and organizational management, marketing, information and communications technology, and by representing their interests at national level. The GTZ sector project has coined the term CHIC (Centre of Health Insurance Competence) for such support centres. *(For further details on the CHIC approach, see the “Know-how for community-based health insurance schemes” box on page 21).* The first CHIC in Tanzania is integral part of the TNCHF. The CHIC Management Seminars is one product of the CHIC portfolio.

**Analysis tools.** The CHIC Seminar is a hands-on method of transferring the knowledge that is indispensable for running a health insurance scheme. This includes information on risk management and the different types of costs, as well as financial accounting. Beyond that, the participants also gain familiarity with computerized tools (InfoSure and SimIns). The information and evaluation software InfoSure (more details on page 50) helps to assess the current status and past development of an insurance scheme. The simulation tool SimIns, developed jointly by the WHO and the GTZ, turns its attention to the future and permits forecasting of financial trends. Routine crisis management by means of role-play is also part of the seminar: for example, at the seminar in Dar es Salaam, Mr Ndangala briefly slips into the role of vice-president of a health insurance fund. He displays visible discomfort because, according to the “script”, his boss, the director of the insurance fund, has borrowed a large sum of insurance fund money for a lavish funeral. Mr Ndangala must now hold a conversation to clarify the situation. It also seems that his boss has allowed uninsured members of his own clan to claim medical benefits. A tough challenge! On the other hand, there is great hilarity as the treasurer of the same imaginary insurance scheme, Dr Mugendi, reminds members to pay their outstanding contributions. “We have some real acting talent here”, comments Christian Nas Amouyé, a trainer from Cameroon.

**People need to be convinced.** The seminar in Dar es Salaam was stimulating in many ways. The participants returned to their workplaces with new inspiration. There they face the challenge of enabling Tanzanian men and women to access affordable health care provision. But the first priority is still to convince people of the benefits of insurance, so as to spread the principle of solidarity throughout the health care sector.

David Kyungu works as a journalist in Tanzania. Dr Bernd Schramm is the coordinator of the social health insurance project at the GTZ.
The problems of the Nigerian health sector have long been taken as read: poor health care, lack of medicines, corruption, unmotivated staff and inadequate management capacities have been its most striking features.

The Catholic Church is trying to put an end to this state of affairs. The inspiration came from a CHIC Management Seminar (also see “Know-how for community-based health insurance schemes” on page 21) run by the GTZ within the framework of German development cooperation. Almost immediately after the seminar, held in July 2003 in the northern Nigerian city of Minna, the Nigerian Catholic Bishops’ Conference began to set up a competence centre on the CHIC model, by the name of CHIP (Catholic Health Insurance Programme).

Its franchise system will support the various dioceses, Catholic health care institutions and other interested partners in planning and introducing local health insurance schemes. The franchise principle works as follows: from the insurance scheme to be established, CHIP receives a one-off joining fee set according to its size and package of benefits offered. It also charges an annual franchise fee of two percent of gross income. In return, CHIP gives start-up help to the health insurance schemes, and furnishes them with information and marketing material. CHIP organizes and takes charge of staff training, supports partners in recruiting members and negotiating contracts with service providers, and is responsible for quality assurance.

Due regard for regional needs. Due to the great variation in economic circumstances from region to region, the insurance policies offered must also be tailored to the people’s needs and life situations. Two examples illustrate the concrete progress made by CHIP with its plans. Enugu, a poor rural region beside the Niger, is a malaria district and has two health centres. For 800 Nigerian nairas (about five euros a year), with only low co-payments, the population living in this region has the right to outpatient malaria therapy, treatment of ten other illnesses, provision with 40 medicines and free vaccinations under the national immunization programme. Every second family member is provided with a mosquito net free of charge. However the insured people must enrol with one of the two health centres for a year. The health centres, in turn, are obliged to have a qualified nurse or midwife on duty seven days a week in two shifts. Furthermore, a doctor must be available twice a week for at least four hours to hold outpatient clinics. CHIP ensures that the centres comply with these requirements. The economic situation of the population is better in the city of Onitsha. Hence, it is possible to offer them different tariffs and benefits packages. Under the “Admission Package” costing 5.50 euros per member per year, the health insurance scheme will cover hospital costs including operations. For higher earners, there is a “Comprehensive Package” for around 50 euros. On top of the benefits in the “Admission Package”, those insured can also claim for the costs of outpatient treatment for a total of 52 illnesses.

Excellent prospects of success. CHIP’s prospects of success are high, particularly since the Catholic Church enjoys the population’s trust. The private HMO (Health Maintenance Organizations) are also interested in CHIP, and have already carried out internal training courses following the CHIC model to upgrade the skills of their staff. So, it is likely that they will also cooperate with CHIP.

According to cautious estimates, five to ten CHIP health insurance schemes should be able to start up within the first year. The Catholic Church hopes that three years on, at least 100,000 Nigerian men and women will have enrolled in one of the insurance schemes. If the health insurance schemes in the pilot regions prove their worth, the CHIP franchise system will be expanded to cover the whole country. 

Bettina Nellen works as an editor for the publisher KomPart-Verlag.
“A real eye-opener”

In July 2003 I had the opportunity to attend a seminar on Health Insurance Management organized by the GTZ.

I am working for the Catholic Bishops Conference of Nigeria and at the same time as administrator of the Annunciation Specialist Hospital (ASH) in Emene, a township of Enugu in the south-east of Nigeria. The ASH, owned and run by the Daughters of Divine Love Congregation (D.D.L.), has been operating a health scheme since 1998. Misereor, the German Catholic donor agency, who provided funds for a vehicle, the office equipment and an expert in Health Policy, Planning and Financing, initially supported it as a pilot programme. The scheme is running relatively well despite the unstable national economy. It has around 2,200 covered members and provides health care coverage with two different policies: admission cost coverage and comprehensive treatment cost coverage. As a pilot programme it had its problems, but we are very happy that our people are buying the policy out of conviction, since there is a lot of negative prejudice and mistrust against insurance business in Nigeria.

The seminar in Minna was an “eye-opener” for our team. It helped us to affirm our strengths and actually to look critically at the weaknesses of the scheme.

On the national level, the seminar instigated the idea of building up a centre of health insurance competence, which can help interested dioceses, providers and other interested groups like communities or unions to start small health schemes in their environment. We have taken up the challenge and worked out a proposal, which was submitted to the annual meeting of the Catholic Bishops Conference of Nigeria (CBCN) in Abuja, Nigeria in March 2004. The proposal was accepted and the CBCN has formed a committee with the task of starting a Catholic health insurance programme for the whole of Nigeria. Without the help of the GTZ-sponsored seminar in Minna, we would not have reached this goal by now.

West Africa

La Concertation: A network of partners

International organizations and local health insurance initiatives have joined forces for the Internet platform, Action Concertation. Internationally, it is generating very positive feedback. By Jürgen Hohmann and Marion Baak

It is no mean feat to achieve the maximum possible success with minimal resources. In West Africa, though, they have managed it: several international organizations and small health insurance schemes (mutuelles de santé) came together to mount the Internet platform Action Concertation. Their aim was to drive forward the development of community-based health insurance schemes. The Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) is one of the founder members of the Concertation campaign.

West Africa has been one of the longstanding priority regions of the Sector Project “Social Health Insurance”. The first pilot project was launched in Guinea in 1997. A local health insurance scheme was set up as a contribution to ensuring effective and sustainable health care provision, particularly for socially disadvantaged groups. Other projects in Senegal and Côte d’Ivoire followed. Expert support from the sector project, and the know-how available from its partner the AOK, were very welcome contributions.

International commitment. Other bilateral and multinational organizations also stepped up their commitments in West Africa: the International Labour Organization (ILO), the American development agency USAID, along with the health insurance alliance ANMC and the non-governmental organization WSM, both from Belgium. At the “Plateforme d’Abidjan” conference in 1998, common objectives were formulated and fundamental measures decided for promoting health insurance in West Africa. The idea of concerted action by multilateral and bilateral donors and the mutuelles de santé was born.

Sharing information. The Action Concertation arose as a platform for information-sharing. Another aim was to make it easier to cooperate and coordinate work among international supporters, promoters and development programmes. Internationally, it generated very positive feedback. In law, however, Concertation does not yet have a specific legal status, because the international organizations are not permitted to combine their development funds with money from other donors in collective institutions.

Within a very short time, the number of mutuelles in West Africa grew remarkably. Their success, measured in terms of the numbers of people insured, was rather modest at first. Frequently, the population lack confidence in the concept of insurance. Also the microinsurance scheme staff are generally voluntary, and lacking in the necessary training.

The Action Concertation, with its public information policy and reciprocal sharing of experience, is helping
to ensure that the theme of health insurance is gaining far more attention in the region than it did in the early years. Meanwhile the original founder members of Action Concertation have been joined by other organizations: the international alliance of health insurers AIM, the French network RAMUS and another Belgian union of health insurance funds (UNMS). The GTZ, too, has increased its support. By means of its health programmes in Guinea, Cameroon and Rwanda, it is supporting the network’s national structures.

Dr Jürgen Hohmann was Project Coordinator of the GTZ Sector Project “Social Health Insurance” from 1997 to 2004. (Juergen. Hohmann@attglobal.net)

Marion Baak has worked for the project since 2001. (Marion.Baak@gtz.de)

Literature: Goetz Huber, Jürgen Hohmann, Kirsten Reinhard. “Mutual Health Organization (MHO) – Five Years’ Experience in West Africa”, Universum Verlagsanstalt, Wiesbaden 2003, E-mail: health-insurance@gtz.de (also available in French)

The Action Concertation is well known as an Internet platform giving access to technical expertise in the field of social health insurance. How does the Concertation get through to people without Internet access?

The Concertation is a broadly-based information network about health insurance schemes in West Africa. Every two years the Concertation organizes an international conference where participants share their experiences and plan activities together. A quarterly newsletter is published called “Courrier de la Concertation”.

The Action Concertation came into being six years ago. How has it developed since?

