Health, Education, Social Protection
Systems of Social Protection

Linking up social protection systems in developing countries

Overview of some experiences and approaches

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Executive summary

This paper aims to provide the reader with some examples of linkages between social protection systems in a selection of countries in which GTZ is operating. In the foreword it will be argued why there is a case for introducing social protection in developing countries and how the extension of social protection can be achieved by linking up systems of social protection. While these experiences should serve as encouraging examples, it is stressed that these specific linkages of systems are by no means blueprints which are universally applicable to all of the countries. It is rather a method that has to be conceptualised and operationalised for each country taking its economic, institutional and cultural specificities into account each time. Essentially, the method involves effective and efficient intertwining of governmental (top-down) measures with societal (bottom-up) approaches and strategies.

Some of the models which have been proposed in the search for possible linkages have become widely known since they first emerged. One example is the public-private partnership model of institutional relationships between the state and the private for-profit and/or the private not-for-profit sector, where the different public and private actors jointly participate in defining the objectives, the methods and the implementation of a cooperation agreement. Another – called the partner-agent model – involves cooperation between NGOs and insurance providers to utilise each other's comparative advantages so that every party can focus on its core business and reduce its overhead costs.

After the introductory note, the theoretical notions will be underpinned with some first successful examples and conceptual ideas from a wide range of different countries and topics (mostly relating to health issues). The Philippines experience relates how a plan was set up to reach parts of the informal sector in the Philippines with social health insurance via organised groups and ultimately how the potential was created for a "triple win outcome" for the different actors – the national health insurance scheme, the organised groups and the members. In the case of India, outreach to the poor is achieved via a state-subsidised fund which targets specific occupations prone to earn low income. The Tanzanian section gives information about the CHIC (Centre of Health Insurance Competence) concept, Tanzania being the country in which it was pioneered and introduced. The Paraguayan section depicts the underdeveloped state of the health system and points out some strategies to be initiated in the future. Chile, in principle, has universal coverage using a combination of Bismarckian and Beveridgean health-financing systems. Less satisfactory aspects are the absence of interaction between the private and the public health insurance sector, and thus problems of equity and fairness in health financing and access. In Vietnam the government has set up a comprehensive multi-component system in order to achieve universal coverage of the population, an aim which has been put high on the agenda of policy makers. In comparison with this, Laos as the last country in this sample lags considerably behind in the linking up of its different social security schemes, which are fragmented and isolated from each other.

In a closing section some lessons derived from the country studies will be presented. Despite the variety of countries, it can be shown that some common features are shared in the linking-up process, and that interesting generalisations and recommendation for future implementations can be drawn.

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

1. Introductory foreword

Current debates about social protection do mirror the fact that social protection is increasingly no longer being seen as merely feasible and expedient for industrialised countries. Donors such as the World Bank, the Regional Development Banks, the European Union and international organisations (e.g. ILO, WHO) have turned towards social protection as a tool to eradicate poverty and to achieve the Millennium Development Goals (MDG). The ILO "Coverage for All" campaign is but one of the current attempts to put this issue high on the agenda of governments and policymakers. Even though the goal of the campaign might be considered as an overly ambitious one – at least in the short run –, it definitely has its usefulness as a normative framework and gives a fresh impetus for tackling the challenges of implementing systems of social protection with broad coverage in developing countries. Nonetheless and admittedly: developing countries certainly do have specificities of their own and one has to go beyond traditional practices of social protection concepts as they are being used in industrialised countries in order to meet adequately the specific challenges of developing countries. This search for new concepts involves a good deal of innovative and creative methods.

One such approach recurring in the debate about how to reach coverage for all revolves around the notion of "linkages" of systems. In order to achieve full coverage of the population social protection systems of different origins (public/private) are being linked together. This rationale is being seen as a powerful method in order to expand the social protection in developing countries – meeting the challenges of limited financial resources and being a pro poor approach tackling the dilemmas of vicious poverty cycles at their very root. To give but a few examples: this can be the extension of insurance coverage with public subsidies (e.g. the creation of a social security fund targeting the poor in India) or the inclusion of the informal sector into health insurance schemes by intermediary of organised groups (Philippines).

This paper aims at providing the reader with basic notions about the "linkages" debate. In a first part some reasons for the introduction of social protection in developing countries will be given and some conceptual delineations about social protection and linkages will be made. After this introductory note some first successful examples and conceptual ideas from a wide range of different countries and topics (health, micro-insurance) will underpin the theoretical notions.

1.1 Partial coverage – historically the best approach to establishing social security

A common objection raised when it comes to introducing elements of social security in developing countries is that most of the developing countries have not grown economically mature enough to be able to shoulder the financial burden associated with social security. All efforts should go towards ensuring macro-economic growth first, social security often being associated with consumptive costs only.

However, looking back at the evolution of social protection systems in Europe and the industrialised world in general, one can observe that the emergence and diffusion of social protection systems have not always been linked to high levels of macro-economic growth. In fact, there is no discernible correlation between the levels of industrialisation and the introduction of social security schemes, the late "industrialisers" such as Germany being the first countries to have introduced social insurance schemes to cover workers against social risks. At the time, the rationale was as much socio-political (to guarantee loyalty to the nation and to ensure a stable cohesion) and normative (human dignity being advocated by philosophers) as it was functional (to maintain the workforce within industrial society). Interestingly, in almost all of the countries the start of social insurance schemes was quite similar: workers from core industries were the first to be covered against social risks, the priorities of their needs determining the order in which the schemes appeared: health insurance first, then occupational injury insurance and finally old age insurance. Gradually, this segmentation was overcome and coverage was extended to the rest of the population by including employees' family members of employees. It turned out that social protection was highly popular and resistant to attempts to withdraw it from beneficiaries – "institutional stickiness" prevailed once the schemes were introduced.

The introduction of the concept of social insurance proved to be contagious in a literal way and as one example one might cite the French case: after the territorial reintegration of Alsace-Lorraine into France the Bismarckian schemes were maintained in this region, and drawing on this model the French government introduced such schemes to the rest of the population. However, since initially social insurance was coupled with formal employment, complementary measures such as social assistance schemes were introduced to support the very poor.

To sum up: we can see a pragmatic and incremental development of social protection programmes gradually evolving over time from partial to fully extended coverage of the population.

1.2 The uninsured majority – what makes extension to the whole population so difficult?

According to statistics by the ILO, four out of five people lack basic social security coverage. This makes the campaign "Coverage for all" a huge but tremendously important task. The key problem while striving towards the goal of full coverage with the application of social protection schemes in developing countries is that most people – and particularly those living in poverty – are employed, and mainly self-employed, in the informal sector if working at all. Hence there are substantial difficulties of an organisational and administrative kind to be overcome concerning the (in-)ability to register revenues and to deduct insurance contributions from salary. Another major problem is the lack of financial resources among the poor to enrol in

social insurance schemes. Even though poor people are more exposed to risks (e.g. unhealthy work environments) and more vulnerable to external shocks affecting the economy (no savings aside) they might not be able to contribute to an adequate insurance scheme.

Another source of problems with the extension of social insurance schemes can derive from reluctance of the elites to abandon their private insurance schemes since the very notion of *social* insurances is about vertical redistribution of resources. In addition, the typically lower risks of financially better-off groups are being pooled with the higher risks of the lower socio-economic strata of society. *Financial sharing* and *risk pooling* as two basic dimensions of social protection schemes have their roots in norms of equity and solidarity. Thus, cultural factors such as lack of solidarity within a society might be impeding the emergence of social insurance schemes.

1.3 Poverty alleviation programmes – a new approach to focus on the poor?

Within the last decade there has been a growing consensus based on scientific evidence that the much-advocated instrument of macro-economic growth alone has not been sufficient to vanquish poverty. In fact, in some countries even substantial growth has led only to increasing divisions in society.[1] These empirical findings together with the overarching normative appeal of the MDGs have led donors to divert their focus away from solely changing the macro-economic structures to enhance growth (typically with Structural Adjustment Strategies focusing on free trade and liberalisation of the country's economy) towards specific mechanisms to target the poor and stimulate *pro-poor growth.*

Mechanisms within the markets should be introduced so as to favour the poor – markets should be (re-)calibrated in favour of pro-poor growth. This is a novel approach: according to this new logic conditionality of loans is no longer linked with institutional restructuring alone, but with strategies aimed at bringing relief and security to the poor.

With the adoption of Poverty Reduction Strategy Papers (PRSP) the World Bank (WB) officially placed the fight against poverty at the very centre of its priorities. While most of the analyses in the 1990 WB report departed from a purely monetary concept of poverty, the 2000/2001 WB report conceives of poverty as a much more complex issue with multiple facets. Poverty now encompasses a wide range of dimensions, including consumption, social services, vulnerability, activity, dignity, and autonomy.

This new approach has practical implications: while the concept of social security was alluded to merely perfunctorily in the 1990 report, the 2000/2001 report concerning social security advocates a modular approach based on a whole plethora of instruments, such as insurances, targeted help, (redistributive) cash transfer, social funds, etc.

The WB is not the only major institution to have directed its attention towards poverty and social protection: the same can be said of the Regional Development Banks, the European Union, bilateral donors and the International Monetary Fund (IMF), all of them adopting policies on *social* development. Substantial parts of loans

[1] See World Bank report 2000/2001 (p. 147): "[…] liberalization of the markets […] can have ambivalent effects and will not necessarily be beneficial for the poor."

and grants are being allocated to the establishment of institutions for social protection mechanisms and to ensure pro-poor, i.e. *social* growth.

1.4 What makes *linkages* between existing systems so appealing?

What is meant by *"linkages"? "Linkages"* is a container concept encompassing a whole array of innovative approaches working towards the goal of full coverage for all. Realising that there is a long way to go before full coverage for all is achieved in developing countries (in industrial countries it took decades), linkages between different existing systems can provide (temporary or permanent) mechanisms to gradually enhance social protection for the whole society in its transitional phase. *"Linkages of systems"* is not a blueprint but it is a method that has to be conceptualised and operationalised for each country, specifically taking its economic, institutional and cultural specificities into account.

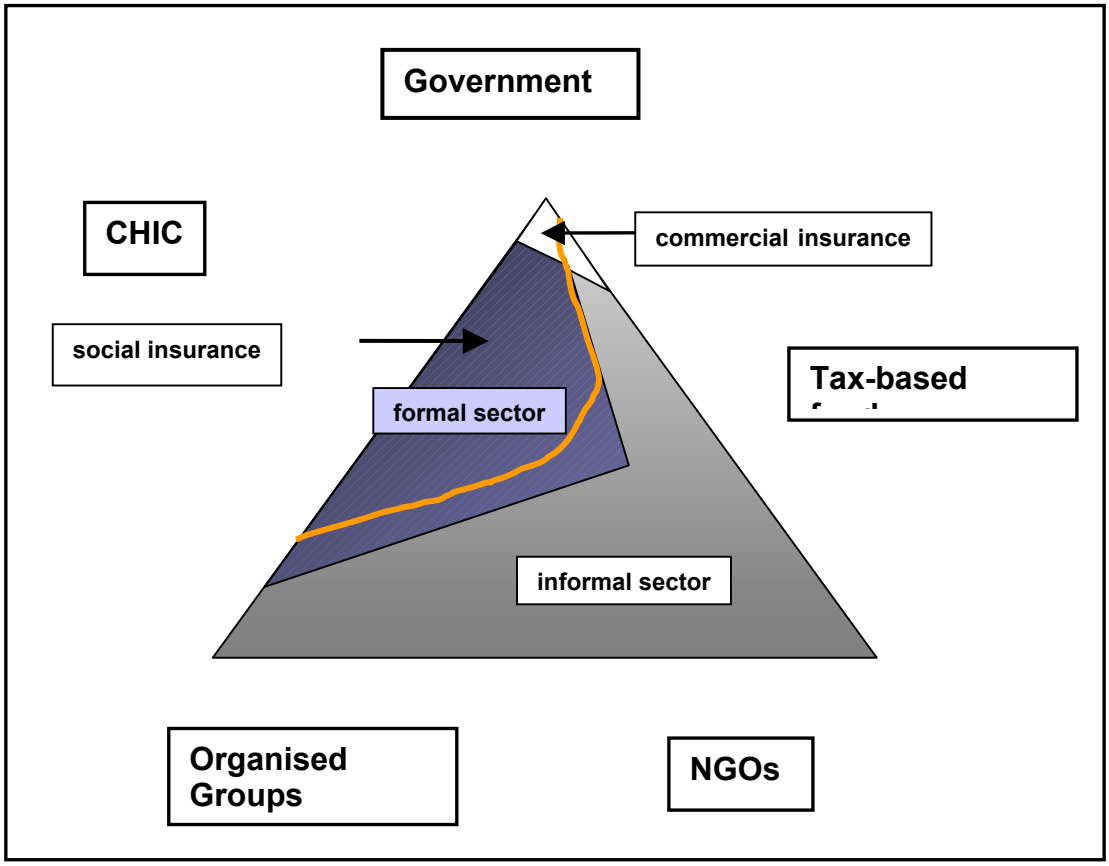
One way of thinking of linkages between systems is to combine different top-down approaches with one another as well as with bottom-up approaches. Top-down approaches aiming at full coverage can be classified either as a) extending social insurance to lower income groups or b) broadening the outreach of social transfers, i.e. tax-based systems (social assistance, public health, free-of-charge services). Of course, multiple interactions and scenarios are possible. A bottom-up view is about supporting groups to manage their members' risks and thus to strive for *empowerment* of the target group – the poor. Here again, there are many examples of how to deal with this.

Of course, systems are never static and evolve dynamically – there are changes both from within the systems as well as external circumstances (for example, the general economic situation). From a longitudinal perspective taking time into account, one can emphasise different mixtures and linkages of systems over the years. For example, one might start with an "output-based approach" health system and move gradually towards including more members in social health insurances. Statutory insurances can be combined with tax-based systems (vouchers and cash transfers).

Figure 1 gives an overview of actors (e.g. government), instruments (e.g. social insurance) and (target) population involved in the linkage approach. The pyramid[2] represents the population stratified by income, i.e. the poor are at the bottom (the darker the grey the poorer). Typically, the rich (at the top in white) are covered by commercial, private insurance against social risks. People in the formal sector (within the thick curved line) are often covered by social insurance, the social insurance extending only slightly to the informal sector. The challenge consists of finding ways of reaching the informal sector and the poor (both categories overlapping to a large extent). Manifold interactions and linkages are conceivable between instruments, not all of which can be shown here (hence no arrows are shown in this figure since many options are possible).

[2] The "pyramid" was developed by M. Loewe, GDI (2001).

Figure 1: Actors, instruments and population involved in the linkages of systems



"Linkages" is also about **public-private partnership** in order to obtain synergies and gains for the poor. Public-private partnerships are institutional relationships between the **state** and the **private for-profit** and/or the **private not for-profit sector**, where the different public and private actors jointly participate in defining the objectives, the methods and the implementation of an agreement of cooperation. There are theoretically sound reasons[3] to expect potential favourable effects from this cooperation and there are positive cases to illustrate the point. As Jütting (2002) notices in a study about health care:

> "Through increasing competition, delegation of power to the local level, the active participation of the concerned population and synergetical (sic) effects positive impacts on the efficiency, equity and quality of health care provision can be observed. Former excluded people have now gained the chance to set up their own systems according to their specific needs and with public support."

Another model – called the *partner-agent model* – is the cooperation of NGOs and insurance providers, utilising each other's comparative advantages so that every party can focus on its core business and reduce its overhead costs. The insurance provider is responsible for designing and pricing the product, the final claims management, investment of reserves, and for absorbing all the insurance risks. Legally recognised insurance companies have adequate reserves, adhere to capital

[3] Public choice theory emphasises that it cannot be assumed that politicians and bureaucrats always act in the public interest, but either pursue their own interests or those of powerful interest groups.

requirements, employ certified insurance professionals and operate under insurance law. The NGO offers its infrastructure for product servicing such as marketing of the product, premium collection, and assisting in claims management. Furthermore, they know the needs of the potential customers and can assess client satisfaction.

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).* 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.

1.5 Linking-up – a strategy with high expectations – who can benefit?

Creating linkages between the systems could benefit all those having a stake in social protection for the poor i.e., the government, civil society in general, the poor, the insurance market, social protection systems and donors. First of all, it will be a powerful tool to enable coverage to reach out to the needy and to create benefits for the target group. Furthermore, with the empowerment of the poor, public institutions will be more accountable and should provide care and benefits of higher quality while maintaining costs. Linkages could drive the creation of an insurance market, being in itself a growth economy, and thus indirectly benefiting the country's economy.

Social security is no longer seen as being a consumptive good only and putting a strain on the economy. Social security, while providing people with a safety net on the one hand, can have a pro-active role on the other hand, enabling them to participate in society and to counter social exclusion. Social security thus contributes to a constant enrichment of human capital and this can yield benefits in terms of gains in productivity and higher macro-economic growth. It is thus macro-economically feasible and affordable and cannot be viewed within the dilemma of an equity-efficiency trade-off. In industrialised countries no correlation between the level of social expenditure and growth can be discerned and even encompassing welfare-regimes such as the Nordic countries in Europe have proven to be viable in times of economic crises. Through the redistribution of resources, social security creates a previously non-existent market and gives an initial boost to the supply side. Via this Keynesian mechanism of stimulating the demand side, social security contributes to sustainable macro-economic growth as well.

Putting the economic benefits aside, social security is also an invaluable investment in the creation of social capital: social policies create adhesion within the population to the nation-state and can increase the social cohesion within a society. Thus, the development of social policies can be of help in developing trust within a society as well as forging a bond between (local) government and society. Social security is able to address the multiple dimensions of poverty simultaneously and to provide poor people with more autonomy and freedom of choice.

1.6 Old wine in new bottles or a real paradigm shift?

Will linkages in social security systems prove to be a powerful tool for reaching out to the poor or will it remain just as unsuccessful as many of the preceding remedies to eradicate poverty? There are two reasons to be more optimistic: firstly, in contrast to earlier declarations, the overarching goals of fighting poverty are firmly implanted, politically and institutionally ,with the declaration of the MDGs, as can be seen from the 2000/2001 World Bank report. This normative framework can foster efforts to direct growth in a pro-poor way. It remains to be seen, however, how far the proclaimed goals will be reflected in operationalised goals and instruments in the PRSPs and Country Assistance Papers. Secondly, the linkages approach departs radically from segmented approaches towards an encompassing approach to change the system and to empower the poor. It thus creates the possibility of a sustainable change within the system itself.

1.7 From strategies to experiences – the search for viable solutions

This study provides some concrete examples of linkages between systems – in different sectors, in different countries and in different ways. In some cases there is already evidence of success and in others the *"linkages"* strategy is just about to be set in this direction. The first example of linkages between systems, from the Philippines, is a firmly rooted success: it illustrates how a triple-win outcome can be reached if members join the national health insurance system PhilHealth via organised groups. The second, from India, describes how the state intervenes with social security funds in order to reach targeted micro-insurance coverage of the poor. The Tanzanian experience will be described, Tanzania having been the first country to adopt the concept of CHIC. Reports will also be included from two countries in South America, Chile and Paraguay, with quite diverging degree of evolution concerning the health insurance coverage of their populations. Finally, Vietnam and Laos will provide some more examples of health insurance extension in the informal economy. To sum up, some first lessons learnt emerging from these examples will be suggested at the end.

2. Country profiles

The following seven examples of experience in linking up systems of social protection in some way or other should serve as illustrations of possible paths to follow and as incentives for exploring the potential for similar mechanisms in other contexts. They are not meant as complete case studies of each country; hence the historic and socio-economic background of each project is sketched out rather briefly.

2.1 Philippines

This study relates how parts of the informal sector in the Philippines could be reached and included within social health insurance coverage via organised groups, and ultimately how a "triple win outcome" for the different actors could be attained.

Country context and background information

PhilHealth, the National Health Insurance Corporation of the Philippines, has made substantial progress since its establishment in 1995, and whilst its reimbursements to members for health services rendered still only account for less than 10% of total health spending, it has now enrolled approximately two-thirds of the population.

In June 2003 PhilHealth Board Resolution 569 (PBR 569) was approved, authorising a pilot scheme in which a number of cooperative organisations were accredited as marketing and collection agents. Symbolically, this resolution was of great significance for PhilHealth, representing a departure from previous approaches, and allowing the development of partnerships with cooperative organisations.[4] The main incentive for members under the scheme is that they receive additional outpatient benefits, but only if the cooperative remits premiums annually to PhilHealth. There may also be further benefits to the member of joining PhilHealth through an organised group e.g. increased flexibility in the payment of PhilHealth premiums,[5] and a lower administrative burden attaching to the process of joining.

Initial implementation experience with PBR 569 prompted discussion around the need for a broader strategic policy framework which strengthens incentives for group-based enrolment. PhilHealth Board Resolution 719 (PBR 719) passed in September 2004, following substantial discussions between GTZ and PhilHealth, approved a preliminary framework to pilot such an approach.

Potential for extension of social protection coverage

The main challenge, as in most low and middle income countries, is how to enrol workers in the informal economy, who are ineligible for publicly subsidised health insurance. The development of a strategic framework to tackle this problem is a

[4] Further details of this scheme can be found in "The Philippines: One Health Plan for All" in "Social Health Insurance – Systems of Solidarity: Experiences from German development cooperation", a GTZ publication 2004.

[5] For example if the co-operative lends assistance to members – in some cases cooperatives give low-cost loans to their members specifically for this purpose.

major focus of GTZ's support to PhilHealth. At the present time, PhilHealth is offering four different types of schemes within its health programme:

1. Individually paying programme (IPP): this is designed for the self-employed and thus has a broad range of target members, ranging from self-employed professionals such as doctors to workers in the informal economy (e.g. ambulant vendors). The premium contribution for the IPP is fixed at P100.00 per month (~€1.10, May 2005). This can be paid on a quarterly, semi-annual or annual basis.
2. Employed programme: employees contribute 1.25% of their salary. Employers match employees' contributions. Though there is a cap, the progressiveness within the contribution structure has been considerably adjusted recently (January 2005) by setting this cap higher than it used to be (now set at P20.000, ~ €218, per month, the contribution is then P500 for both employer and employee).
3. Sponsored (indigent) programme. It aims to provide Medicare privileges to the marginalised sector of Filipino society and is meant for those with no visible means of income and who are not covered by health insurance. Target members of the programme are those belonging to the bottom 25% of the population. This is a joint undertaking of PhilHealth with local government units (LGUs). Potential member-families are identified through a "means test", a social survey to determine their capacity to pay the premiums. Local governments take the lead in the means test. Premiums of sponsored members are subsidised by the National Government and the LGUs where they reside. The annual premium is fixed at P1,200 annually. The LGU's share depends on its income classification and could be as low as 10% to as high as 50%. The remainder of the premium is paid by the national government through PhilHealth. For LGUs that have difficulty in enrolling their indigent constituents due to budgetary constraints, they may tap other national government agencies (i.e. PCSO, DAR, etc.), legislative and private entities to seek financial assistance to pay for their annual premium contribution.
4. Non-paying programme. This is for those members that have reached the age of retirement (usually 60 years old) and have paid at least 120 monthly contributions.

Routes taken towards extension of social protection, and options

The new resolution – group premium discounts PBR 719 authorises discounted premiums to be offered to any type of organised group (OG) which enters into an enrolment contract with PhilHealth, and meets certain criteria with respect to size. The total discount given must not exceed 10% of the annual premium of P 1,200. Building from first principles, the resolution is designed to mitigate anticipated problems of adverse selection, which is to be expected when membership is voluntary and based around individuals, and hence to strengthen risk-sharing, solidarity, and financial stability.

A central element of the new resolution is that discounts increase as the size of the group increases, and fall as the size of the group decreases. "Group" in this context refers to the total number of members in the respective OG eligible for

PhilHealth's "Individual Paying Programme (IPP)".[6] There are many reasons why discounts should be given for the enrolment of groups, including the administrative savings to PhilHealth of enrolling groups rather than individuals, and the role of groups in countering adverse selection.[7] Table 1 details the proposed percentage discounts, which have two elements. First, OGs are categorised into one of four size-related bands. As already mentioned, this number refers to the number of members in the OG that are eligible for PhilHealth's IPP.[8]

Table 1: Group size discount: PhilHealth

		% eligible members enrolling in PhilHealth		
Band	***Size of organised group (eligible members for IPP)***	***70%***	***80%***	***90%***
4	4,000+	***6.50%***	***6.75%***	***7.00%***
3	3,000-3,999	***5.50%***	***5.75%***	***6.00%***
2	2,000-2,999	***4.50%***	***4.75%***	***5.00%***
1	1,000-1,999	***3.50%***	***3.75%***	***4.00%***

Discounts also increase as the percentage of eligible members enrolled increases. A minimum of 70% is required before any contract is signed, and the discount applied. The resulting discount scale follows the simple principle of "*the bigger the group the bigger the discount*".

A second discount built into the framework rewards advance payment of the premium (e.g. paying the annual premium in one go). The actual percentage discounts are outlined in Table 2.