The remarkable thing about the Concertation campaign is that it encourages a highly diverse group of actors such as non-governmental organizations, educational institutions, mutual health insurers, ministries and bilateral and multilateral organizations, to pull together for a common purpose. I am encouraged by this development and I see it as the main role of Action Concertation.

What role does the GTZ play in Action Concertation?

The GTZ is one of the promoters providing technical and financial support for Concertation activities. They are ascribed a steering role in Concertation activities. In the context of German development cooperation, the GTZ is also working actively on related issues, for instance combating AIDS and malaria, and health insurance legislation. Furthermore, it takes an active part in discussions on strategy issues. Its input on the sectoral level is indispensable. The studies it carries out, for example the field report on “Mutual Health Organizations” in West Africa [see the “Literature” tip, above] are received with considerable interest. In this way the GTZ is playing its part in satisfying the enormous thirst for knowledge in the field of social health insurance in Africa.

What is your vision for Action Concertation in five years’ time?

The Concertation now runs almost without a hitch, and we are on the right track. Another point is that the Concertation accomplishes its work with minimal financial resources. So, it is more vital than ever to exploit synergies. Continued support must be given to the networks, so that they gain greater political influence when it comes to issues like the population’s access to adequate health care. Much work remains to be done in this area. I also hope that the Concertation will acquire an official status in the foreseeable future.

Contact: La Concertation, Pascal Ndiaye, E-mail: concemut@sentoo.sn, Internet: www.concertation.org

“"We are on the right track"

Six years after the founding of Action Concertation for the promotion of health insurance in West Africa, its coordinator Pascal Ndiaye takes stock – and calls for more support from the political sphere.
Epidemic diseases have no regard for national borders: In the year 2003, there were some 40 million people worldwide with HIV or full-blown AIDS. Of these, 26.6 million were concentrated in sub-Saharan African countries. There most of all, many victims are too poor to afford the medicines they desperately need. Systems of social protection, which would afford these people some financial support, range from very basic to non-existent. Where health insurance schemes do exist, the treatment of chronic illnesses, and especially HIV/AIDS, is not included in the schedule of benefits. To do so would exceed the financial resources of the insurance organizations.

Although many international organizations in the poorest countries are now engaged in fighting HIV/AIDS and other epidemic diseases like malaria and tuberculosis, the victims frequently miss out on the medical treatment they need. One reason is the absence of efficient health insurance schemes capable of channelling donor money to where it is needed.

Kenya has embarked on a new course. Its government has declared the introduction of a health insurance system, the National Social Health Insurance Fund (NSHIF) to be its foremost priority. At the request of the Kenyan government, the GTZ and the World Health Organization along with others have been supporting the country with the immensity of this undertaking.

To realize the importance of health insurance, one only has to stop and think about the extent of HIV/AIDS in Kenya: 15 percent of the population between the ages of 15 and 49 are infected. Because of this, the NSHIF will in fact be covering the cost of treatment for HIV/AIDS in future. However, the funds to do so will not be drawn from normal contribution revenue, but from money given by donor countries. By the end of 2005, for example, Kenya will have received 180 million euros to combat HIV/AIDS from the United Nations’ Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

This illustrates how health insurance schemes provide an effective distribution mechanism for donated funding – an incentive for potential donors that should not be underestimated.

GHANA

No contributions

Ghana was the first country in Africa to gain independence from British colonial rule in 1957. Today the average life-expectancy of its 20.5 million inhabitants is in the region of 56 years. Close to one-third of the population lives below the poverty line.

In September 2003, the Ghanaian parliament enacted a law providing for the organization of a new, decentralized national health insurance system. Accordingly, everyone living in Ghana will be compulsorily insured. Under this scheme, the very poor population will be covered by insurance without paying contributions. The costs of their treatment will be recouped by an increase in value-added tax. The responsibilities of a health insurance fund will be assumed by local Mutual Health Organizations (MHOs), of which there are an estimated 150 throughout the country.

However, the project is encountering certain difficulties: large sections of the population see no direct personal benefit in investing money in a solidarity-based system. The MHOs frequently have insufficient trained staff or financial resources to maintain their own administrations responsible for collecting contributions, corresponding with members, running information campaigns and accounting for services. Hence, as part of German development cooperation, the GTZ is supporting the organization of the national health insurance system in Ghana by training the staff of selected MHOs and working to set up CHIC-style competence centres (see also the article on “Know-how for community-based health insurance schemes” on page 21).
At the invitation of the World Bank Institute, representatives from 15 francophone African countries, and from Tunisia, Ghana and Kenya, met in Paris in April 2004 to share their experiences on health insurance. The two-day meeting made it clear that although different countries are pursuing a variety of approaches, the two main objectives are the same everywhere: solidarity-based contributory financing, and working towards universal access to appropriate health services for all segments of the population. The success of both objectives, all participants agreed, stands or falls on the political will of the government. The event was supported by the GTZ and other international organizations.

The term “health insurance” is an alien concept to most people in developing countries. From developments in Senegal, it is clear that this is gradually changing. Since the late 1980s, more than 30 community-based health insurance schemes (mutuelles de santé) have taken shape, growing out of traditional forms of mutual assistance.

The mutuelles are firmly embedded in village structures and their aim is to enable the disadvantaged rural population to gain access to appropriate health services. The question of whether they are achieving this aim was the subject of an analysis by the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ). It was conducted using the evaluation tool InfoSure, which was specifically developed for health insurance schemes. Overall, eleven community-based health insurance schemes in the two regions of Diourbel and Thies were analysed.

The individual mutuelles, which have about 500 members on average, vary greatly in their efficiency. Some of the initiatives are already providing benefits to their insured members; others are still far from that stage. Why is that the case? What makes successful mutuelles successful? What particular difficulties need to be overcome? The collection and subsequent analysis of data with InfoSure shows which health insurance systems will be capable of surviving in the long-term, and which, despite equal financial starting conditions, are most likely to fail. Key factors that can determine success or failure are the commitment of the mutuelle’s initiators and founder members, and its management competence. Other relevant factors include contributions set at appropriate levels, and an appropriate schedule of benefits including cover for dependants.

Furthermore, the evaluation showed that educating and informing the population about how insurance works is important for success. The more successful mutuelles in Diourbel and Thies had frequently been set up on the initiative of religious institutions or respected non-governmental organizations. They were strongly geared towards the needs of their customers, and the trust they had previously established with people in the region gave them a head start when setting up their insurance schemes.

The study can be ordered in French from health-insurance@gtz.de. Further information www.infosure.org

For over 20 years, the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) has been actively engaged in development cooperation with Guinea. Initially, support focused on organizing a decentralized health care system. Numerous health centres were set up, the administration was strengthened, medical care was improved and quality controls and professional training programmes were established successfully. Moreover, a pilot project on support for health insurance schemes was implemented, in cooperation with the Institute of Tropical Medicine in Antwerp and the Belgian non-governmental organization Medicus Mundi.

Finally, in mid-2002 the Health Programme/AIDS Control (Programme Santé et Lutte contre le VIH/SIDA, PSS) was launched as a follow-on project. It is running in eleven project regions, which comprise about one-third of the country. Apart from combating AIDS, another central element of the new programme is quality management. Efforts are being made to establish quality benchmarks for use even beyond the actual project region. All interested health centres begin by carrying out a self-evaluation, and subsequently undergo an audit. One-third of them receive a seal of quality which entitles them to subsidies from the GTZ.

Since the project began, 18 health insurance funds with around 20,000 members have commenced work. However, this only covers one percent of the total population in the pilot region. By the end of 2004, the GTZ expects 20 more health insurance funds to start up. The new project phase is also being supported by the World Bank.

At the invitation of the World Bank Institute, representatives from 15 francophone African countries, and from Tunisia, Ghana and Kenya, met in Paris in April 2004 to share their experiences on health insurance. The two-day meeting made it clear that although different countries are pursuing a variety of approaches, the two main objectives are the same everywhere: solidarity-based contributory financing, and working towards universal access to appropriate health services for all segments of the population. The success of both objectives, all participants agreed, stands or falls on the political will of the government. The event was supported by the GTZ and other international organizations.
Solidarity between the healthy and the sick

In the Chilean health sector, richer and poorer patients face highly inequitable conditions of access to health care. The government of Chile wants this to change: a solidarity fund between the statutory and private health insurance schemes is set to correct the imbalance – guided by German input on risk structure equalization. By Camilo Cid and Nicola Wiebe

The health of the Chilean people has improved immensely in the last decades. Average life expectancy at birth has risen to 76 years, and infant and maternal mortality has fallen by half. However these average values mask extreme inequalities. For example, in Vitacura, an elegant quarter of Santiago, the capital city, infant mortality is around 2.6 per 1,000 live births. A few kilometres away in the more socially deprived district of Independencia, the level is six times higher (14.6). Worst of all is Puerto Saavedra in the south of Chile, where out of every 1,000 children who are born there, over 42 die before their first birthday. Of course, those kinds of health indicators can be influenced by many non-health-sector factors. But they are not the only manifestation of the prevailing disparities. Similar
inequalities pervade access to medical services as well as the quality of treatment. Although in theory there is universal access to the health care system, it is not unusual to have to wait six to twelve months or even more for a hospital appointment for a specific test or operation. On the other hand, patients who can afford high co-payments see graph on page 33 will have taken out a private policy anyway, or resorted to private providers.

What are the causes of these extreme disparities? A look at the structure of the Chilean health service reveals the answer. The health care system consists of a public and a private sector. All employees must pay compulsory contributions of seven percent of income into a health insurance fund. Theoretically, every working person has the right to choose between the public health insurance fund FONASA and 24 private health insurance schemes, as well as lifelong options to switch between the different schemes. Contracts with private health insurance schemes are generally set up for one year, or sometimes two. The contributions for private funds are often more than seven percent of income; in fact, private contributions currently amount to 9.2 percent of income on average.

Disparities in contribution revenues. In practice, it is predominantly people on higher incomes who are insured with the private health insurance funds, whereas poor households and families with lots of children tend to belong to the public scheme. That is how the private insurance funds come to receive more than half of all contribution income although they cover less than 20 percent of the population. Admittedly, FONASA’s expenses are defrayed by subsidies from tax revenue. Nevertheless, with barely more than half of total revenues, it has to fund care for two-thirds of the population.