Table 2: Frequency of payment discount: PhilHealth

Premium payment frequency	***Annual***	***Semi-annual***	***Quarterly***
% discount	***3.00%***	***2.25%***	***1.50%***
Discounted premium (Pesos)	1,164	1,173	1,182

Tables 1 and 2 show the premium discounts provided by PhilHealth. Table 3 outlines the way in which these two sets of discounts are shared between the OG and the member. Discounts are shared by the individual member covered under the group contract, in terms of a lower premium, and by the OG in terms of income. Income to the OG is the difference between the premium contributions they collect from their

[6] By definition this group serves those commonly referred to as the "informal sector". Essentially, they constitute a default group i.e. those who are neither eligible for the compulsory programme, nor for the fully-subsidised indigent or sponsored programme.

[7] Group discounts are common practice amongst private health insurers, and the logic for this approach is equally relevant for social health insurance schemes.

[8] Note that some members of the OG may already be members of PhilHealth under the indigent or compulsory programmes, or if not they may be eligible for one of the two. As a result, they are not eligible for the group premium discount.

members, and the funds remitted to PhilHealth; both these figures will be specified in the contract.

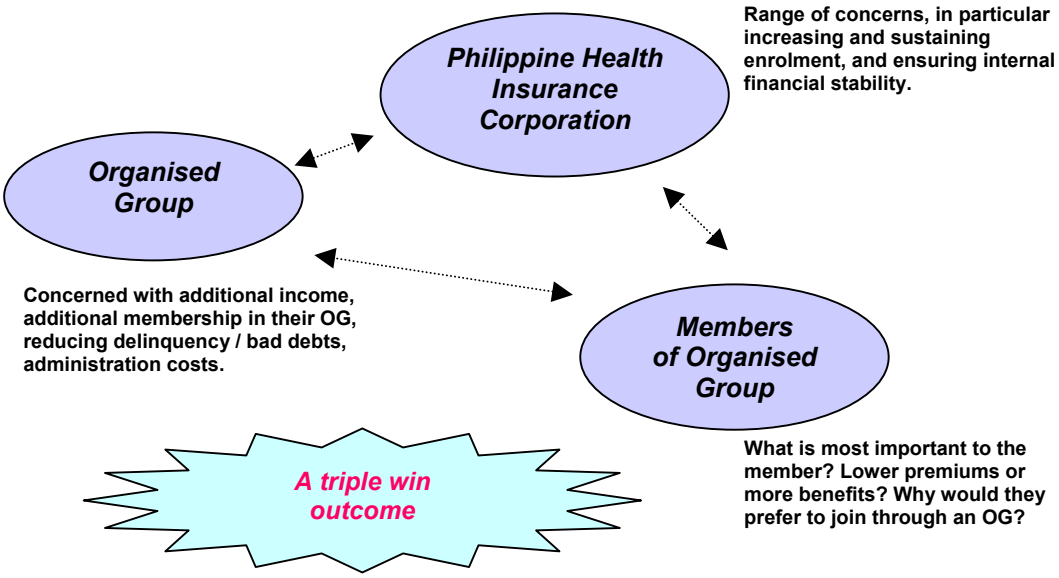
The sharing of discounts between the member and the OG is an important aspect of the design, and one that is subject to much discussion, and will be monitored closely during the pilot period. For example, if it is felt that greater priority should be given to advance payments, a greater share of the 10% discount could be allocated to this. If, however, it is felt that more weight should be given to enrolling the largest numbers possible, more weight will be given to the group size discount.

Table 3: Sharing of discounts: PhilHealth

	Organised Group	Member
Discount 1: Group size	28.6 %	71.4 %
Discount 2: Frequency of payment	33.3 %	66.7 %

Triple-win outcomes

For this new approach to succeed, each of the three primary stakeholders must consider the arrangement worthwhile. The following figure outlines some of the key concerns for each stakeholder.



Amongst other things, OGs will be concerned about the additional administrative costs they incur, and how much income they make to cover these costs. However, OGs are also likely to weigh up the costs and benefits of a range of other possible effects, such as changes in the membership of their organisation, changes in their reputation based on their formal association with PhilHealth, and for micro-credit

organisations, changes in their core business.[9] For PhilHealth there is a wide-range of concerns, from boosting membership, to reaching out to the poor, limiting adverse selection, and strengthening risk-sharing and financial stability for the programme as a whole.

Finally, unless the discounted premium changes individual demand for PhilHealth, this approach will not succeed. For the member, the key issue is whether the discount is attractive enough for them to prefer joining PhilHealth through a group rather than as an individual. This will depend to a large extent on how they value PhilHealth, which in turn is contingent on access to quality health services locally, and how price sensitive they are.[10]

Reaching out to the informal sector: concrete examples

Which type of organised group? PBR 719 allows discounted premiums to be offered to any type of OG, although it will be necessary to ensure that the OG meets minimum standards, so that it is in a position to adequately represent its members, enter into a contract, and if the need arises, to be held to account for its actions. There are many candidate OGs for the piloting of PBR 719 in 2005, two of which are profiled below:

CARD Mutual Benefit Association CARD (Center for Agriculture and Rural Development) MBA is comprised of CARD Bank (loans and savings) and CARD NGO (loans), and has a total membership of around 110,000 individuals. CARD MBA itself offers insurance products, and follows the Grameen "group lending" approach. Its members are almost entirely women working in the informal sector. It is a financially stable organisation, with repayment rates consistently above 97%, and is governed by the Securities and Exchange Commission / Office of Insurance Commission of the Philippines. Provisionally they estimate that less than 30% of their members are currently enrolled in PhilHealth, and are currently in the process of confirming this figure through an internal survey.

KSK Kapanidungan sa Kalusugan is a local health insurance scheme based in Batanes, remote islands to the north of the main Philippine island of Luzon. Together with support from HealthDev, a Filipino NGO funded by the German organisation AWO (*Arbeiterwohlfahrt*), KSK has developed a scheme with around 2,500 members. For the long-term viability of the scheme, however, the managers wish to link with PhilHealth, the national insurer. PBR 719 offers the potential for KSK to act as an organised group, and "deliver" a block of new members for PhilHealth's individual paying programme (IPP). At present, internal surveys are being conducted to establish precisely what percentage of KSK members are actually eligible for the IPP.

Conclusion and perspectives

Over the course of 2005, and probably beyond, PhilHealth will begin entering into contracts with a number of organised groups. Strategically, it may be necessary in

[9] For example, it is expected that PhilHealth membership will help to reduce bad debts (i.e. non-repayment of loans) by borrowers. The basis for this claim is evidence that illness, and its related costs, is a major cause of portfolio-at-risk in the Philippine micro finance sector.

[10] Evidence from the literature suggests that poorer households are more price sensitive than wealthier ones.

the short-term to develop contracts with some of the more established organised groups, which have the administrative capacity to implement PBR 719 without major internal adjustments, or additional administrative costs. This would include computerised and smooth running information systems relating to membership and contributions.

Furthermore, a critical factor for the success of this entire strategy is the presence of good quality health facilities in the area where the OG operates (and its members live). For this reason, it may be necessary to select OGs which are located in such areas. Some additional challenges are expected, including ensuring that PhilHealth's own systems are flexible enough to administer the scheme and generate the necessary data for evaluation purposes. Can it develop effective marketing messages in support of the strategy? And will OGs find the minimum group size of 1,000 and the minimum percentage of 70% too ambitious? These questions, and many more, will be answered over the course of the next year by PhilHealth, in partnership with GTZ.

2.2 India

In this example, outreach to the poor is achieved via a state-subsidised fund targeting specific occupations prone to earning low income.

Country context and background information

India spends around 5 per cent of its GDP on health care. Of this more than three-quarters are financed by the private sector, mostly in the form of out-of-pocket payments. This high level of household expenditure on health care exists even though the Indian government plays an important role in financing and providing almost free health care. However, most people prefer the private health care sector because of its perceived better quality compared to public health facilities.

Despite the vast need for health insurance the market is generally very limited. The various schemes can be categorised into four broad groups: a) mandatory health insurance schemes; b) voluntary health insurance schemes; c) employer-based insurance schemes; d) NGO-based insurance schemes. The four categories together are estimated to cover roughly 10 percent of India's population. Thus, there is a strong need for financial mechanisms to protect the people belonging to lower income groups from high financial burden arising out of sickness. The India MAPHealth[11] study found that 10% of households spend more than their annual income on health care. Clear inequalities exist, since the burden of health care is three times higher for the poorest (14.4% of their income) than for the wealthiest (4.4% of their income).

In the public sector, employees are covered by the Employees State Insurance Scheme. The benefits include: sickness, occupational injury (disability and dependants benefit), maternity, and funeral expenses. It is funded through contributions from employers and workers (employers pay 4.75% of employees' wages while employees pay 1.75% of their wages).

Potential for extension of social protection coverage

The informal economy in India comprises roughly 92% of the population able to work. Thus, the extension of social security plays an essential role in the prevention and alleviation of poverty. This has been recognised by the Indian government and the Insurance Regulatory and Development Authority (IRDA).

In order to tackle the problem mentioned above, the central and several state governments recently drafted social security bills for the "unorganised workers". Furthermore, they are considering extending the *Employees State Insurance Scheme* for the formal economy to selected occupational groups in the informal economy. Since neither initiative has yet received approval from the cabinet, the government is supporting social security schemes which subsidise insurance for the poor and for low-income groups. These schemes are implemented through public insurance providers in collaboration with civil society organisations.

In addition, responding to the rapid development of micro-insurance, the IRDA released a concept paper on the *Need for Developing Micro-Insurance in India*.

[11] MAPHealth is a multi-country project coordinated by the principal investigators of the CDS-UDeM action research project, which evaluated the effects of macro-economic and sectoral reforms on health systems in eight countries.

According to the IRDA, micro-insurance has proved to be the most important means to reach the poor with insurance products in India. In order to further promote this trend, insurance companies are required to conduct 15% of their business in rural areas. This important policy decision provided increased flexibility for insurance providers and civil society to develop customer-oriented insurance products and innovative delivery models.

Routes taken towards extension of social protection, and options

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The central government set up a Social Security Fund of ~€20m and entrusted the Life Insurance Corporation of India (LIC) with the responsibility of managing this fund. The purpose was to support insurance group schemes providing life and disability protection to rural and urban poor people living below or marginally above the poverty line. In 2000 the scheme in greatest demand, the *Janashree Bima Yojana* micro-insurance, was inaugurated and implemented through LIC in collaboration with Nodal Agencies such as NGOs, local government institutions, or self-help groups. The Nodal Agencies act on behalf of the insured members in all matters relating to the scheme. Experience rating adjustment will be allowed after 3 years on the basis of claim experience.

Table 4: Overview: Life Insurance Corporation India

Target groups	Benefits	Pricing
Rural and urban poor persons below the poverty line and marginally above the poverty line provided they belong to 24 identified vocational groups (e.g. handicraft artisans, fishermen, self-employed, forest workers) Persons between age 18 and 60 organised in groups of 25 members	In the event of death Rs.20,000/- In the event of death by accident or partial or total permanent disability due to accident the following benefits will be payable: 1) On death due to accident Rs.50,000 2) Permanent total disability due to accident Rs.50,000 3) Loss of 2 eyes or 2 limbs or one eye and one limb in an accident Rs.50,000 4) Loss of one eye or one limb in an accident Rs.25,000 In addition the children of the insured persons studying in class 9 to 12th standards will be entitled to scholarship at the rate of Rs.300 per quarter for a maximum period of four years. (This benefit is restricted to two children only)	A premium of Rs.200 per member to be shared as follows: 50% of the premium to be paid by members or nodal agency or state government at the time of submitting proposal and subsequently on each annual renewal date; 50% balance of the premium to be borne by the Social Security Fund

The beneficiary of the deceased member will be required to furnish the original death certificate to the Nodal Agency who will forward the same along with the claim papers to LIC. The local insurance office will settle the claims by sending a cheque directly to the beneficiary. In case of claims for accidents, a police inquiry report will also be required. Experience revealed delays in claim settlement, so several NGOs negotiated simplified terms and conditions for claim management such as payment in cash through the Nodal Agency if the beneficiary does not have a bank account.

Ups and downs of the partner-agent model As the Indian government and the regulatory authority have shown their political will to extend insurance services to the poor and to low-income groups in the informal economy, micro-insurance products and services are emerging which build upon the strong organisational structure of

civil society. The learning process was, and still is, characterised by experimentation with different delivery models. When the insurance market opened up to low income groups, many NGOs sold insurance products offered by public and private insurance providers to their group members. However, not being fully informed about the concept of insurance they faced a number of difficulties: clients expected (a part) of their premium back when not submitting a claim, claims settlement proved to be a cumbersome process leading to low renewal rates, etc. Considering these difficulties and realising the amount of premiums collected and forwarded to the insurance industry compared to the low number of claims, several NGOs and cooperatives decided to terminate their agreements with the insurance provider. They offered the product on their own (full-service model or community-based system) without properly assessing the risk involved. This step, however, caused its own problems. On several occasions the insurance scheme became insolvent when large numbers of claims occurred due to covariant risks or adverse selection; customised product design and pricing turned out to be highly complicated; and the knowledge needed to deliver the services professionally required significant investment in terms of human and financial resources. After these initial experiences with existing products, NGOs became more aware of the complexity of the insurance business and – once again – increasingly realised the need for joint collaboration.

Reaching out to the informal sector: concrete examples

***Uni Micro Health Insurance* – a comprehensive package deal** One outstanding example is the partnership between the organisation *Self-help Promotion for Health and Rural Development* (SHEPHERD) and the *United Indian Insurance Company* (UIIC). Realising the demand for coverage of several risks on the one hand and the confusing number of insurance products on the other, SHEPHERD entered into an agreement with the UIIC. In order to design customised products UIIC, SHEPHERD and potential clients jointly developed an insurance package, *Uni Micro Health Insurance Scheme*, combining health insurance with cover against death, disability and loss or damage of housing. As this product package was distinctly different from other insurance schemes it had to be approved by the regulatory authority and can now be officially launched all over India.

Table 5: Overview: Uni Micro Health Insurance India

Target groups	Benefits	Pricing
Group members: age 18-59 providing a declaration of good health	Rs. 15,000[12] accidental death (including the costs of transporting the body) Rs. 15,000 permanent disability Rs. 250/month up to max. Rs. 750 for up to three months for temporary disability Rs. 5,000 hospitalisation expenses Rs. 5,000 for house fire and allied perils **Exclusions**: 30-day waiting period (except for accidents), HIV/AIDS, childbirth, pre-existing diseases in the first year, afterwards no exclusion	Voluntary scheme for group members Rs. 100 per annum (Rs. 84 for insurance provider, Rs. 16 administration fee for SHEPHERD – which is not yet covering all costs)

[12] Exchange rate as of January 2005: approx. 1€ = 50 Rs.

Considering earlier delays in claims settlement, SHEPHERD and UIIC established an Insurance Review Committee consisting of representatives from the insurer, SHEPHERD and insured clients. This committee will meet every two months to ensure that under-writing and claims processes are properly implemented. In case of problems, the committee is supposed to suggest measures for making the service more efficient. This unique delivery mechanism is possible due to the regulatory provision to explore innovative delivery channels.

Ashwini health micro-insurance and health care facilities Action for Community Organisation, Rehabilitation and Development (ACCORD) is working exclusively for indigenous groups, "*adivasis"*. As the *adivasi* people were almost completely excluded from Indian society, with no social activities or structure and negligible access to government health services, the groups asked ACCORD to start a hospital to complement the ACCORD Community Health Programme. Considering the extremely weak financial situation of *adivasis* it was not possible to finance the hospital infrastructure and ACCORD tried to use the existing government and private health care facilities. However, they were found to be unsatisfactory in many aspects.

While the community was willing to contribute towards hospital expenses, ACCORD realised that the traditional "fee for services" would create a lot of financial barriers for the *adivasis*. In 1992 ACCORD established linkages with the "Tribal Health Insurance Policy" offered by insurance companies and implemented the benefit package through the sister organisation ASHWINI (provider model in collaboration with NGO). The programme is operated at two levels: the insurance product is provided by the insurance company to ASHWINI and another (more comprehensive) package is provided by ASHWINI to the *adivasis*.

Table 6: Overview: Ashwini health micro-insurance, India

Target groups	Benefits	Pricing
• Members of *adivasi* groups. • Non-group members of *adivasis*. • Non-tribals from the surrounding areas.	**Insurance product**: Hospitalisation coverage up to Rs 1000 for admission > 24 hours. **ASHWINI package**: • Most common illnesses – free universal health coverage without upper limits. • First two deliveries and family planning operations. • For **insured** members: outpatient (OP) services (including medicines and diagnostics) at the Adivasi Hospital for a co-payment of Rs 10 per visit. • For **non-insured members**: payment of Rs 100 for every hospitalisation and costs of OP medicines. • For **non-tribals**: payment of Rs. 150 (which is higher than the actual costs and cross subsidises some of the services for the *adivasis*). • For all AMS members, irrespective of their insurance status: promotive, preventive and basic curative care through its network of voluntary health workers and health centres. • No exclusions (contrary to the period before 2002).	**Insurance premium:** Rs 22 per annum (ASHWINI receives a discount due to high number of insured and five years advance payment of premiums – *adivasis* (re)pay the premium on an annual basis to ASHWINI). **Hospital costs:** All in-patients Rs. 10 as standard admission fee. Additional fees according to patient's status (see "Benefits").

ASHWINI with its network of health centres and the hospital is the main provider of health care. They retain complete control over the quality and the costs of these

services through payment of fixed salaries, using essential drugs and standard treatment guidelines (the average hospital bill is about Rs 750 per patient per episode of illness – 2001). The *multi-tier system* with Gudalur Adivasi Hospital at the central level, Health SubCentre at the regional level and health workers at village level (Community Health Programme) has created a functioning reference system, where the sick can be "passed along" the chain of health care depending on their needs. It refers patients to tertiary centres when necessary and has established linkages to other health institutions which provide subsidised or free access to medical experts and treatment:[13]

Adverse selection is kept to a minimum by encouraging the family to enrol as a unit and by having a definite collection period. Moral hazard is reduced by a system of co-payments. Moreover, the indirect costs of transport, food and loss of wages are significant barriers to unnecessary hospitalisation.

Claims and reimbursements are simplified. Neither does the patient have to pay any fees (cashless system) nor does she/he have to provide any documentation, except the insurance card at the time of admission. Reimbursement from the insurance provider to ASHWINI usually takes 15-20 days.

This health insurance programme has been functioning over the past 12 years, currently has more than 12,000 insured members and has brought about significant improvements in the health status of the *adivasi* community. Sixty per cent of hospitalisation costs are recovered through the insurance programme by the communities. The balance is met by donors and cross subsidies from non-tribal patients. The main drawback of the scheme is that the insurance policies are not commercially viable. The first policy with the New India Assurance Company (NIAC) was a loss-maker for the insurance company, and it remains to be seen how much this situation has improved with the current Royal Sundaram Alliance Private Company (RSA). At the same time, both the companies were prepared to make a social commitment to support the scheme and gain experience in the rural market – and did not enter into the agreement only for (immediate) financial returns.

This was expected by ACCORD. Considering the extreme poverty of the *adivasi* communities, universal health coverage would not be affordable if funded by clients' contributions alone. The objective was to provide health care and then to collect revenue to recover some of the costs, in the aim of eventually developing a sustainable system owned and run by the tribal people themselves. Furthermore, ACCORD wanted to explore the potential for micro-insurance as a risk management tool for very poor communities. In this respect, sixty per cent of cost coverage is a significant amount for this target group.

Conclusions and perspectives

Micro-insurance – one instrument among others for social protection For the last ten years GTZ has been supporting micro-insurance in India. Although the potential for micro-insurance is high, social protection for the informal economy requires a multilevel approach involving all stakeholders. Such an approach combines instruments complementing each other at the household and community level (informal arrangements) with formal systems from the private sector to public programmes (e.g. statutory schemes, social welfare programmes).

[13] ASHWINI is linked to both the government District Hospital and Calicut Medical College, from which treatment is available at no charge. These tertiary institutions are able to cover most additional procedures. There is also government support for immunisation, family planning and tuberculosis control programmes (provision of medicines, funds for laboratory materials and subsidised hospital treatment) as well as weekly and monthly visits of doctors from private clinics and referrals to private hospitals in town paid by ASHWINI.

As the Indian government is in the process of reforming its social protection policy, an integrated risk management strategy should be developed and implemented in collaboration with the government, the private sector such as insurance providers, organisations of civil society, and self-help groups or other community-based networks. Unfortunately, it rarely happens and systematic planning of vertical and horizontal linkages is rather limited.

The Ministry of Labour requested GTZ to carry out a risk and vulnerability analysis of selected occupational groups. Based on this study the relevant perils and the efficiency of existing risk management instruments can be assessed and the most suitable strategies jointly developed – taking the specific situations of women and men and girls and boys into account.

2.3 Tanzania

Another approach to linking up different systems of health protection for the poor is the implementation of a Centre of Health Insurance Competence (CHIC) in Tanzania.

Country context and background information

51 per cent 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. Under these circumstances, Tanzania is facing major challenges in socially protecting its population and in establishing mechanisms to protect its people from the financial risk of illness.

In 1999 the government of Tanzania established a compulsory National Health Insurance Fund (NHIF) for civil servants and state employees. Within a short period it has become operational and is now offering benefits from a whole variety of health facilities across the country. In 2002, it widened its membership to all employees in the public sector, including local government administrations and parastatal organisations. With more than 242,000 paying members, its coverage now extends to about 1.1 million potential claimants (members and their immediate families). Employers and employees pay three per cent each of gross salary per month into the fund. However, the issue of identifying ways to extend social protection to workers in the private sector remains a challenge in Tanzania.

Apart from the NHIF and a government Community Health Fund (CHF) initiative, cooperatives, non-governmental organisations and churches all over the country have been initiating community-based health insurance schemes. Since 2000, work has been under way to establish a National Network of Community Health Funds to represent and support both public and private health insurance schemes. In October 2003, the Tanzanian Network of Community Health Funds (TNCHF) was officially launched and registered as a NGO. The main thrust of the Network is experience-sharing and joint capacity building. The Tanzanian-German Programme to Support Health (TGPSH) and the Sector Project "Social Health Insurance" support this initiative through technical assistance and training in order to help build health financing and insurance competence within the TNCHF.

Potential for extension of social protection coverage

In the rural areas of Tanzania, insuring against the risks of ill health is largely unheard of. Many people living there have difficulty 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.

In order to improve access to health care for the poor, the Tanzanian government is in the process of setting up voluntary CHFs in every one of the 113 districts. According to Gaspar Mwambezi, CHF Coordinator at the Ministry of Health,

the CHF system has compelling advantages: broad coverage of the population and 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. GTZ is supporting the development of these CHFs through technical advice and capacity building via recently-established regional CHF competence centres (RCCC) inspired by a CHIC seminar held in Dar es Salaam in February 2004.

Routes taken towards extension of social protection, and options

In view of widespread poverty, government and non-government organisations are trying various approaches to improve the level of health care provision. 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 public sector employees. The NHIF came into being in 1999 by resolution of parliament, and has been in operation since July 2001. The NHIF is looking for ways to expand its membership structure to people formally employed in the private sector. There is also exchange between NHIF and TNCHF in order to learn from each other and benefit from the two parties' respective methodologies and health insurance expertise. GTZ has been requested to identify synergies between the formal and informal sector schemes in Tanzania, and advise on the potential for linking up different systems.

In Dar es Salaam, the umbrella organisation of entrepreneurs in the informal sector, VIBINDO, is trying to insure its members against the costs of ill health. For this purpose it has set up its own micro insurance programme based around workers cooperatives. 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 number is pitifully small. The main difficulties of self-organised health insurance schemes are the low business profits made by corporate members, who often have no permanent place of business and hence dependable income, posing an ever-present threat to the scheme's sustainability.

Reaching out to the informal sector: concrete examples

The CHIC concept: know-how for community-based health insurance schemes and community health funds. The objectives of CHIC are:

- Developing standardised insurance products and administrative procedures suited for local adaptation.
- Providing the organisational and administrative competencies needed to set up and run health insurance schemes and community health funds successfully.
- Stimulating entrepreneurial behaviour and supporting the ownership of community schemes by local actors.

- Promoting efficiency in implementation, whilst at the same time respecting the principles and time sequences associated with a bottom-up, community-based approach.
- Setting up health protection systems with the potential to expand membership and adapt to the needs of interested groups.

The applied methodologies offered by CHIC include an evaluation tool *(InfoSure)* and a tool for financial simulations *(SimIns)*. The software tools enable the development of a health insurance scheme to be assessed and projected over time. Apart from this, CHIC conducts training courses for health insurance managers and executive staff on such issues as enrolment, risk management, financial management, cost analysis, quality assurance and IT.
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 for community-based health insurance schemes and community health funds makes (semi-) standardised 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 organisation's resources and membership structure. In this form, Centres of Health Insurance Competence help to improve access to health care provision.
Competence centres for health insurers operate on a regional basis, helping to ensure that poor segments of the population have better access to high quality, affordable health care. Special attention is focused on persons in the informal sector in both urban and rural areas. These groups are exposed to higher risks of ill health and poverty by their low incomes, their living conditions, and environmental factors. Often, when they are most in need of medical treatment, they cannot afford to pay for it. In cooperation with local and national governments, public health insurance schemes and the private sector, CHICs create basic administrative and legal conditions for expansion of the health insurance sector. They also promote individual initiative and self-help, and strengthen the self-administrative capacity of community-based insurance systems.
A CHIC not only provides positive impulses for the health care sector, but also plays a part in boosting incomes and employment in a region. There are strong links with the German Federal Ministry for Economic Cooperation and Development (BMZ) priority area "Economic Reform and Development of the Market System" (WIRAM). For instance, upgrading the professional competence of health insurers, developing marketable products, and improving the macro-economic framework conditions for growth all contribute to this theme. The CHIC approach also aims for better partnership between the state, business and civil society, including the establishment of strategic cooperation links between local, national and private insurance initiatives. Similarly, by cooperating with professional training institutions to develop and implement new curricula in the fields of health care financing and health insurance, it stimulates employment in the private and non-profit sector.