Risk selection. Those people with higher health risks are generally members of FONASA; for instance, this is true of 99 percent of people with HIV. How does this unequal distribution come about? Private health insurers take the opportunity to reject customers who are likely to incur high costs, or try to deter them by offering insurance policies with high co-payments. Whenever a main or secondary policyholder passes an age limit for certain risk factors, the contribution rises or the policy conditions become more restrictive. This leads to systematic migration into the public sector as people get older and sicker.

The existing system suffers not only from social inequality, but also from inefficiency and gaps in coverage. In the private insurance sector, the pursuit of young, well-paid members and the checks on expenditure drive up administration and marketing costs. At the same time, hundreds of different insurance packages make the situation anything but transparent.

Regulation of the health care system is therefore in need of review. In June 2002, the Chilean government set out the key points of its proposed reform: defining a standard schedule of benefits with explicit guarantees (in relation to waiting times, quality and financial coverage), introducing a risk-equalizing solidarity fund between the public and private insurance funds, improving regulation of the private insurance sector, and conferring wider powers upon the supervisory authorities. The principle of the solidarity fund is simple: insurance schemes whose members have a higher overall risk of illness receive a compensatory payment from schemes covering lower-risk members (risk structure equalization). Institutional elaboration and political realization present major challenges, however. Exchanging information with other countries, which operate different risk structure equalization models to make

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The Chilean Health Care System

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The Chilean health care sector is characterized by a two-tier system of public and private health insurance (HI). People in employment pay at least seven percent of their income into their respective health insurance funds. With private providers the percentage is usually higher. People with statutory insurance can only circumvent the waiting lists of public health facilities by accepting high co-payments and seeking out private service providers.
"Better data is key"

Professor Jürgen Wasem of the University of Duisburg-Essen in Germany is advising Chile on the introduction of a risk structure equalization mechanism – and his input could be equally productive for the German policy debate.

What do you think of the proposal for reforming the Chilean health sector by introducing a risk structure equalization mechanism between public and private health insurance?

It is necessary to introduce at least an element of risk solidarity into the Chilean health insurance system. This is important in order to give poorer social groups a real chance to obtain essential medical services under their health insurance, without being hit by exorbitant co-payments. I personally would be sympathetic to an equalization that also introduced an element of income solidarity. Then there would be income-related payments, rather than the per capita contributions which the health insurance funds pay into the risk structure equalization fund. But of course, as an advisor, one must accept political decisions reached through a democratic process.

What is your recommendation to the Chilean government on implementing the risk structure equalization mechanism?

A central problem in the implementation of risk structure equalization mechanisms is the availability of data. I recommend that initially, the Chilean government should introduce equalization based on the data and indicators that are available today. As a next step, the emphasis should be on improving these data bases. For instance, very little information is available as yet on outpatient diagnoses and treatments, at least not in a form that can be readily evaluated. Hence, in the first instance, it is advisable to base the equalization of risks on hospital care data.

How important are European models of social protection to the Chilean debate on reform?

European health care systems achieve a relatively high degree of solidarity in the financing of medical services. Where European health care systems work with competition between health insurers – which applies to the Netherlands, Belgium, Switzerland, the Czech Republic and Slovakia, as well as Germany – they have implemented a risk structure equalization mechanism to ensure the compatibility of solidarity and competition. This same principle runs through the Chilean reform.

Would it be conceivable to introduce risk structure equalization between public and private health insurance funds in Germany?

In fact, the situation in Germany is not all that different from Chile, because in both countries, higher-paid employees and the self-employed can opt out of solidarity-based health care funding. This issue is at the forefront of the current debate in Germany on a universal “citizen’s insurance”. And one of the proposals in this debate is to integrate private health insurance into the risk structure equalization mechanism which has operated among the statutory health insurance funds since 1994.

Proposal for redistribution. The government went into the political negotiations with the following proposal for a risk structure equalization mechanism: the insurance companies will be required to pay a per capita levy for each member into the solidarity fund, regardless of the insured person’s level of income or individual risk rating. In settling for a per capita levy, the decision has fallen in favour of risk solidarity (redistribution between the healthy and the sick), whilst the original proposal for an element of income solidarity (redistribution between higher and lower earners) has been dropped. For the poor population who can only afford to pay contributions lower than the per capita levy, if any at all, the revenue authorities will make up the difference. This introduces a tax-financed redistributive element. The solidarity fund allocates the resources among the insurance schemes according to the risk-structure of their memberships. Transfer payments are made on the basis of indicators, which approximate to the overall risk level of the insurance scheme membership, taking into account at least its age and gender structure. In the course of introduction, which will take several years, other morbidity-related indicators should be added into the risk structure equalization mechanism.

The social policy objective is to alter the incentives, so that insurance schemes compete on business efficiency. They should be discouraged from chasing after young, healthy and highly paid members. At the same time, risk structure equalization will enable a fairer distribution of resources in the health sector according to need – a key contribution to socially equitable development in Chile.

Camilo Cid is Head of the Department of Health Economics at the Chilean Ministry of Health, and currently a doctoral student supervised by Professor Jürgen Wasem at the University of Duisburg-Essen, Germany.

Nicola Wiebe works in the GTZ section for “Sustainable Social Protection”. (Nicola.Wiebe@gtz.de)
Doña María Yegros is angry and disappointed. “First they said that with insurance, all the treatment would be free, and now I have to pay for the infusion needles!” As she speaks, she points to the thin arms of her one-year-old son, Alberto. From the cot where he lies, he stares glassy-eyed at the ceiling. One day earlier, the infant was admitted to the district hospital in Caazapá, South Paraguay, with serious pneumonia. Since then, he has been attached to a drip, which supplies his tiny body with antibiotics.

In principle, the treatment should cost his mother nothing because last year she joined the newly created “Caazapá comprehensive insurance scheme”. The community based health insurance scheme is currently being set up in the underdeveloped Caazapá Department with support from the Paraguayan Health Ministry, the World Health Organization (WHO) and other development organizations such as the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ). During the introductory phase, all efforts are being concentrated on the district capital’s hospital. This is where the health insurance fund has its office, where enrolment takes place, and where treatment is provided.

Lacking social protection. It is one-and-a-half decades since the German-born despot Alfredo Stroessner was overthrown, ending his prolonged patriarchal dictatorship. Today Paraguay is one of the poorest and most backward countries in South America, with the classic population structure of a developing country. Two-thirds of Paraguayans are under 30, indeed two-fifths are under 15 years of age. Almost half of the population is rural. Many people live a hand-to-mouth existence without any prospect of increasing their income.

For the vast majority, social protection is an alien concept, if not wishful thinking: only one in five has any kind of safety net to fall back on in the event of illness. If they fall ill, most citizens must resign themselves to their fate, or stump up the money for treatment themselves. This plunges many into ruin.

Overcoming vulnerability. With international support, the initiators of the insurance project in Caazapá want to overcome the social vulnerability that is endemic among the Paraguayan population. Studies confirm the enormous need for social protection systems, especially in poor outlying urban settlements and in rural areas, where health care facilities are not even provided in many cases. But political debate in the capital, Asunción, barely even touches on this priority problem. Granted, passionate disputes take place over the future of social protection systems, especially in poor outlying urban settlements and in rural areas, where health care facilities are not even provided in many cases. But political debate in the capital, Asunción, barely even touches on this priority problem. Granted, passionate disputes take place over the future of social protection systems, especially in poor outlying urban settlements and in rural areas, where health care facilities are not even provided in many cases. But political debate in the capital, Asunción, barely even touches on this priority problem. Granted, passionate disputes take place over the future of social protection systems, especially in poor outlying urban settlements and in rural areas, where health care facilities are not even provided in many cases. But political debate in the capital, Asunción, barely even touches on this priority problem.

Establishing health insurance. Nearly one person in three is linked directly or through a family member to one of the country’s more than 700 cooperatives. As well as the collective sale of agricultural and other products, the cooperatives are taking on saving and lending functions. These play an important part in the Paraguayan national economy. The cooperatives hold a tenth of all savings balances. Yet they are not content just to improve and safeguard their members’ incomes. As a study commissioned by the Paraguayan Planning Ministry and the GTZ PLANDES project discovered, small, often rudimentary health insurance structures are now being established all over the country to cover cooperative members against the risks of illness.

For this process, the cooperatives can draw upon a certain level of organization and reliability, as well as on their existing rules of solidarity. In many places, members can claim grants or loans on particularly favourable terms in the event of births, illnesses, deaths and other critical incidents.

Recently, a growing number of cooperatives have been developing these solidarity funds into health insurance schemes, occasionally even pension schemes. The country is not short of inspirational exam-
Social Health Insurance

Latin America

treated free of charge. Children up to the age of five should be sure, the money she had to spend on nee-
to this are the consequences of demo-
day interventions. However, there are discounts on contributions from large families.


Building confidence. The Caazapá insurance project shows great promise. Given the limited resources, those running the scheme are initially concentrating on the most vulnerable groups in the population – young women and small children. Due to the high rate of complications in pregnancy and childbirth, and an infant mortality rate that is alarming by international standards, these groups will be given priority access to the benefits of the new insurance scheme. That is why Doña Yegros came to enrol at the insurance office not long after giving birth to her son Alberto. And is disappointed that the people from the health insurance fund have not kept their word after all. To be sure, the money she had to spend on need-
dies in the pharmacy over the road is just a fraction of the overall cost of treatment. Yet, the young woman feels cheated: after all, children up to the age of five should be treated free of charge.

There is still much to be done to make the insurance project in Caazapá self-sustaining and to build people’s confidence in the system. For past experience has taught them, time and again, that they will end up having to pay.

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BRAZIL

Health care systems and HIV/AIDS – a conference in Brazília

On the theme of “Current challenges and perspectives of health care systems in Latin America and the Caribbean: universal social protection and an integral answer to HIV/AIDS”, a regional conference was held in the Brazilian capital, Brasília, in May and June 2004. The Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) played a substantial part in the proceedings.