Conclusions and perspectives:

Experience has been gained in setting up the first competence centre in Nigeria, and first attempts are being made in Tanzania to put CHIC concepts into practice. These seminars have met with a positive response so far. Immediately after participating in

the seminar, the Catholic Church in Nigeria decided to set up a Catholic Health Insurance Programme (CHIP) for their health service establishments and health schemes. Other countries have also shown strong interest (e.g. Rwanda, Guinea and India) – there is a real demand for seminars of this kind, which are seen as being able to address the major problems health insurance schemes face all too often: managerial weakness, difficulty in striking an appropriate balance between the technical requirements of a health insurance scheme, and the lack of community participation in the setting-up and implementation process. Being designed specifically to meet these weaknesses, the CHIC provides a feasible and innovative answer.

2.4 Paraguay

This country study reveals the currently deplorable state of the Paraguayan health system and points out some strategies to be initiated in the future.

Country context and background information

Paraguay is one of the least developed countries in Latin America. Almost 50% of the population still lives in rural areas. Generally it stands out as a country with little economic growth and high poverty. Its epidemiological profile shows the typical transition of developing countries that combine elevated rates of infectious and parasitic diseases with a high prevalence of chronic-degenerative diseases, cancer and accidents. One-and-a-half decades after the end of the Strössner dictatorship, political institutions remain weak, and little progress has been made with the implementation of democratic and participative social structures. Access to social protection is limited to a better-off minority, mostly concentrated in urban areas.

Recent research has revealed that only one in eight Paraguayans is contributing to some kind of pension fund, and just about 20% of the population is paying into some kind of health insurance fund. Thus, social exclusion in a generally poor and regressive socio-economic environment is a major problem in a country with a high prevalence of corruption and little or no experience of good governance. On the other hand, the current Paraguayan situation offers special opportunities to prove that the difficult task of consolidating economic development by means of progressive extension of social protection is not only possible, but actually a successful approach.

Potential for extension of social protection coverage

Health Care System The Paraguayan health care system is a mixture of public entities and private for-profit and not for-profit organisations.[14] The diversity of actors is accompanied by a lack of institutional coordination between the different sectors. In some communities, health care services are completely missing while in other geographic areas the duplication of responsibilities is inducing unnecessary competition between medical providers. The segregation of the health insurance and the health care provision sectors reduces the effective performance of the overall system.

Private out-of-pocket expenditure is high and severely affects the household income of the poor, one typical indicator of a lack of fairness and effectiveness. Though public spending on health is very low, even compared to other countries in the region, the public health care system shoulders the health care provision of the majority. The Ministry of Health and Social Welfare provides and finances a network of public facilities for the poor population, and the National University offers low-cost treatment for the worse-off. The Social Insurance Institute (*Instituto de Previsión Social*—IPS), which combines health and pension insurance, is limited to the formal sector except civil servants who are obliged to take out a private insurance policy. Up to now, the medical service of the army and the police has been restricted exclusively

[14] Namely the Ministry of Public Health and Social Welfare, Social Insurance Institute (IPS), National University, Military and Police Health System as well as collective insurance companies, private insurances, physicians, clinics, hospitals, charitable and cooperative establishments.

to members of the armed forces and their families, and the same applies to the insurance schemes of the Itaipú binational power plant enterprise.

Routes taken towards extension of social protection, and options

Public institutions Since 2001, the Paraguayan health ministry has organised a regional health insurance scheme in the rural department of Caazapá (*Seguro Integral de Salud Caazapá* – SI). Focusing firstly on young mothers and children up to five years, the SI represents an important effort to introduce public insurance at the Caazapá hospital, and to draw citizens' attention to the whole insurance issue. First steps towards the inclusion of first level providers in the department have been undertaken recently. If extension of the scheme's coverage is wanted, contracting of additional public and also private facilities will be unavoidable in order to guarantee overall access and adequate services to the beneficiaries.
In the East Paraguayan department of Itapúa, the relatively affluent community of Fram built a communitarian insurance scheme (*Seguro Comunitario de Salud de Fram*) in order to make the services provided by the local health clinic available and affordable to poorer citizens. Unlike the Caazapá experience where the solidarity principle is implemented in a rudimentary way, the Fram scheme applies the equivalence principle offering different packages according to contribution levels. The communitarian insurance has implemented an interesting system for assessing income, and has contracts with several providers in and outside the village.

Private initiatives A series of urban and rural communities, mainly in the above mentioned department of Itapúa, have organised Social Pharmacies (*Farmacias Sociales*) in order to provide less expensive drugs to the poor. In spite of some problems and wide variability in experiences, in today's Paraguay these drug programmes represent an important low-level approach to improve access to affordable health care, and can transform into a starting point for the implementation of more sophisticated pre-payment schemes.
A number of private insurance companies and other health financing organisations complete the fragmented scenario of the Paraguayan health care system. Most of the private insurers, which are known as Prepaid Medicine (*Medicina Prepaga*) and cover one-third of insured Paragayans – namely 7% of the whole population –, offer a reduced benefits package with many exclusions and limitations. With the exception of very few cases, private insurance companies do not pretend to link up with other health care provision and even less with other health financing institutions. Many of the Prepaid Medicine enterprises are facing serious economic problems, and their potential to contribute to universal coverage is low.

Reaching out to the informal sector: concrete examples

Unconventional approaches Other schemes were implemented by health care providers with charitable goals in order to assure affordability for their clients and their own financial sustainability.[15] In this respect the project of the *Paraguayan Trade Union Confederation* to offer health care for their members is noteworthy

[15] Namely the Servicio de salud integral El Buen Samaritano S.A. and the Servicio médico San Cristóbal, which are philanthropic health care financing and providing organisations, though the latter is limited to co-operative members.

because their project tries to make use of underemployed infrastructure by overcoming traditional social separation. The Health Service of the Trade Union Confederation (*Servicio de salud de la Confederación Paraguaya de Trabajadores*) to be implemented will establish a cooperation with the military health sector. As the armed forces still run an over-dimensioned network of health care services, some trade-unionists established negotiations with several facilities, mainly in the capital of Asunción, to find a way to assure adequate treatment for workers and their families.

The widespread lack of quality health care is leading to an outbreak of alternative health care financing mechanisms on a regional, local, cooperative or enterprise level. The growing cooperative movement in Paraguay, especially, offers a wide range of health care financing approaches based on risk sharing, mutual aid and solidarity mechanisms. Recent field research carried out by the GTZ project PLANDES in Paraguay with technical support from the Sector Project "Social Health Insurance“ revealed an impressive variety of small-scale social security schemes in different parts of the country. Obviously, the lack of coverage has driven an increasing number of Paraguayan citizens to look for alternative social protection mechanisms in order to face the typical risks of life and, especially, ill health. The schemes exhibit great variety in terms of lifetime, experience, coverage, benefits and other essential aspects of health insurance, but all of them are worth taking into account if universal coverage is defined as a goal of social policy.

Cooperative movement Recent developments of the Paraguayan cooperative movement were largely unknown until the aforementioned GTZ study uncovered a surprising number and variety of health care financing mechanisms, organised and partly implemented by different types of cooperatives all over the country. This group of health insurance schemes is playing an increasingly important role in economic and social life. As governance, stewardship and political reliance are weak and corruption is omnipresent in the South American country, about 650,000 people are affiliated directly, and about one in three Paraguayans indirectly, to one of more than 700 cooperative organisations.[16] The cooperative movement’s economic and financial relevance and its high level of organisation make it a promising counterpart for the extension of social protection in health.

Even given the obvious differences in the size, activity and performance of cooperatives, their health insurance schemes show wide variability. Depending on their economic activity and financial situation, some of them are implementing modest packages of health care services while others offer a plan that covers a wide range of benefits, in some cases including complex or intensive care unit treatment. Undoubtedly, the increasing coverage of cooperative members and their families will induce a growing demand for health care services. That raises the necessity of establishing links and regulating the relationship between different actors within and, in the medium term, also outside the cooperatives. The cooperative confederations face the challenge of creating a support unit for consultancy, technical advice, management of knowledge and interchange of experience, and could even organise a reinsurance structure in order to achieve better financial stability and sustainability of the schemes in a generally regressive macro-economic situation.

The need for implementing health insurance derives either from the wish to achieve access to affordable, decent-quality health care for affiliated members or from an interest in guaranteeing the financial viability of existing cooperative-run

[16] At the same time, co-operatives’ assets were estimated around 1 billion euro (≈ 1,500 € pro member), and their savings account of 180 million euro represents 11 % of national savings.

health care providers. The dual motivation is reflected in two different types of insurance schemes within the emerging or existing funds: Some of them are acting as mutual health organisations or as “classical” insurance organisations contracting independent providers and focusing on financial aspects of care, while others are implemented by providers and characterised by vertical integration. In some cases, affiliation is mandatory, in others voluntary within the target group. The schemes also exhibit different approaches concerning financing, solidarity mechanisms and redistribution of income. Most of the cooperatives feel hindered by the legal obligation to contribute to the public social security fund IPS in spite of being eligible for alternative social protection schemes.

Exceptional schemes Until now, only the best developed social protection scheme implemented by the Mennonite colonies in the Western Chaco region has achieved full independence from the IPS monopoly. Due to the practical non-existence of Paraguayan health care facilities in the area, the 45,000 colonists of German origin started to organise their own network of health care facilities and to implement a sustainable financing system for health and other branches of social insurance. Though the Social Insurance Chaco (SVCh) has a number of elements that bear little relation to the Paraguayan value system and reality, the simple fact that it could be established in the South American country is proof of the wide range of options. The main success of the SVCh on the national level is its acceptance as a fully-fledged social security institution whose members are eligible to opt out of mandatory affiliation to the IPS. SVCh is a living example of what alternative social protection schemes can achieve if they fulfil a series of conditions and criteria.

Even more relevant for networking and linking-up seems to be the social security scheme created by the Mennonites in Chaco for the original Paraguayan population. In 1987, they started to implement the Mutual Hospital Aid (*Ayuda Mutual Hospitalaria*, AMH) in order to offer social protection to the indigenous workers and day labourers contracted by the colonists. In the case of formally employed workers in the Mennonite colonies, both the employer and the employee transfer 5% of wages to the account of a local health fund. In order to make affiliation possible for non-regular workers who subsist as independent farmers, they must contribute 5% of their income to the AMH while the employer transfers another 10% to the fund. As long as an independent farmer pays the contribution once a month, he is entitled to a relatively broad range of primary and hospital health services. The AMH, however, is currently not accredited as a full-cover social insurance institution that allows its members to opt out of the IPS.

Conclusions and perspectives

Facing the challenge to overcome the existing patterns of social exclusion in health, Paraguay has taken some promising steps on the long way towards universal coverage. The current administration is making serious attempts to offer better and more affordable health care. Due to expanding needs, a closer collaboration of public and non-public institutions will be essential to achieve reasonable success in the medium term. Implementing an adequate legal framework, enforcing regulatory entities and capacity not only in the public, but also in the private sector, improvement in public health care provision and the definition of a basic mandatory health plan for all insurance schemes and the whole population will be of the utmost importance. In this context, the implementation of a single fund or various co-ordinated funds will promote solidarity and equity in the Paraguayan health care

system. Therefore, the enormous potential and richness of health financing mechanisms calls for a systematic approach to link up the various existing and forthcoming schemes within a clear political vision of health needs and priorities in order to improve health outcomes. This could substantially reduce the large number of people still excluded from health insurance coverage.

2.5 Chile

In the sample of countries gathered in this paper, Chile is to some extent an outlier since it is considerably wealthier than the other countries. It presents the interesting picture of a combination of Bismarckian and Beveridgean systems in order to reach out to the poor. Nevertheless, despite the achievement of universal coverage, problems of equity and fairness in health financing and unequal access to quality health care persist.

Country context and background information

Chile is one of the very few countries in Latin America that provides practically universal coverage in health. This has become possible due to the combination of the so-called Bismarck and Beveridge systems. The formal economy and parts of the informal sector rely on a contributory insurance system. The poor are protected by a tax-financed welfare system administered by the same public health insurance scheme. In spite of some conceptual limitations and relatively high co-payments for the better-off, both sub-systems are solidarity-driven and their combination guarantees progressive financing and effective re-distribution in the public health care sector. A set of waivers and exemptions within the public system is diminishing the negative social effects and the discrimination produced by out-of-pocket payments. Altogether, under the roof of FONASA, an effective linkage of contributory and non-contributory system elements has been implemented and continuously managed.