The central focus of this year’s conference was the double challenge facing all health care systems south of the Rio Grande. Under conditions of chronic underfunding, often far-reaching exclusion of the population from social protection systems, and substantial deficiencies of solidarity within the systems as a whole, the considerable costs of epidemic illnesses are becoming a growing burden. Epidemics include not only tuberculosis and malaria, but also infection with HIV, and especially the AIDS syndrome. Added

to this are the consequences of demographic-epidemiological change: the rising number of elderly people is accompanied by an increase in chronic-degenerative diseases. Generally, these require longer-term treatment and incur correspondingly higher costs. The HIV/AIDS epidemic is a pithy and dramatic object lesson on the medium-term challenges facing social protection systems.

The impetus for the event came from participants of two previous conferences on the same complex of issues, run by the GTZ together with the UN Economic Commission for Latin America and the Caribbean (CEPAL) in Santiago de Chile. This year’s conference was deliberately held in Brazil because this South American country is making innovative strides in health care financing including its universal tax-financed health care system, SUS, and its internationally respected policy on AIDS.

EL SALVADOR

InfoSure analysis of health fund

The crisis of the public social insurance fund, ISSS, El Salvador’s social security institute, has dominated national headlines for several months. Strikes, demonstrations and vocal protests are largely paralysing health care. But, barely registered by the media, there are parallel social security structures. For instance, the country’s Ministry of Culture provides all teachers in the public education system with their own social insurance scheme “Bienestar Magisterial” (BM). For years it muddled along, not always meeting the health care needs of its clientele. But in the last four years, the small offices full of densely stacked paperwork in its San Salvador headquarters have felt a breath of fresh air. The aim of new contractual modalities for service providers is to improve the quality of care and bring about a more rational allocation of resources. In order to document the effects of these structural changes, BM has used the InfoSure method developed by GTZ.

On behalf of the local GTZ project on “Support of the Modernization of the Health Services” (PASS), the Sector Project “Social Health Insurance” analysed the teachers’ insurance fund. In the process, it came across cost-curbing strategies which are also of importance to the international debate. For example, salaried family doctors guide insured patients through the system. The assumption of costs is coupled to a system of payment transfers and reimbursements. The insurance scheme negotiates package prices with medical consultants and hospitals, and maintains a positive list of pharmaceutical products. However, problems were found in the areas of client participation, transparency and, most of all, administrative procedures.

32 Social Health Insurance
Reports in brief

LATIN AMERICA

Initiative launched against social exclusion

Social exclusion is a widespread phenomenon in Latin America. Only very few countries between the Rio Grande and Tierra del Fuego provide all their citizens with safeguards against the risks associated with old age and illness. Especially in the poorer states of Central and South America, the majority of the population is excluded from the existing social protection systems.

Whilst there are social insurance institutions all over, access is normally confined to those in formal employment. In most developing countries and countries in transition, social insurance only works for the benefit of a minority. People from the informal sector and the rural population are still excluded.

Two international organizations have been engaged in the introduction of social protection systems for a number of years: the Pan-American Health Organization (PAHO) in the field of health care provision, and the International Labour Organization (ILO) for pension and health insurance as well as local microinsurance schemes. Thus far, their efforts had been pursued separately, even though there are common elements and areas of cross-over when it comes to setting up pension and health insurance schemes. In order to utilize existing synergies, the two organizations got together to create the “Joint initiative to overcome social exclusion in Latin America”. Along with other bilateral organizations of development cooperation, the GTZ section for “Sustainable Social Protection” and the Sector Project “Social Health Insurance” are participating in the ILO-PAHO project. Germany’s longstanding experience in designing health care systems and advising health insurers in developing countries will thus contribute to the work of the newly launched initiative.

LATIN AMERICA

Initiative launched against social exclusion

From their own pockets
High co-payments for Chile’s private patients

People from the lowest income groups have to shoulder the highest co-payments under Chilean private health insurance schemes. Those who earn more have to pay less out of their own pockets. This effect is particularly striking in relation to the fees women are charged for normal childbirth. Privately insured women on a monthly income of 400 dollars have to find more than five times as much from their own pockets as those with statutory insurance. The financial burden on private customers lessens as income rises, in comparison with co-insurance charges in the public sector. High earners with private insurance pay, on average, only half the amount towards their own treatment that statutory scheme members have to contribute.

This is the outcome of a study commissioned by the Sector Project “Social Health Insurance” on the Chilean health care sector. A similar trend was identifiable across the board for other illnesses too. The ratio of co-payments to income encourages private insurers to engage in even more risk selection, to the detriment of those on low incomes. Particularly dramatic evidence of their exclusion is found in relation to chronic illnesses requiring longer-term treatment.

Facts and figures

From their own pockets
High co-payments for Chile’s private patients

Chile’s private patients on a monthly income of 400 US dollars pay 9.7 times as much for treatment of depression as those with statutory insurance. Even with a monthly income of 1,600 dollars, the factor is still 7.8. Private insurers use this practice to deter the chronically ill.
One in two inhabitants of the Philippines is still unprotected by health insurance. But the Philippine government has plans which will change that rapidly: by 2010 all Filipinas and Filipinos should be members of the national health insurance scheme – an ambitious target. By Matthew Jowett
The Philippines consists of over 7,000 islands with a total land area somewhat smaller than Germany’s. The country is home to around 80 million people, who generate a gross national product of 840 euros per capita. Of the 7,000 and more islands, which stretch from the South China Sea to the Pacific Ocean, fewer than 1,000 are inhabited. These special geographical circumstances are by no means insignificant when considering how to achieve universal coverage of the Philippine population under the national health insurance scheme, PhilHealth.

The Philippine Health Insurance Corporation (PHIC, commonly known as PhilHealth) was founded by the Philippine government in 1995. The aim was to enable all segments of the population to access appropriate health care provision within 15 years. PhilHealth replaced the Philippine Medical Care Commission (PMCC, generally referred to as Medicare), which, by the mid-1990s, was only open to those in regular employment. Under Medicare, public and private sector employees were covered by mandatory health insurance. The insurance scheme only covered the costs of inpatient treatment. Charges capped at four euros a month. PhilHealth maintains its own offices in all 16 regions and in over 80 provinces. Employees and employers each contribute half towards the monthly membership contributions, which are set at 2.5 percent of income. The maximum monthly charge is fixed at 260 Philippine pesos (four euros). PhilHealth covers hospital charges as well as the costs of outpatient services in a limited way. PhilHealth also finances health education and preventive care.

Ten years after PhilHealth was established, the formal sector still accounts for two-thirds of those in the scheme (see also the diagram “Who is insured by PhilHealth?” on page 36). Less than one in five scheme members come from the informal sector.

In the Philippines, only one in two working people have an official contract of employment, the basis for classification as part of the formal sector. The other half of the labour force works on a non-contractual basis in the informal sector or in self-employment, for example as street traders or motorcycle taxi drivers. One-third of the population is classified as poor. A serious illness can mean financial ruin for a whole family. Currently, patients are still expected to pay over 40 percent of the costs of their drugs and medical treatment themselves.

Interface to the community. To speed up the expansion of the national insurance scheme to the informal sector, the “PhilHealth Organized Groups Interface” (POGI) was launched at the end of June 2003. The basis of the POGI approach is a formal tie-up between PhilHealth and selected organized groups, e.g. village cooperatives, at the community level. Once they have been accredited and rated, local and regional microinsurance schemes can become POGI partner organizations and represent PhilHealth in their communities. The interface structure gives small rural insurance initiatives the opportunity to work within the national scheme.

For the accreditation of POGI organizations, PhilHealth has adopted the COOP-PESO Standard (Compliance, Organization, Operation and Management, Plans, Programmes and Performance, Portfolio Quality, Efficiency, Stability, Operations). Based on this standard, PhilHealth partner organizations are assigned

Quality provision costs money

On behalf of the German federal government, the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) has been supporting projects to promote economic and social development in the Philippines for over 30 years. Through the German Federal Ministry for Economic Cooperation and Development (BMZ), the Philippine government and the German federal government jointly agree on objectives, methods and projects.

One of the priorities of development cooperation is the health sector. Half of the Philippine population are not covered by health insurance. In particular, segments of the population such as those in the informal sector, workers without contracts, the self-employed and the extremely poor are often unable to afford health insurance. Health expenditure has now climbed to 3.5 percent of gross national product, which is about 29 euros per head of the population per year – comparatively high for a country in transition. Current expenditure by the national health insurance scheme PhilHealth on benefits is three times as high as it was five years ago. Equally, the quality of health care provision has improved over the same period. Ninety-two percent of health care providers are accredited. Nevertheless the Philippine population still have to pay around 40 percent of their health care costs out of their own pockets.

The GTZ is supporting the efforts of the Philippine government to increase the inclusion of people from the informal sector in the national health insurance programme. This is being done by forging stronger ties between local insurance initiatives and PhilHealth activities, and by developing new models.
to one of three categories (see also the “Ratings and responsibilities” panel on page 37), reflecting their level of organizational and financial management capacity. The stronger the financial and managerial skills of the organization, the greater the level of responsibility they are given by PhilHealth. They may take on a range of tasks, from simply marketing the social health insurance scheme through to responsibility for the collection of contributions, for which PhilHealth gives financial incentives.

**Up to 60 percent administration costs.** In years gone by, German development cooperation made the support of community-based health care organizations (CBHCOs) one of its priority work areas. Over time, however, there were growing doubts about their long-term success. A key problem is that administration costs are often extremely high, accounting for up to 60 percent of income. Another problem is that scheme members who pay in for some time without ever claiming any benefits tend to drop out in large numbers. To date, only around 50,000 people nationally have accessed financial protection against the high costs of health services through CBHCOs. The contribution of such organizations to achieving universal coverage of the Philippines is hence likely to remain limited.

This is why new ideas and approaches are called for, especially to increase the number of people from the informal sector covered by PhilHealth insurance. To this end, comprehensive and informative data are needed on the core issues of income variations, access to health services and flexible contribution structures:

- **Income variations:** The informal sector is composed of a very heterogeneous group of workers and dependants. In the past, PhilHealth did not take sufficient account of differing ability to pay. However, this is highly relevant when trying to work out a contribution structure which can adapt to irregular and fluctuating incomes.
- **Access to health services:** On this issue, there are great disparities between different segments of the population. The health facilities available in urban Manila are worlds apart from those in the rural regions, where a lengthy boat and bus journey will often be the only way of reaching the district hospital. While some of these are modern and very well equipped, others are totally antiquated. PhilHealth has always assumed that the better-off and the poorer segments of the population have the same health-seeking behaviour and the same access to health services. Neither is the case, and both factors will influence interest in joining the national health insurance scheme.
- **Flexible contribution structure:** The tariffs for self-employed people from the informal sector stipulate an annual contribution of 1,200 Philippine pesos (17 euros), regardless of an individual’s annual income. Yet incomes can vary enormously. The amount is quite cheap to a successful entrepreneur earning an annual income of several thousand euros, but not for a domestic servant earning 300 euros or a rice farmer making as little as 140 euros.

Who is insured by PhilHealth?

(As of December 2003)

Insurance coverage under the national health insurance scheme remains dominated by formal sector workers, accounting for 65 percent of PhilHealth membership (22 percent from the public sector and 43 percent from the private sector). The informal sector paying members account for only 17 percent, less than one-fifth of all PhilHealth members. Almost exactly the same proportion of non-paying poor people (16 percent) is insured through their communities.

All in just 12 months. But how can these problems be solved? And how can POGI interfaces help? Through the regional offices of PhilHealth, POGI partner organizations make contact with potential members from the informal sector (see the diagram on “Framework for expanding PhilHealth” on page 37). Today their outreach already extends right into communities and villages, through groups known as health cells. The health cells, for their part, are small groups of workers who collect contributions, recruit new members and carry out health education by teaching hygiene, birth control and healthy nutrition.

This model is currently running as a pilot project with five cooperatives in Leyte and Southern Leyte Provinces. Another seven cooperatives in Cavite Province, bordering metropolitan Manila, are running comparable projects in a trial phase. The Board of PhilHealth approved a twelve-month pilot period, after which success in the two provinces will be evaluated. The results will determine the potential for extending the delegation of responsibility for administrative tasks to other regions. Even in the pilot phase, some positive effects have already been observed. In early 2004, two of the twelve participating cooperatives passed resolutions at General Assembly meetings, mandating all of their members to have PhilHealth coverage.

Besides the POGI model, PhilHealth is also discussing other ideas for insuring people in the informal sector against illness.
One interesting approach consists of offering group contracts at discounted contributions to defined groups of people, to enable them to access adequate insurance protection. Group contracts are also common in the commercial insurance industry, and represent a particular form of risk spreading. A sliding group-contribution scale, with higher discounts as the group grows in size, could create further incentives for enrolment. It has also been suggested that many groups of workers in the informal sector can indeed be subject to mandatory enrolment. For example, drivers of motorized tricycle taxis must licence their vehicles annually. One measure being considered for this occupational group is to make issue of the taxi license conditional upon payment of the PhilHealth membership contribution.

The challenge remains. Whilst the Philippines have made great advances in expanding their national health insurance scheme, the goal of enabling all segments of the population to access appropriate health care by 2010 will be a sizeable challenge. In view of this, the GTZ is committed to offering long-term assistance to the Philippine project within the framework of German development cooperation.

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In essence, the POGI partner organizations act as PhilHealth agents, reaching out to underserved communities. Their main task is to recruit more PhilHealth members from the informal sector. Depending upon their organizational and financial management capacities, POGI partner organizations – often village cooperatives – are assigned to categories A, B or C after PhilHealth accreditation. PhilHealth will delegate greater responsibility to a Category A than to a Category C cooperative. The tasks expected of partner organizations may range from basic marketing measures to full responsibility for collecting contributions.
Begum is 40 years old. She and her husband are farmers, and have taken a lease on a piece of land. Other than this she owns a cow, whose milk earns her one euro a day. When her husband had an accident, he needed hospital treatment, which cost 600 euros. On top of that came transport costs of 120 euros. But the injuries were extremely serious, and Begum's husband died in hospital. To meet the costs of the treatment herself, Begum would have needed to cash in all her savings and borrow heavily. But fortunately, the couple had taken out a health and surviving dependants' insurance policy in her husband’s name, for a small annual contribution (3.20 euros). The insurance fund reimbursed half of the hospital expenses and even a share of the transport costs. Also, after her husband died she received a payment of...
1,300 euros, which she will be able to live on in the short term. According to custom, she is not allowed to leave the house for 40 days after the death of her husband, so she will be unable to earn an income. Without insurance, she says, she would have been finished.

Relatively few Indians are protected against high health care expenses like Begum’s family. A quarter of people admitted to hospital descend into poverty as a result of the associated costs. Admittedly, the Indian government is endeavouring to provide low-cost health care in public facilities, particularly for the benefit of the poor. But state hospitals do not have a good reputation. Waiting times are long and frequently the medical equipment needed for essential treatment and diagnosis is not available.

**Still in its infancy.** In the Indian health sector, over 80 percent of expenditure is borne by private households. Yet, despite the vast need, the health insurance market is still in its infancy. Even among the wealthier sections of the population, it is not that common to have health insurance; people from poorer classes are unlikely even to have heard of it. Up to the end of the 1990s, the Indian government’s strict regulatory policies severely limited the range of products the state insurance companies could offer. This meant that low earners could not obtain appropriate insurance cover. Today, the government’s declared aim is to extend social protection to the very poorest population groups. It is using regulatory requirements and programmes in an attempt to steer the insurance industry towards the development of appropriate insurance products. In spite of this, the choice of products aimed at poorer social classes is only improving slowly. The reason is simple: poor people carry a high risk of illness. And given the limited amounts they can afford to pay, it is also difficult to develop appropriate products that are financially acceptable to all parties involved. Another factor is that insurance company staff do not come into contact with these population groups.

One possible way of tackling this problem is to work with organizations that already have links with low income communities. For example, non-governmental organizations (NGOs), hospitals or religious congregations, which have a long tradition of working directly with these people in other areas of life. Some of these organizations are even developing their own insurance products for the poor. While this makes great demands on their management and entails risks to their long-term financial stability, it gives those insured more opportunity to contribute to decision-making. Other organizations are looking to cooperate with the insurance industry as a means of arranging cover for poor population groups against the most important risks. One of these initiatives is BAIF, the Bharatiya Agro Industries Foundation.

BAIF was founded in 1967 with the aim of improving living conditions for small farmers, strengthening the position of women in society and pressing for better health care. Most of the BAIF projects are based on self-help groups, in which 20 people come together for a purpose. Building on this structure, which had been in place for many years, BAIF began to introduce a health insurance scheme in a number of agricultural villages outside Pune (a city of several million people). Here, the BAIF groups are made up entirely of women. They meet once a month to exchange news and views, and to invest their collective savings. Membership of the group also gives them access to small bank loans, which they would be denied as individuals.

**School fees for children.** Since the BAIF staff have close links with the self-help groups, borne of years spent working with them in the locality, they enjoy a high level of trust. Like BAIF health expert, Dr Shrikant Khadilkar. During the group meetings, the women feel able to tell him what they need and expect from a health insurance scheme. For example, what matters to them is that the insurance should cover most, if not all, of the costs of hospital treatment, including maternity services. There have also been requests for a life insurance scheme.

Dr Khadilkar eventually negotiates with various insurance companies on the women’s behalf to find an acceptable product, consisting of a number of different components: hospital costs up to the equivalent of 90 euros will be reimbursed; this amounts to around one-and-a-half times a family’s average monthly income for the target group. In the event of death or disablement, the insured receive between 360 and 900 euros. In addition, the state subsidizes their children’s school fees, while BAIF arranges an annual health check-up and a 50 percent discount at its own natural healing centre. The whole package costs the women 4.50 euros a year. Not all of them can afford this, but many can.

The project has now been running for a year. Representatives from the self-help groups form an insurance scheme committee which meets with Dr Khadilkar once a month. Here they review the doctors’ bills that have been submitted, check them for completeness, and then take the documentation to the insurance company’s office some 20 kilometres away. They also discuss suggestions for improvement and make decisions on organizational changes.

**In India, over 80 percent of health care costs are borne by private households. Why?**

Because health insurance is not widely available, even to wealthier sections of the population – among the poor, it is virtually unheard of.
The women on the committee are also responsible for collecting the annual contributions from their neighbours and friends. So, the project not only protects the women against financial hardship, at the same time it trains them to deal with bureaucracy and the authorities, opening up new dimensions of opportunity.

Meanwhile, the Indian government is following such initiatives with great interest. It has recognized the necessity for people in the informal sector to have social protection, and is promoting activities in this area. For example, the government’s Insurance Regulatory and Development Authority (IRDA) checks that insurance companies are complying with the requirement to conduct 15 percent of their business in rural areas, and that they are taking social criteria into account.

Meanwhile, various non-governmental organizations are putting themselves forward as an interface between their clientele and the insurance industry. But not everyone is moving into this new territory as systematically as SHEPHERD. Together with the United India Insurance Company (UIIC), it has developed a benefits package for the poor and for low-income groups. As well as health insurance, the package also includes cover for property and surviving dependants. Potential customers were brought in and consulted during the product development phase. As a result, the structure that evolved for subsequent work was democratic in style and completely new.

A joint insurance committee, consisting of representatives of UIIC, SHEPHERD and the insured clients, makes the strategic decisions. It meets every two months in an effort to settle claims efficiently and to expand its insurance operation in a professional manner to the entire Indian market, as it has been authorized to do since March 2003 by the insurance regulator.

A similar arrangement whereby NGOs and the German company Allianz Versicherungs-AG cooperate to offer micro-insurance products was made possible through German development cooperation. Working on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ), the GTZ has developed the Indian NGOs’ capacities to such an extent that the insurance companies are able to accept them as partners.