Since its market-oriented social sector reform in 1981, Chile is generally considered as the prototype of privatisation of health care. In fact, the intention was to reorganise the widely state-run system in a way that allowed for the increasing involvement of private insurers and providers. The reform was realised under the conditions of a military dictatorship where political opposition against the radical restructuring of the whole social sector was non-existent. However, reality defeated the ideology-driven attempt to shift health care from a public to a private responsibility. Even in times of robust economic growth and relative prosperity in the late nineties, affiliation to private health insurance companies (ISAPREs, *Instituciones de Salud Previsional*) never exceeded one-third of the population. Due to economic recession, the proportion of privately insured Chileans is currently below 20%.

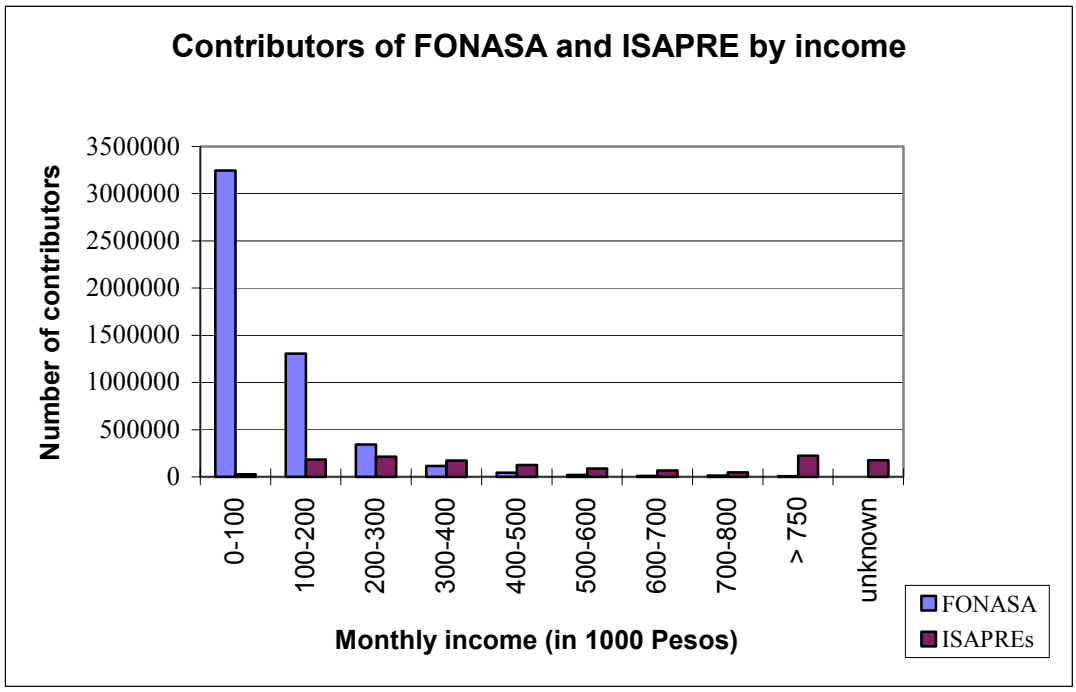
Towards privatisation of the social protection systems – a success story?

In theory, all citizens have the freedom of choice between FONASA (*Fondo Nacional de Salud*) and an ISAPRE. The latter, however, can select their enrollees according to economic capacity because affiliation to an ISAPRE is not compulsory while FONASA has to enrol any person who requires it. The entrepreneurial logic forces for-profit insurance companies to make sure that the expected expenditure for services does not exceed the income from premiums. In a social security system with externally fixed premium rates (7% of taxable salary) the need to generate profits restricts the target segment of private enterprises *a priori* to the population with higher relative income. This leaves the public health insurance to act as the last resort for citizens.

Problems of the system shift – marked risk and income selection

In Chile, customers are allowed to switch insurance company after a minimum period of 12 or 24 months. On the other hand, ISAPREs have the right to "adjust" their health plans to general economic conditions and to the current individual situation of the contributor and his dependants. By allowing this, the reformers wanted to give customers the possibility of inducing effective competition in the health insurance market by opting out in the event of dissatisfaction. Due to the horizontal permeability of the dual system, however, the short-term conditions of private health plans cast serious doubt on the sustainability of social protection in Chile. As private health insurance companies in Chile concentrate on the healthier and the better-off, they induce strong risk and income selection which has relevant effects on the efficiency of the system overall. In fact, in 2000 nine out of ten contributing FONASA-enrollees earned less than US$ 400 per month, and the income of two out of three members was even below US$ 200.

Figure 2: Contributors of FONASA and ISAPRE by income (Chile)



Source: Data of the Study Department of FONASA from January 25 of 2000; Superintendencia de Instituciones de Salud Previsional. Statistical Bulletin January-December 1999 and January-December 2000. Santiago 2000/2001.

Please note: Due to the availability of aggregated data only, the column ">750" resumes the FONASA-insured with the mentioned income and the ISAPRE-insured with a monthly income of more than 800,000 Pesos. So the discrepancy in the distribution of high-income earners is underestimated in this figure compared to the reality.

The serious equity and fairness problems the Chilean health care system depicts are mainly attributable to *ex-ante* as well as *ex-post* risk selection applied by the private insurance companies. Chilean legislation and regulation give them broad options to avoid the affiliation of poorer people, and even to get rid of older enrollees before they start presenting higher risks.

The coexistence of a solidarity-driven public sector and a for-profit private sector operating with risk-adjusted premiums has led to a two-tier health insurance system. Additionally, the exogenous, wage-related fixing of contributions forces private insurers who work according to the equivalence principle to apply hyper-

regressive user fees on the expenditure side: the lower the income, the higher the average burden of cost-sharing, while the better-off are free from relevant co-payments. Figure 2 illustrates the degree of *cream skimming*.

More than 20 years after the wide-ranging sector reform, the results are relatively far removed from the initial intentions. The pretended extension of private health care and financing has not been achieved, and more than two-thirds of the South American country's citizens still depend on public services.[17] Evidence shows that micro- and macro-economic efficiency gains are rather more likely to be located in the National Health Fund (FONASA) than in the private health care sector. During the last fifteen years since the end of the military regime, democratic governments have invested heavily in public services. At the same time, FONASA underwent a series of internal reforms and a restructuring of its functions.

Perspectives in linking up the systems

A major problem affecting overall efficiency as well as cost constraints on health care in Chile is the strong segmentation of the system. Organisational and financial relationships between the public and private sector are incipient and weak. In case ISAPRE beneficiaries receive treatment in public hospitals, the latter have little chance to charge the insurance company for the services granted. On the other hand, contributing FONASA beneficiaries have the chance to use private providers only if they are willing and able to shoulder relevant co-payments. The most dramatic consequences of the separation between both sectors have been overcome due to the legal obligation for all providers to provide emergency care to any patient, regardless of insurance status. The interaction between FONASA and ISAPREs, however, is still limited and more or less casual, except for the recently implemented catastrophic insurance for ISAPRE beneficiaries. Facing the real costs of complex and cost-intensive care, the private insurance companies decided to sacrifice one of their crucial reasons for being. The freedom of choice has always been a key argument for the private health care sector. But in order to receive medical care according to the catastrophic insurance implemented in both sub-sectors, ISAPRE beneficiaries are in most cases entitled to use only public hospitals.

In fact, ISAPREs are under pressure to offer affordable treatment of complex diseases without putting their own financial viability and profitability at risk. On the other hand, FONASA feels a growing demand to offer a broader set of free choice options to their beneficiaries. From a systemic point of view, the implementation of an administrative and economic relationship between public and private sector institutions has the potential to lower the existing barriers between both sub-systems.

In order to overcome strong risk selection as well as cream skimming, and to contribute to a fairer financing of health care in Chile, the introduction of overall risk adjustment mechanisms between FONASA and the ISAPREs and others appears to be of the utmost importance. As all citizens are obliged to pay 7% of their taxable income towards health insurance, irrespective of the sub-system they belong to, all income-related contributions can be considered generally as a part of the social security system and as public funds, regardless of whether they are administered by public or private entities. This is a strong argument to introduce mechanisms of income- and risk-solidarity in the reallocation of mandatory contributions, either

[17] About 10 % of the population relies on the autonomous insurance schemes run by the armed forces including the police, the large universities and some public enterprises such as the national copper industry CODELCO, and others (Holst 2001).

through a solidarity fund between FONASA and ISAPREs or the introduction of risk-adjusted premium subsidies that effectively reduce the ISAPREs' incentive for risk selection. In June of 2004, however, the legal initiative to implement a social risk equalisation mechanism was stopped by the political opposition in the Parliament in order to ensure the approval of the so-called Plan AUGE that guarantees time and co-payment frames for access to the treatment of epidemiologically relevant diseases.

Conclusions and perspectives

Within the Chilean public health care system, access to health care facilities is not as equal as the universal coverage and the application of the solidarity principle may suggest. A major concern of the public insurance FONASA was to find out potential reasons for the gap observed between the provision of health care facilities and the level of demand and need of the indigenous population in the South of Chile. Surprisingly, the impact attributable to ethnic and cultural reasons and specific characteristics of the indigenous groups did not turn out to be any more significant than general social conditions. Disparities in the take-up of health care depend mostly on socio-economic factors and on the educational level of citizens. Access is also determined by geographic and logistic conditions. Hence, a special programme addressing ethnic groups does not seem more important than general initiatives to improve the suitability of public institutions for the poor and to lower potential barriers to access.

In addition to the existing discrimination against the poor within FONASA, there are other problems in the overall health care system in Chile. The evident lack of equity and solidarity within the Chilean health insurance system has a series of undesired effects in terms of macro- and micro-economic efficiency, the distribution of financial burdens, and sustainability.

Even before the implementation of the "Plan AUGE" (Universal Access with Explicit Guarantees), it was possible to implement an additional insurance for severe and cost-intensive diseases in both sub-sectors once the private health insurance companies had managed for the first time to build their own reinsurance scheme and to agree mutual guarantees to cover extreme financial burdens on an individual insurer. This might be a first step towards a risk adjustment within the private health insurance market in order to prevent catastrophic expenditures for one ISAPRE. At the same time, the additional insurance coverage and the Plan AUGE are an option for freeing FONASA from its implicit reinsurance role and the financial burden caused by those who drop out of the private system. After more than 20 years of segregation, a risk adjustment scheme seems to be a preliminary step towards linking up the existing sub-systems in order to improve accessibility, affordability and quality of care for all citizens.

2.6 Vietnam

This section deals with the extension of social health insurance in Vietnam in order to achieve universal coverage, an aim which has been put high on the agenda of policy makers. A comprehensive combination of different strategies is being put into action. This multi-component system is far reaching.

Country context and background information

Vietnam has experienced rapid economic development and dramatic social change involving a wide range of social and economic reforms over the past two decades. It has undertaken a transition from socialist planned to market-oriented economy. Since the mid-1980s, the average levels of household income have increased considerably, while income disparities, particularly between urban and rural areas, have widened. Health care was provided free of charge under the planned economy. User charges were introduced at public health facilities in 1989 as part of the broad economic market reforms known as "Doi Moi – Renovation".

In 1993, Vietnam initiated a Social Health Insurance System with a compulsory membership component for civil servants and employees of state and private enterprises employing more than 10 staff. Voluntary Health Insurance has been established as second component of the system, which has been designed for the rural population, the self-employed and family members. Health insurance has initially been operated by provincial health funds.[18]

By 1 January 2005, the total number of members in the health insurance schemes has reached about 18.6 million people, which accounts for 21% of the Vietnamese population. 8.5 million members are covered by the compulsory health insurance scheme (including 1.9 million pensioners and 1.1 million so-called meritorious people[19]), 6.3 million by the voluntary schemes, and the remaining 3.8 million members belong to disadvantaged groups eligible for free health cards. Coverage is almost universal for civil servants and reaches almost 90% for employees of state-owned enterprises.

The compulsory health insurance scheme[20] covers only the insured persons, not their dependants. Members are entitled to a full range of health care services but have to share the costs in the form of a 20% co-payment up a to ceiling of 6 times basic salary. Only pensioners and meritorious people are exempted.

The government is by far the major client of Vietnamese Social Security (VSS), the executing agency of the National Social Health Insurance Scheme. The government fully pays the contributions for 6.8 million people, among them public

[18] During the first decade of operation, a number of administrative reforms have been accomplished. By 1998, the provincial funds first merged into a single national fund, which again has been amalgamated with the existing pension fund. Today, the Vietnamese Social Security (VSS) is executing agency of all national social security funds. Besides headquarters in Hanoi, VSS runs 64 provincial branches and another 618 district offices.

[19] The meritorious group consists of those who contributed to the wars in Vietnam as well as their immediate relatives. The government recognizes compensating its meritorious citizens as the most important objective of social security.

[20] Compulsory members have to pay 23% of basis salary for social security contributions, which entitle them to both the health insurance and the pension fund. Whereas the employer will have to pay 17% of the salary, the employee bears 6%. Out of the total, the VSS health insurance component receives only 3% of basic salary (2% by employer, 1% by employee). The bulk of contributions finances the VSS pension fund (15%), which has been established as the most important pillar by far. The remaining 5% is allocated to administration. The yearly revenue gathered by means of contributions reaches approximately 13,000 billion dong. Exchange rate January 2005: 1 US$ = 15,600 VND (dong).

sector pensioners, the poor, and meritorious people.[21] As the employer of an additional 4.5 million public sector employees, again the government is responsible for 2/3 of their contributions. In other words, the Vietnamese Government pays the majority of contributions for more than 60% of all VSS members.

Although participation in Vietnam's Social Security system is mandatory by law for all employers, compliance among private companies is still very low. Since January 2003, the criteria for mandatory membership have changed. Social Security became obligatory for all employees in the private sector, starting with the first employee of any company. These changes brought another 500,000 people into the system within the first two years of implementation. Nevertheless, with currently one million members from the private sector, health insurance coverage has still reached only 16% of the total labour force.

Potential for extension of social protection coverage

The extension of social health insurance coverage has been placed as a top priority on the Vietnamese government's agenda. Its declared aim is to achieve universal coverage by 2010. Therefore, the VSS is putting some effort into enforcing the compulsory membership of all public and private sector employees and trying to gradually enlarge the scale of coverage of the informal sector through the parallel voluntary health insurance scheme. The following steps are currently being undertaken in order to attain the goal of universal coverage:

- Inspection measures will be implemented to increase compliance with social security regulations. The regulation on inspection stipulates close collaboration with the tax department of the Ministry of Finance and access to customers' bank accounts.
- First attempts to institute family membership (for example) have shown positive results and it has been proposed to make them mandatory in the future.
- The number of community based health insurance schemes supported by the government, which have been introduced as pilot projects over the last two years in each province, are to be tripled, it has been announced.
- Coverage for schoolchildren, which currently applies to 6 out of 16 million pupils, is expected to be increased by a million children by the end of 2005.

Furthermore, two large programmes have been launched, targeting the poor and disadvantaged groups:

- The "Free Health Card for the Poor" as part of the "Hunger and Poverty Reduction Programme (HEPR) by the Ministry of Labour (MOLISA), already introduced as of 2001. Funds allocated by the government for this programme are derived from general tax revenue and donor money.
- The "Programme for Children under 6" approved in 2004, aiming at the target of direct coverage for a total of 9 million children.

[21] Health Cards for the Poor 3.8 million, pensioners 1.9 million, meritorious people 1.1 million.

Routes taken towards extension of social protection, and options

Voluntary Health Insurance developed slowly and has had little success in increasing enrolment amongst adults who are neither eligible for the compulsory health insurance scheme, nor for the poor relief scheme.[22] As a result over 95% of voluntary members are school children.[23]

Premiums vary in different areas, according to the local economic situation.[24] Voluntary health card members are entitled to the same benefit rights as compulsory members. For farmers and school children, the threshold for co-payments is set at 1.5 million VND per year. Employees with mandatory insurance are offered a 5% discount to enrol their family members into the voluntary scheme. But only a small number have taken advantage of this offer. One of the main problems is the very low rural population coverage by the Voluntary Health Insurance Scheme. The reasons for this include 1) premiums which are too expensive for a vast majority of the rural population; 2) the distribution of designated health facilities for the insured is not convenient for most of the farmers; and 3) the unsatisfactory quality of services provided at the commune and sub-district levels.

In 2003, comprehensive guidelines on the voluntary health insurance scheme were stipulated for the first time. This had a very positive impact on the voluntary system and boosted enrolment considerably. Circular No. 77 proposed significant changes in the basis for enrolment of the informal sector. Instead of individual membership, VSS now favours family and group enrolment by mass organisations, schools, or communes. Every province started a pilot system called Community Based Health Insurance (CBHI). The new programme, implemented since 2004, brought about 300,000 new members into the system during the first year of implementation. Two-thirds of the new members enrolled by means of group membership through mass organisations like the Vietnam Women's Union, the Labour Confederation, Vietnam Youth Organisation, and the Vietnam Farmers' Union.[25] Financial measures, such as contribution discounts for organisations to compensate for their additional work and expenses incurred as a result of contribution collection, are not currently established.

VSS announced the tripling of pilot schemes in the course of the year 2005 and expects to gain another 900,000 members. In addition, family membership has been placed in the centre of interest by VSS. The organisation advocates mandatory family membership as a top strategy toward universal coverage. Promotion via the mass media and local organisations has already started.

Admittedly, the capacity to implement the new policy within VSS is still not sufficient. In addition, problems persist of adverse selection and financial debt in the case of the voluntary scheme. However, this new policy development is technically interesting and quite promising. Compulsory family membership and group coverage would enhance the principal of solidarity and cross-subsidy within the still voluntary health insurance scheme. The risk pooling of VHI is at the national level, which is already a potential strength. And the mass organisations are strong enough to advocate the interests and rights of their members.

[22] Nearly 80% of the Vietnamese population lives in rural areas and is engaged in farming activities.

[23] To some extend VSS is competing with existing privately and state owned insurance companies. For instance, Bao Viet, owed by the Ministry of Finance, competes with VSS in the market for schoolchildren's coverage. In general, collaboration with private insurance companies is very limited.

[24] Parents pay an average of 30-33,000 VND for their school-age children. Farmers are charged around 70 – 73,000 VND and the general population 110,000 VND per year.

[25] These mass organizations have already ventured into establishing micro-credit and saving schemes and founded autonomous NGOs to run the schemes, sometimes supported by international NGOs.

Reaching out to the informal sector: concrete examples

In recent years, two major poverty reduction programmes have been established to increase access to health services for poor and disadvantaged groups:

Health Care Fund for the Poor:[26] Vietnam's Health Care Fund for the Poor was conceptualised in 2001 as a social safety-net mechanism to improve access to health services and protect the poor from catastrophic health expenses. The programme targets 14 million people. The fund management is under the control of the Provincial People's Committee. Provinces can choose whether to issue health cards for the poor or provide free treatment at public health care facilities (costs are shared between the central government – 70% – and the provinces). Registered poor are given fully paid health cards which entitle them to comprehensive health services. Provincial social insurance offices grant health insurance cards to these households. The list of poor households is defined by MOLISA based on the national poverty line, with due consideration of the local context. At grassroots level, Commune Committees on Poverty Reduction select the households to be put on the list. By now, the government has allocated funds to issue 3.8 million free health cards. Those poor people without health card may still be supported if the Provincial People's Committee directly reimburses health facilities. Details on direct support to the providers are not known.

The additional fiscal burdens of this new policy will be substantial. In addition to the increasing number of health cards for the poor, it is argued that the current government allocation for the Health Care Fund (VND 50,000) is below the average health care cost per member (estimated at VND 70,000). It remains to be seen how this gap will be filled.

In spite of all budgetary efforts, it is highly unclear whether the poorest and most vulnerable groups really benefit directly from the increased health expenditure. Out-of-pocket expenses as introduced for farmers still have to be paid by the poor. The situation differs from province to province, as each sets its own poverty line which determines whether or not individuals are registered as poor. In principle, all the poor have access to health care but utilisation is difficult and the quality of health services rendered often unsatisfactory. In principle, however, the benefits package is the same for the compulsory scheme, the free health cards scheme, and the children under-six scheme.

Programme for children under 6 On August 26, 2004, the Vietnamese government in accordance with the children's convention reached agreement on another major poverty reduction programme, aiming at health coverage for schoolchildren under the age of six. An annual total allocation of 800 billion VND (~ 45 million euro) is envisaged. 9 million children below the age of six have been targeted for direct coverage. The implementation, announced for 2005, has already encountered some problems. Firstly, VSS lacks capacity to implement this huge programme. Furthermore, the health insurance coverage excludes some benefits, e.g. treatment for congenital malformation, which is seen as unfair to affected pupils. Therefore, it is most likely that the money will be allocated to the hospitals for direct exemption of the schoolchildren, at least for a transitional period, rather than through VSS.

[26] Health Insurance for the Poor was implemented in 2001 by Inter-ministerial Regulation No. 05 as part of MOLISA's HEPR Programme (Hunger and Poverty Reduction Programme). By the year 2003 and in accordance with Decree 139 (15 October 2002), the Health Fund for the Poor was officially established.

Conclusion and perspectives

As a whole, there are many opportunities for Vietnam to develop equitable and sustainable (rural) health insurance systems. The introduction of (partially subsidised) community-based health insurance schemes operated by NGOs under the umbrella of mass organisations is seen by many as one promising way to bring health insurance coverage even to low-income people in the informal economy. However, covering a substantial proportion of the rural population in Vietnam is a difficult task and requires strong organisational capacity.

The government has made firm commitments to ensure access of the rural population to basic health care. Government subsidies to Voluntary Health Insurance will increase health insurance coverage by making the scheme more acceptable and affordable to the target population. In addition, the subsidies allocated to the providers in some provinces through both poverty reduction programmes ("Health Care Fund for the Poor" and "Programme for Children under 6") could be made conditional upon setting up an insurance-based system within a certain period of time.

In contrast to many other countries, extension of health insurance coverage in Vietnam and linking up approaches are initiated by and seen as a government task. Clearly, VSS plays a central role and should be further supported through capacity building and innovative ideas towards strengthening decentralised insurance mechanisms. However, the bulk of subsidised contributions in conjunction with poverty reduction programmes produce a substantial fiscal burden, which can only be sustained by a prosperous economy and rising government revenues.

The Vietnamese top-down approach to social protection is both an opportunity and a challenge to reach the goal of universal coverage. A network of licensed insurance brokers, which promote and administer VSS products for different regions and target groups of the informal economy, is likely to boost the extension of coverage. The network should not be limited to sub-structures of mass organisations, but also include private agents. The payment of a commission per beneficiary combined with discounts for group enrolments should enable private institutions to run a brokerage business profitably.

Many lessons and experiences have been learnt from Vietnam over the past decades. These lessons and experiences should help the country to continue its efforts towards universal coverage by linking up different insurance approaches, and prevent the recurrence of previous mistakes.

2.7 Laos

In this last section a country is shown which has made some first promising steps in the extension of social protection in a relatively short time – Laos.[27] The main challenge, however, will consist of linking up the different social security schemes, which have so far co-existed rather than interacting.

Country context and background information

The Lao social security system looks back at a relatively short history but has made significant progress since the mid-nineties. In 1999, a historic step in the development of social protection was achieved through Decree 207/PM[28] which stipulated the social security policy for the private sector. However, the Social Security Organisation, responsible for its implementation, only became operational in 2001 and has only reached about 30% of the defined target population so far.

Before 1999, only civil servants were covered by a social security scheme which was introduced in 1986. The health insurance component of this scheme is characterised by fee-for-service reimbursement. However, maximum amounts per episode and per year are very low and in many provinces the public sector health insurance scheme does not function at all.

In 1994, a new Labour Law came into effect, establishing social protection for the formal sector. Articles 50 to 53 stipulate that the employer is responsible for the social welfare of the workers, including health care. However, the Labour Law did not provide very reliable protection, depending largely on the willingness and ability of employers to pay for workers' social security benefits. Hence, the government advocated the elaboration of the mandatory system, laid down by Decree 207.

Beside public and private sector schemes, in 2000 the Community Based Health Insurance (CBHI) scheme was launched as a third health insurance approach. Theoretically, it targets the remaining part of the population, but as yet only three pilot CBHIs have been established, located in the north (Luang Prabang Province), the centre (Vientiane Province) and the south (Champassak Province) of the country. The WHO has offered substantial financial and technical assistance.

Potential for extension of social protection coverage

The Social Security System in Laos is still rudimentary and highly fragmented. Attempts to link up the different schemes are still in an early stage and are currently confined to applying comparable procedures for membership administration and purchaser-provider relationships. In the following, the three schemes are introduced in detail followed by a discussion on the linking-up approaches.

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[27] The Human Development Report 2004 states a GDP per capita of 304 USD in 2002 and a Total Health Expenditure of 3.1% of GDP in 2001, which is equivalent to around 10 USD per capita. Of the national health expenditure in the Lao PDR, 8.7% comes from government sources, 30% from external or donor sources, and 55% comes from households as out-of-pocket expenditure on services at the time of use. The major part of household out-of-pocket expenditure does not go to the public system, but rather to private pharmacies and private practitioners. Source: JICA report 2002

[28] On 23 December 1999 the Prime Minister's Office signed Decree 207/PM on the Social Security System for Enterprise Employees. The social security scheme was declared a compulsory and state-guaranteed insurance. Its purpose was described as "to ensure welfare rights and benefits for employees, with the objective of improving living conditions and contributing to the socio-economic development of the country".