This looks to be a promising method of supporting micro-insurance schemes. It has led to the planning of further training programmes for NGOs and the insurance industry, under a cooperation agreement between the International Labour Organization (ILO) and the GTZ. International organizations, too, see the potential for reducing the impact of high health care costs on individuals. Small regular payments rather than larger one-off sums give even people on low incomes the security to plan ahead and the chance to escape poverty. In the process, they also protect their most valuable asset: their own health.

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**Microinsurance**

Microinsurance is a form of health, life or property insurance, which offers limited protection at a low contribution (hence “micro”). It is aimed at poor sections of the population and designed to help them cover themselves collectively against risks (hence “insurance”). Normally, microinsurance schemes are linked to associations (besides non-governmental organizations for instance trade unions, religious congregations and hospitals), whose main area of work puts them in direct contact with the target groups. They may, but must not necessarily, act as the insurance provider: in many cases, they have transferred the risks of the insurance business to a professional insurer. An international microinsurance working group has been formed to analyse and improve upon the potential of this system, and the GTZ is one of its members.
Workable new ways out of poverty

An ambitious goal: the Vietnamese government wants social insurance to cover all population groups within the next few years. What contribution can be made by social organizations?

By Hans Gsänger and Bettina Nellen

Just a fledgling: social insurance in Vietnam only took off in 1995, when the government introduced an extended social protection programme (Vietnam Social Security). This helps to maintain living standards and prevent the descent into poverty during old age and illness. Up until now, the main groups to benefit from this provision have been workers in the formal sector; in other words, civil servants and private sector employees. That is now set to change. By 2006, the Vietnamese government would like to see half of the Vietnamese population covered by a social protection system.

Until now, the only social safety net for people in the informal sector has been their families. Around 80 percent of the population live in rural areas and earn their living from agriculture and forestry, from fishing or as independent small traders. Most are so poor that they cannot afford the contributions for health insurance, let alone make provision for old age. The state does provide certain forms of assistance, including a health card which guarantees free access to health care for the poor, micro-credit programmes, free education for children from poor families, and training measures for farmers. But these measures tend to reach only a small section of the population.

For civil servants and private-sector employees, health insurance is compulsory. In contrast, it may be taken out voluntarily by people in the informal sector. As of January 2003, however, only five percent of them had joined the voluntary health insurance scheme. Most of them find it just too expensive. Yet, so far, contributions are still calculated without factoring in rising costs. And when people claim for the costs of medical treatment, substantial co-payments are inevitable.

The per capita costs of health care are around 150,000 Vietnamese dong (7.50 euros) per year. A doctor’s visit can cost more than five euros including medications (which represent 20 percent of the cost of treatment). Patients are frequently forced to borrow money or sell livestock in order to afford the co-insurance.

Strong partners on board. Since take-up of the voluntary health insurance scheme has been very tentative so far, one possibility might be to develop products tailored to poorer population groups, channelled through local insurance schemes. A national government policy supported by social organizations such as trade unions (Women’s and Farmers’ Unions) or non-governmental organizations appears to be a promising approach. Somehow it needs to bring home to the poor the notion of health insurance, and offer affordable benefits. The Vietnamese Women’s Organization, for example, offers Vietnamese women membership of a mutual relief fund, which provides small loans and financial assistance in the event of illness or death of a family member. Members pay 200 Vietnamese dong (one euro cent) per week into the fund, and are then entitled to a grant of around 10 euros if they need an operation. Even if, as is often the case, this payment only amounts to ten percent of the full cost of the operation and is only paid once in a lifetime, participation is worthwhile from the recipient’s point of view.

The German Federal Ministry for Economic Cooperation and Development (BMZ) provides support for social protection measures of this kind under its Program of Action 2015 (also see “Glossary” on page 11). For the period 2002 to 2005, the German federal government has set up a special fund to combat poverty. It will help support Vietnamese initiatives to increase social protection for poor and disadvantaged groups. In the course of this work, the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) is conducting an analysis of existing social protection systems, and drawing up proposals as to how these can be brought together on the national level.

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A distinguished gathering: Under the banner of “Health Sector Reform for Social Change”, around 100 development experts met in New Delhi in the spring of 2004 for the eighth Asian Regional Conference of the GTZ Health Sector Network Meeting. Experts from the Philippines, Indonesia, Cambodia, Pakistan, India, the Yemen and Germany met in workshops to discuss the topics of health and young people, employment, urban development, the environment, macroeconomics and poverty reduction, from a development policy viewpoint. The participants were able to extend their knowledge and see certain things from alternative perspectives.

The “Fair Financing/Health Insurance” working group adopted a joint strategy for dissemination on the issue of social health insurance in Asia, entitled “Intelligent networking, better exchange of information and experience.” The working group was a meeting place for experts from various bilateral projects who are engaged in health sector reform in their respective partner countries. Their discussions centred on three main questions: How can entrepreneurial practices be promoted in the health care sector? What decentralization strategies are successful, and under what conditions? How can the strengths of socially equitable systems best be incorporated into policy?

In the search for answers, there was no question of seeking patent remedies. Everyone agreed that the different conditions prevailing in each country ruled out ready-made solutions. Nevertheless, the exchange of experience is important because it helps people to set aside entrenched points of view from their own work context, and to take new ideas on board.

Cambodia is one of the poorest countries in Southeast Asia. To date, its 13.7 million people have not fully recovered from the fall-out of the civil war, which went on for over 20 years. This is particularly noticeable in the health care sector. With average monthly income the equivalent of 100 euros, it is not surprising that the population makes little use of health care facilities. Moreover, the clinics and hospitals charge high prices for what is frequently sub-standard care.

One consequence of the systematic elimination of academics under Pol Pot is that today it remains difficult to find competent medical and administrative personnel. The establishment of a health service in Cambodia only really began in the mid-1990s.

In the context of German development cooperation, the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) is working with the German Development Service (DED) and the “Centrum für Internationale Migration und Entwicklung” (CIM) to support the setting up of a health insurance system in Cambodia. The experts advise selected institutions at various levels of the health care sector, as well as political decision-makers. The main priorities are the introduction of quality standards on a sustainable basis and the training of health care staff.

Once a pilot health insurance scheme is up and running successfully, the aim is to transfer it to the rest of the country as quickly as possible with financial assistance from other international donors. The pilot regions are the provinces of Kampong Thom and Kampot, each with 600,000 inhabitants. Support will extend over a ten-year period.
China’s new ten-year programme on poverty alleviation was announced in the year 2001. The measures planned include producing development plans for particularly backward villages. The government Poverty Alleviation and Development Offices (PADO) are responsible for financial and technical aspects of local implementation. The Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) is under contract to the German Federal Ministry for Economic Co-operation and Development (BMZ) to provide ongoing support for the Chinese poverty alleviation programme in Jiangxi province (approx. 41.1 million inhabitants).

There has been a German-Chinese project office in Nanchang since July 2003. European development experts here are supporting Chinese professionals from the Jiangxi province PADO office in developing and implementing a participatory system for the continuous monitoring of poverty. With this system, it will be possible to analyse the effects of measures carried out under the poverty alleviation programme, with the participation of the people affected. So far, 1,200 villages in the province have been nominated, and each will receive around 66,000 euros for poverty alleviating measures.

Through the monitoring system, the village authorities and PADO will obtain vital information to enable maximally effective use of the money. Plans for setting up the monitoring system have already been produced, and are now being implemented in stages.

To accompany this work, targeted training is being provided to staff on the poverty alleviation programme. If the approach works well, the aim is to transfer the experience gained to nationwide poverty alleviation programmes.

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**INDONESIA**

**Unifying vision**

Another step closer to its goal, the Indonesian government is working on the introduction of a national health insurance scheme to cover the whole of the island nation.

Currently a mere 15 percent of Indonesia’s 216 million inhabitants are members of one of the four state health insurance schemes. One in seven Indonesians have to cover their own medical expenses in the event of illness. But that is about to change. Draft legislation contains plans for merging the four existing health insurance funds within the next ten years. The resulting public-benefit insurance organisation will serve all sections of the population.

The first step will be to introduce compulsory insurance for everyone in formal employment. Both employers and employees will pay insurance contributions, set at six percent of earnings. In the course of time, the strategic reorientation will make it possible to take the next step: broadening the package of benefits for people with insurance. In addition, it will enable the 20 percent of Indonesians officially classified as poor to be integrated into the future insurance system.

German development cooperation is mounting a new project in support of the Indonesian government’s programme of reform. Over a period of ten years (January 2004 to December 2013) it will provide legal, organizational and economic advisory services. Furthermore, it will provide in-depth support for development in two pilot regions on the island of Java. The practical experience gained will guide the successive extension of the new health insurance system to other regions.
The “World Health Report 2003” puts strong emphasis on effective and equitable health care systems in developing countries. What are the major health policy shifts needed in order to deliver adequate health services to the poor?

One of the first and most important health policy shifts is to integrate health systems more centrally into the health development agenda. At the moment we are focused on specific disease, or age-group specific challenges, such as HIV, tuberculosis, malaria, and maternal child health. These are critical priorities but experience is revealing that they are constrained by a common set of health systems issues. Looking back on the last twenty to thirty years of development assistance in many countries the public sector provisioning of services has at best remained the same and in many cases even deteriorated. Therefore, a lot of these disease programmes lack the platforms they require to deliver services. First, financing systems are neither promoting access to care nor protecting people from impoverishing out-of-pocket expenditures. Far too many people lack access to health services as long as this access depends on what they can pay out-of-pocket. Second, health facilities often don’t have the staff needed, or the staff is present only part of the time. Third, policy and evaluation are still not guided by evidence, because information systems aren’t being developed. These “systems” issues have to be put much more centrally on the health development agenda.

Despite the efforts of international organizations and donors the majority of health insurance schemes in developing countries reaches only a fraction of the population. The key to improvement, according to WHO Assistant Director-General Dr Tim Evans, are solid financing systems.

“Too many people lack access to health services”
of a given country. The major international financial institutions have developed financing frameworks that follow certain models and assumptions that haven’t been tested sufficiently according to the health needs. These financing frameworks are traditionally tied to growth and GDP [gross domestic product]. But many African countries have had declining GDPs over the last 15 years and as such the public health sector has been shrinking. Of even greater concern is the fact that the burden of disease in Africa has been growing enormously over this same period.

**What could be the way out of this dilemma?**

First we must acknowledge the considerable financing gap between what the health system needs and what it has currently. If delivering an essential package of interventions to the population of a country requires expenditure of 40 US dollars per capita then it doesn’t make sense to spend only 4 US dollars. This gap needs to be bridged by significantly increased donor commitments in the short-term and in the long-term the development of equitable and sustainable financing mechanisms. We need to invest in the development of such mechanisms now as they require years to develop effectively.

The “3 by 5” initiative—getting three million people on antiretroviral therapy by the end of 2005—aims at scaling up measures to fight HIV/AIDS. What do you think of the idea of making better use of GFATM (Global Fund to Fight AIDS, Tuberculosis and Malaria) resources by channelling those funds into social health insurance?

The idea is worth exploring. The challenge is that in many countries where the GFATM is providing support for HIV therapy, there are no comprehensive insurance systems at this time. It would be wise for the GFATM to encourage the rapid development of social health insurance or other insurance mechanism for several reasons. HIV treatment is lifelong and represents an expense that very few people are able to afford—especially those living on less than a dollar a day. The GFATM will not last forever and countries will be expected to take on the financing of HIV and other health care expenditures in the future. Social health insurance is both an equitable and an efficient way of ensuring long-term access to care and minimizing the likelihood of impoverishment due to individual out-of-pocket expenditure on health care.

**What is needed to build up a health insurance scheme that contributes to the “3 by 5 initiative” and to stemming the spread of infectious diseases?**

The sooner there is a policy shift towards strengthening countries’ financing systems inclusive of social health insurance within the context of the Global Fund, the greater the likelihood for a solid base on which the health care system is financed. If there is no investment in social health insurance systems now, then there will be no sustained financing once the global fund disappears. So first, we have to put this topic on the agenda. Second, we have to look at the kinds of skills that are required to build insurance systems. Just because we understand infectious diseases doesn’t mean we understand how to strengthen health insurance systems. We have to think about how to provide effective policy and technical advice to governments that would foster the rapid emergence of reliable insurance systems.

**What kind of expertise is needed?**

I think we need to look for public sector or health economists. And these experts need to be engaged in-country. It is not sufficient to fly in and provide a report. The expertise is needed within the country on an ongoing basis 24 hours a day, 7 days a week, 365 days a year. Not only can we make recommendations then, but we can follow them up and solve emerging problems. In addition, there are lots of problems that arrive when you try to get an insurance system up and operating or improve on existing mechanisms. Expertise is needed to, first determine what interventions or services are covered by insurance, second advise how the insurance system will operate in terms of sources of revenue and mechanisms for disbursements, and third monitor the performance of the insurance system. These sorts of skills are not a given in the health sector: doctors who understand how to treat AIDS are unlikely to understand what is required to design and implement an insurance system.

Donors and technical agencies have been working increasingly together to achieve the Health and Millennium Development Goals. GTZ, for instance, has been supporting social health insurance systems for a long
Interview

time. What do you expect from a bilateral technical agency as collaboration partner of WHO?

GTZ’s work on social health insurance has been really impressive. GTZ has taken on this challenge in an era of vertical disease efforts. The trend would have been to support the fight against AIDS or malaria. GTZ is doing that as well, but at the same time they understand the imperative of developing a critical platform upon which equitable access to care now and into the future is dependent. They invest in the development of social health insurance systems while linking up to aids, tuberculosis and malaria programmes. That attitude is not the flavour of the month.

To work on health insurance at a time when it’s not very much in the media is a reflection of good leadership.

Second, it is the way of being engaged. GTZ is raising the flag, saying yes we are interested in this topic, and we are willing to work with the multilateral partners. This is important, because at the moment health development at country level is a very chaotic market place with a tremendous number of initiatives going left and right: disease programmes, global funds, immunization initiatives, and if you multiply that across every bilateral cooperation then it becomes an unsupportable number of transaction costs for ministers of health or people who are actually trying to get work done. The multilateral mechanism is there for a reason: to give the best consistent technical advice to countries. If more bilaterals were to support multilateral leadership at country level, we could strengthen the quality and quantity of technical advice and deliver it more effectively to governments.

Are there other examples of good bilateral cooperation with regard to health system development?

We are moving in that direction. In the area of health information systems, for example, there is growing recognition that the absence of coordination amongst bilateral and other technical agencies is extremely expensive and inefficient. In this era of Millennium Development Goals (MDGs), all development partners require reports that measure progress towards development targets and indicators, for example decline in child mortality or increase in access to immunization. The rush to monitor these outcomes has created a mushrooming of independent initiatives in countries, many of which are trying to measure the same thing and imposing inordinate and unreasonable demands on over-worked health personnel. Partners, under an initiative called the Health Metrics Network, are now beginning to align their monitoring demands to reduce these inefficiencies and strengthen country health information systems for more effective health action.

Why is the cooperation between WHO and GTZ so important, especially on technical assistance on the country level?

It sends a very positive signal to the broader community and that signal goes two ways. One is that GTZ is giving a vote of confidence to WHO. That is important in the broader community where people might see WHO not able to deliver at country level. Therefore, we have a very credible technical assistance effort that is coming through the country and the WHO offices. Although there has been a good relationship between countries, regions and headquarters in Geneva the country offices will be increasingly independent of headquarters. This is important, because it proves that the country office can deliver when it is supported. And it’s also important for the government who understands that there’s no need to respond to six different groups that are saying: “Well, this is the way you should do this.”

What should be the answer of the global health community to the various challenges we face and the growing health inequalities in the world?

First of all, we have to recognize the inequalities and health crisis such as HIV/AIDS and look into what is required by the affected people. We then need sustained investment to overcome these burdens put on people. However, it is as important to address health systems issues, health information requirements and much needed professional human resources for health. It is especially important to invest in health systems issues at the same time as the disease-specific programmes are pursued. GTZ seems to understand the imperative of co-investing in the strengthening of health systems and priority diseases: hopefully this thinking is highly contagious amongst other development partners.
German bilateral development cooperation (DC) operates in a multi-level context of project partners, donors, international organizations and multilateral institutions. In practice, the efforts of numerous actors frequently overlap. If they all work towards a common goal, international DC becomes more effective and worthwhile.

With this in mind, the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) launched the “International Cooperation and Programmes” (ICP) initiative. Its mission is to provide colleagues at the GTZ and their network partners with tools for initiating and improving cooperation arrangements. International cooperation should be understood as a permanent component of DC, and used accordingly. ICP has developed and tested practical approaches for cooperation with multilateral and bilateral organizations and programmes, exemplified in particular thematic contexts. One of these strategic themes is “Social Health Insurance”.

The benefits of German DC’s international cooperation links are evident: partners can learn from one another by seeing how other organizations work, what approaches they follow, and how they achieve their goals. Multilateral organizations, such as the European Union, the World Bank or the World Health Organization, have a substantial influence on the international agenda. Cooperation links are thus a means for German DC to present its position on strategic issues with a higher international profile. Projects and programmes of partner countries are more effective when their objectives and activities are internationally coordinated. And the better the reputation of German DC for performance and competence, the greater the demand for its services, and the more it can contribute to in-country development initiatives and international conventions and treaties.

In recent years, the GTZ has increasingly networked with national and international partners on the issue of social health insurance, and will link up with more partners in future. As a result of the trust built up over time, advisory missions such as the ones in Kenya (see also the article “A national act of courage” on pages 16 to 18) always take place in the name of all organizations involved, without the need for each one to send an expert on every occasion. The collaborative approach has enabled not only the Sector Project “Social Health Insurance” but all the participating organizations to learn a great deal, and benefit from one another’s experience. The partner countries have received better advice as a result. Our cooperation is based on values like solidarity, equal opportunities and access to social services, which are also the underlying values of the United Nations and its special programmes. Now the challenge is to transfer these values to the international health sector, and to highlight the crucial role of health insurance schemes financed on the basis of solidarity.

Ole Doetinchem is Project Manager for the Sector Project “Social Health Insurance” and also works for the GTZ “International Cooperation and Programmes” (ICP) initiative.

**News Flash**

At the instigation of the GTZ, the Federal Republic of Germany placed the topic of Social Health Insurance on the agenda for the Executive Board of the World Health Organization (WHO) in May 2004. Germany wanted the most important global steering body for international health policy to clarify what priority its member countries place on the social aspects of health insurance. Social health insurance, it was unanimously agreed, is one of the most important instruments for achieving the Millennium Development Goals (see “Glossary” on page 11). The member states particularly emphasized the values of solidarity, equal opportunities and universal access to health services. However, in order to set up social health insurance systems appropriate to local cultural circumstances, the majority of countries need competent specialist support. In this respect, Germany has pioneering experience to offer. Consequently, the GTZ was invited to work with the WHO and the International Labour Organization (ILO) to found a consortium, which will provide such specialist support. At the same time, the Executive Board of the WHO called for greater attention to the issue in future.
InWEnt – Capacity Building International, Germany

Advanced skills for specialists

International training and development is the core business of InWEnt gGmbH – Capacity Building International, Germany, the leading German organization for human resources development, advanced training and dialogue. It was created in 2002 by merging the Carl Duisberg Gesellschaft e.V. (CDG) with the German Foundation for International Development (Deutsche Stiftung für internationale Entwicklung, DSE). Thus, it builds on many decades of experience in international cooperation. InWEnt’s international training and dialogue programmes are aimed at executives, specialists and decision-makers from the spheres of business, politics, administration and civil society all over the world. Every year, 35,000 people take part in InWEnt programmes. Participants are drawn from developing countries, from Germany and other industrialized nations, and from Eastern Europe.

On health themes, InWEnt offers a range of advanced training programmes for partner countries. Along with personnel development in the health care sector, reproductive health (maternity care), and HIV/AIDS, the InWEnt health experts have made health sector reform and financing of public health a priority for years. Back in 1997, for instance, InWEnt’s predecessor organization DSE supported the reform of health care financing in Kyrgyzstan.

In parallel with the introduction of a statutory health insurance scheme, following independence, it supported local health insurance experts by staging special dialogue events and training courses. This grew into a successful cooperation between InWEnt, the GTZ Sector Project “Social Health Insurance” and the AOK, Germany’s largest statutory health insurance fund.

The German health insurance sector took a leading role in the “Health Insurance Development” seminar series, which InWEnt held in the late 1990s in close cooperation with the GTZ and is currently reworking. With a remit “To strengthen the capacity of participants to develop and implement (social) health insurance schemes adapted to their country context”, the seminars build the competence that participants need in order to develop and introduce health insurance systems. There is a growing demand for information and training courses on the theme of health insurance in many developing countries. Joint training courses are being planned by InWEnt, the GTZ and the AOK, which will be geared towards a country’s specific needs.

In addition, InWEnt is pioneering innovative training methods. With its own online platform GLOBAL CAMPUS 21 (www.gc21.de), it is making an important contribution to the design and implementation of e-learning courses.

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KfW Development Bank

Vouchers for health care

As the German development bank, the Kreditanstalt für Wiederaufbau (KfW) provides loans and grants to assist projects in developing countries, thus supporting their economic and social development. The core activity of the KfW Entwicklungsbank (KfW development bank) is financial cooperation. Currently, its main objective in the field of social protection is employment programmes. Health insurance projects are planned for Georgia, Uganda (microinsurance schemes), and South Africa (insurance for people with HIV).

Furthermore, the KfW Entwicklungsbank is conducting preliminary studies in Kenya. Within its technical cooperation programme, Germany is already supporting the establishment of a National Social Health Insurance Fund for the whole of the Kenyan population (see also the articles “Health care for all” on pages 12 ff. and “A national act of courage” on pages 16 ff.).

KfW is also applying its “output-based” approach to the financing of medical services in Kenya, Uganda and Mali. This approach aims to strengthen the involvement of the private health care sector, side by side with public sector provision of medical services. The strategy of output based aid (OBA) is to give financial support for the diagnosis and treatment of particular illnesses by public and private sector health care providers. The system revolves around vouchers which patients can buy at a subsidized price. Once treatment has been provided, the voucher can be used to settle the account for the cost of medications and the doctor’s fee.

By selling the vouchers through selected outlets, for example in youth clubs or through midwives, people who would not otherwise be reached by public health care institutions can benefit from them. This might apply to young people, or women who are afraid of discrimination. Working people who find it impossible to obtain treatment because state health centres have limited opening hours can also use the vouchers to be treated privately. One benefit of the OBA voucher system is that the involvement of private providers makes services more accessible, and overall service quality improves. It would be quite possible to convert the OBA approach into a functional insurance model.

The KfW Entwicklungsbank is striving to do more in the field of social protection. This will be an important contribution to poverty reduction and to achieving the Millennium Development Goals (see “Glossary” on page 11).

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The think-tank of German development policy is how the German Development Institute (GDI) likes to be known. It supports German development cooperation with research, advisory work and training. Its joint owners, the Federal Republic of Germany and the Land of North Rhine-Westphalia have contractually guaranteed the academic independence of the Institute.

Recent studies by the GDI have analysed poverty in the Arab world. They came to the unexpected conclusion that despite the relative economic prosperity of this region, poverty is widespread. One reason is the inadequacy of social protection for people in the informal sector. Several wealthier countries have improved the situation of this heterogeneous population group with free-of-charge public health care facilities. In particular, Libya and several Gulf states have managed to provide reliable health care even for the rural population. Other Arab states, like Algeria, Tunisia, Egypt, Bahrain and Kuwait, despite considerable efforts and generous subsidies, have not succeeded in extending their social protection systems to more than half of those in informal employment. In Tunisia and Algeria, welfare, social credit and job creation programmes benefit just a quarter of those living in poverty. At the same time, traditional and informal modes of social protection in the Arab world – for example, mutual support among relatives and neighbours – have dwindled in significance and reliability.

A general reluctance on the part of governments to tackle reform means that the Arab world trails behind other regions of the world on social policy. So new ideas are needed for development cooperation in the field of social protection. One possible approach appears to be the promotion of microinsurance systems. With their distinctively low contributions, limited benefits and flexible contractual conditions, they are appropriate to meet the needs of those in informal employment. Microinsurance companies should form alliances with financial institutions, non-governmental organizations and self-help groups in order to pool the necessary financial and management know-how. So far, very few structures of this kind have been set up in the Arab world. The Sector Project “Social Health Insurance” and its partner organizations – in this connection, primarily the International Labour Organization (ILO) – have vast experience with local insurance schemes. This should be contributed to a joint effort to support Arab partner countries in setting up appropriate systems for social protection.

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The Church Development Service (EED)

 Contributions payable after harvest

The newly established Church Development Service (Evangelischer Entwicklungsdienst, EED) was formed in 1999 as an Association of the Protestant Churches in Germany from four previously independent church development agencies. It supports church organizations and private agencies in developing countries. Its work in Cameroon is one example: at the end of 2002, with assistance from the EED, the first village health insurance funds grew out of local initiatives.

Although Cameroon has all manner of local and informal associations in the form of savings associations, solidarity-based cooperatives and women’s organizations, self-organized insurance schemes failed to become widely established for a long time. The impetus for setting up health microinsurance schemes came from advisory work done with farmers’ organizations by a Cameroonian non-governmental organization, SAILD (Service d’Appui aux Initiatives Locales de Développement). SAILD is a partner organization of the Church Development Service. In the course of this advisory programme, SAILD made the wise move of choosing the farmers’ self-help organizations as core cells for its advisory work. These tend to gather clusters of other local initiatives around them, enabling outreach to additional groups in the village community.

Even today, SAILD continues to promote the establishment and operation of self-organized health insurance schemes. It receives EED support through the German Program of Action 2015 for poverty reduction. The non-governmental organization is currently assisting a total of six community-based schemes from its own resources, and ten more in cooperation with the GTZ and the European Union. A programme to finance 26 additional community-based health insurance funds is in its pilot phase. It has proved helpful for new health insurance funds to link up with existing cooperative institutions. In Cameroon, these largely consist of the rural savings and lending banks, which SAILD also supports. For one thing, contributions for the health insurance fund now come directly out of these cooperative funds: savers are not just able, but required, to pay a proportion of what they save directly into the health insurance fund by standing order. And secondly, the farmers’ organizations pay their members’ insurance contributions for the whole year – but only after the harvest, when their coffers are full.

In the meantime, the self-organized health insurance funds have become a model for the emerging state health insurance system in Cameroon. Admittedly, benefits under the national scheme are primarily available to regular employees. But at the same time, the social insurance fund, through the existing microinsurance schemes, should guarantee that everyone not employed in the formal sector still has access to a minimum package of health benefits.

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Resources

Further Reading


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Infoletter on social health insurance

The Sector Project “Elaboration and Introduction of Social Health Insurance Systems in Developing Countries” publishes a six-monthly newsletter, the Infoletter. It keeps readers up to date with current activities and the latest findings on social health insurance in Africa, Asia and Latin America. The Infoletter is produced in four languages and can be ordered by e-mail from health-insurance@gtz.de or downloaded from www.gtz.de/health-insurance.

Online links

The GTZ cooperates with the following organizations in the field of social health insurance:

● Federal Ministry for Economic Cooperation and Development, Germany (www.bmz.de/en)
● The Federal Association of the AOK, Germany (www.aok-bv.de/theaok)
● Alliance Nationale des Mutualités Chrétiennes, Belgium (www.mc.be), in French
● Association Internationale de la Mutualité, Belgium (www.aim-mutualite.org)
● World Health Organization (www.who.int)
● International Labour Organization (www.ilo.org)
● World Bank (www.worldbank.org)
● Asian Development Bank (www.adb.org)
● European Union (www.europa.eu.int)

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Priority themes of German development cooperation in the field of social protection

Social health insurance

The supraregional sector project on “Elaboration and Introduction of Social Health Insurance Systems in Developing Countries” enables partner countries in Africa, Asia and Latin America to establish and organize health care systems financed on the basis of solidarity. The focus is on people in the informal sector, who are generally excluded from social protection systems. However, these people are exposed to the highest risks of ill health and poverty by their low incomes and their living conditions. Health insurance systems are therefore a key component of poverty reduction. The services of the sector project include policy advisory work, planning support, feasibility studies, assisting with the introduction and reform of social protection systems, building management capacity, and evaluating health insurance schemes.

Basic social protection

In the context of German development cooperation, the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) has been providing advisory input on the design of basic social protection systems. The target groups of this advisory work are the poorest of the poor, who are practically beyond the reach of self-help promotion. Support is particularly focused on older people, people with disabilities, and families affected by HIV/AIDS. The programmes are a contribution to protecting people’s livelihoods and safeguarding children’s opportunities to develop.

PSIA – Poverty and Social Impact Analysis

What socio-economic impacts might result from a planned structural reform? What can be done to increase the positive consequences of such reforms for disadvantaged groups in society? What can be done to limit the negative effects? What compensation measures need to be introduced? These policy impact assessment questions can be clarified by development experts ahead of any reform, using the approach and instruments of the PSIA method (Poverty and Social Impact Analysis). Along with the World Bank, the German Federal Ministry for Economic Cooperation and Development (BMZ) is promoting the regular use and ongoing development of PSIA.

Microinsurance

Because there are so many places where people lack proper social protection, local microinsurance schemes are gaining importance in many developing countries. They provide insurance, primarily for poor people and their dependants in the informal sector, against the financial risks of illness and old age. The GTZ works on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ) to support partner countries in developing microinsurance schemes and integrating them into national or regional systems of social protection. Working with international partners, it builds up competence in areas such as risk and financial management, and develops training programmes for the other participating actors.