Routes taken towards extension of social protection, and options

The Private Sector Social Security Scheme The Lao Social Security Organisation (SSO) was set up in 2000 and started work in 2001. The organisation focuses on employees (as well as their dependants)[29] of private companies, including state-owned enterprises, with 10 or more staff.[30] Though the underlying Decree 207 stipulates mandatory membership, compliance of Lao businesses in subscribing their employees to SSO is still very low.[31] Presently, employees of 181 enterprises are enrolled with 23,119 paying members and 48,096 beneficiaries.[32] According to a recently presented actuarial review of SSO, this represents only 31.4% of the population legally covered by the scheme. All insured are located in the Vientiane area. It is planned to extend the regional scope to other provinces of Lao PDR within the coming year, namely Savannakhet and Vientiane Province.

Apart from health insurance, the social security scheme is a broad scheme covering several short-term and long-term benefits.[33] Medical care benefits are presently offered within Vientiane by four public hospitals. They are provided without additional user fees.[34] The health care package is quite comprehensive and very few treatments are excluded.[35] The hospitals are presently paid on a capitation basis, i.e. for each beneficiary, SSO pays an amount in advance for the possible costs of treatment. The amount has constantly been adapted in the past, because the basis (how many dependants are covered) has changed and hospitals claimed that the per capita amounts were not covering their treatment costs. For the year 2004 the capitation paid was 60,000 kip (~€4.70 as of May 2005)[36] per beneficiary for health care provision. These capitation amounts were paid to the contracted hospitals according to the number of patients that chose them as their hospital for treatment.

By decree, employees have to contribute 4.5% of their salary for social security. Employers are obliged to pay 5% of the employees' salary on top of this to assist with social security provision. An assessable income ceiling has been set at 1,000,000 kip and not yet adjusted to changes in the national income level.[37] The following table gives more details of the exact contributions and the internal allocation key to the different benefits.

[29] Spouses and children up to 18 years are covered as family members without any additional contribution.

[30] However, voluntary subscription for small enterprises is obtainable, too.

[31] The private insurance company Assurance Général du Laos (AGL), part of Allianz Group, is offering a comparable health insurance product for the same target group and is a real competitor to the mandatory scheme. Although this contradicts Lao law, it has been a reality for some long time now.

[32] Female members represent around 2/3 of all primary members. In consequence, the coverage in employment sectors with a high female workforce, such as the garment industry, is comparably higher than in typically male employment industries (construction, transport).

[33] The short-term benefits include 1) sickness benefit, which is income compensation in case of temporary loss of working capacity, 2) work related injury or illness benefit, 3) maternity benefit, and 4) funeral grants. Long-term benefits cover 1) retirement pension, 2) survivors' benefits to protect dependents of deceased employees, and 3) invalidity benefits in case of permanent loss of working capacity. All these benefits are financed by four separate funds in SSO.

[34] By Decree 52, introduced by the government in 1995 for specific services in government health care institutions. User fees are levied for patient registration and ancillary services but not for consultations by professional health workers. By decree, monks, students and indigents are exempted from paying user-fees. But implementation of the rules has been rudimentary, especially for the poor.

[35] Excluded are: in-patient services beyond 60 days of stay within one year, chemotherapy, open heart surgery, organ transplant, artificial insemination, sex change, haemodialysis, cosmetic surgery, (non-work related) motor vehicle accidents, and diseases covered by the government.

[36] The capitation rate exceeds by far the calculated rate of 35,000 kip, calculated by a costing study undertaken in November 2004 for one of the contracted hospitals. This study takes into account the utilization rates of SSO members from October 03 – September 04.

[37] Currently, 20% of male members and 6% of female members earn above the ceiling.

Table 7: Details on contribution rates as percentages of insurable earnings, Laos

Description of benefit	Percentage from employee	Percentage from employer	Total contribution
Health insurance	2.2%	2.2%	**4.4%**
Short-term benefits	1.2%	1.2%	
Sickness	0.5%	0.5%	
Maternity	0.3%	0.3%	**2.4%**
Birth grant	0.2%	0.2%	
Death Grant	0.2%	0.2%	
Employment injury and illness benefits	-	0.5%	**0.5%**
Long-term benefits: Pension/Invalidity/Survival	1.1%	1.1%	**2.2%**
Total contribution	**4.5%**	**5%**	**9.5%**

Note: Including 10% of total for administration, Source SSO.

The Public Sector Social Security Scheme The public sector scheme was established in 1986 and targets civil servants, the military and the police as well as their relatives. In 2003, the scheme covered around 875,000 people.[38] The scheme is funded by a 6% contribution from employees based on their basic salaries and a government subsidy to pay the non-covered expenditures. The benefits offered comprise pensions, disability benefit, survivor benefit, sickness benefit, maternity benefit, occupational injury and medical care. However, the current contributory revenue is mainly used for pensions, and reimbursement for health care expenditure is dependent on the amount remaining in the fund. Health insurance is administered as a reimbursement scheme, based on a fee-for-service system with a threshold for reimbursement. Beneficiaries complain about high co-payments as well as complicated and very prolonged processing of claims, taking six months or more. The system is not very transparent and few people know about the benefits they are entitled to.

The scheme is currently undergoing major reforms to enable broader protection in the area of health care. ILO, via its project on “Development of Social Security in Laos”, is providing substantial technical assistance. Pilot projects are targeted for the year 2005 in Vientiane Municipality and Vientiane Province and are expected to scale up gradually to nationwide coverage by 2008. As for health insurance, the new public sector scheme takes advantage of many design features and arrangements which have already been tried and tested by SSO and partly by CBHI. Hence, capitation will be also established as the single provider payment mechanism and replace the current fee-for-service system. The benefits package will be similar to the SSO health insurance package.

In addition, this scheme will take a leading role in testing a referral system for health care provision. Beneficiaries will be required to register with a district hospital first. The intention is to stop the overuse of provincial and national hospitals as preferred providers of primary health care services. However, this will only be accepted by enrollees of the public sector if district hospitals significantly upgrade the quality of their services.

[38] Among these, roughly 91,000 civil servants, approximately 100,000 armed forces and police officer and 680,000 dependents.

Reaching out to the informal sector: some examples

The Community Based Health Insurance Scheme (CBHI) Over 80% of the Lao population is in the informal labour sector and currently excluded from the two social security schemes described. The Ministry of Health (MOH) therefore sought ways of providing social protection for this population through voluntary community-based health insurance (CBHI). In 2001, a MOH–WHO project was launched to develop 3 pilot schemes within 2 – 3 years.

- Sisathanak District, Vientiane Municipality (Centre) – since November 2002
- Nambak District, Luang Prabang Province (North) – since June 2003
- Champassak District in Champassak Province (South) – since February 2004

In July 2004, the number of members reached 554 (2,928 beneficiaries) in Sisathanak, 645 (3,880) in Nam Bak and 275 (1,569) in Champasak. The design features were the same for all CBHI schemes, following the Health Plus Scheme (OHPS) model, a CBHI set up in two locations in the Philippines with technical assistance from the WHO.

However, the real advantage of the envisaged collaboration of social security schemes is the fact that all CBHI pilot models have made use of an insurance scheme design, management mechanisms and an evaluation system which have already been implemented successfully for the SSO private sector system. Examples are:

- Enrolment is based on family membership[39]
- No co-payments are applied
- SSO benefits package and entitlement conditions have been similarly applied for the informal sector schemes
- Provider payment is based on capitation[40]
- Both systems use ATD (Admission-Transfer-Discharge) health information systems

The replication of previously implemented and tested procedures of health insurance is a matter of equality between the insured, no matter what kind of insurance system they belong to. Despite the favourable similarities in the structure, CBHI is challenged by many problems which are typical to small-scale micro-insurance systems:

- The total membership remains limited (275 to 645 families and 1,500 – 3,900 beneficiaries) and the capacity is too small for an extension toward large scale coverage
- Especially in Sisathanak, the first implemented scheme has experienced high drop-out rates since the start of the operation (31%)

[39] The CBHIs work on nominal fees which are set in relation to family size. The monthly contribution varies from 10,000 kip for single members, 17,000 for 2-4 persons per household and 21,000 kip for 5-8 people up to 23,000 for more than 8 family members. In Nambak, a Swiss Red Cross Equity Fund subsidies the contributions of 111 poor families.

[40] The capitation rate is 35,000 kip/person/year in Nam Bak, 42,000 in Sisustanak and 58,000 in Champasak. In contrast to the SSO system, the CBHI schemes split the capitation amount between district hospitals (70%) and referral hospitals (30%).

- Contributions are paid late, if at all. The schemes report a percentage between 17% and 47% of late payment behaviour.
- Health workers show a negative attitude towards insured patients as they cannot gain any additional profit. In consequence, they tend to over-prescribe drugs in order to reduce counselling time and keep the patient satisfied.
- Members have unrealistic expectations on service delivery and also tend to over-use the benefits (this is in line with supplier behaviour, especially for drug prescription, which is reflected in the high proportion of capitation payments used for drugs).
- The much larger average sizes of families in the CBHI scheme (5.6) causes proportionally higher health expenses per member in relation to the SSO formal sector scheme (2.1), as capitation is based on beneficiaries.
- The cost of transport to the hospitals, especially to the referral hospitals, causes major financial problems for members since transport is not part of the benefit package.

The pilot project has shown evidence that CBHI is a valid system enabling access to health care for low-income populations. In particular, financial barriers of unpredictable use-charges have been eliminated. However, the CBHI schemes will have to elaborate strategies to cope with the aforementioned challenges. The expansion of membership remains a top priority. However, there is also a need to raise additional revenues in order to cover the poor. This could be done either through a gradual increase of contribution rates or through access to equity funds from international donors.

Conclusion and perspectives

The Lao government is fully supporting the current reforms and extension plans of all three schemes. Particular focuses of interest are the extension of the SSO formal sector scheme to the provinces, the reform of the public sector scheme and the extension of CBHI. However, due to fiscal constraints no budget has been allocated to introduce mechanisms for exemption from out-of-pocket payments, as laid down in Decree 52 of 1995.

To date, the high consistency of all three health insurance schemes in terms of their underlying principles of family membership, insurance design and provider payment, provides a good opportunity to link-up the schemes wherever this is worthwhile. The provinces of Savannakhet and Vientiane, where all three schemes will coexist in the near future, are probably the best-suited locations to prepare for very close collaboration. In the future, merging the two formal economy schemes would probably be the next step.

At the current stage of development, any reform initiative should not be limited to one system, but also (after a successful testing period) implemented in the other systems. Thus, the vital asset of comparable and equitable solutions for all health protection schemes can be retained. Examples of such reforms are:

- Referral system: already implemented in CBHI and prepared for in the public sector scheme, but not yet proposed for SSO

- Capitation payment: SSO, ministries and hospitals have agreed to evaluate the development of payment mechanisms beyond capitation, and envisage more volume-orientated payment mechanisms for the future
- Coverage for road traffic accidents: unfortunately, benefits for injuries caused by road-traffic accidents are excluded from the benefit package of any scheme.

In the long run, SSO could fulfil a central function in linking up the different approaches. After a successful pilot phase for the public sector scheme, merging the two formal sector systems would be a rational step in order to avoid parallel structures.

Moreover, SSO would be best placed to take the lead in negotiating and controlling contracts with providers for all health insurance schemes. Applying the same capitation or other form of provider payment will bring equity into the system and implicitly built up cross-subsidisation from the formal to the informal sector, as the size of households is much larger in informal and rural settings.

In respect of the CBHI approach, SSO could share office space in the branches and carry out some key administrative functions on behalf of the CBHI (registration, financial management, claim processing, contracting of providers). Health insurance under one roof in line with the partner-agent model would make the system more attractive for the population. However, differences in income, education and demand for health services will persist and require specific solutions (e.g. contribution procedures) for the various target groups.

3. Concluding comments

This final section sums up major mechanisms and dimensions depicted in the various country profiles and extracts from these experiences some lessons learnt.

3.1 Lessons learnt

The country profiles have shown an impressive variety of possibilities for tackling the issue of linking up social security schemes and spreading the outreach of social protection. The guiding principle and objective behind all these strategies is the achievement of (near) universal coverage. If possible, the whole population should be entitled to an affordable basic package of quality health care. In this respect, targeting people in the informal economy and even more importantly, the poorer strata of society, calls for efforts going beyond traditional social security structures and mechanisms.

Table 8: Overview of the social security schemes and their linkages

Country	Linking-up actors and mechanisms	GR	RP	IE	PP	Experiences & challenges
PH	Organised groups as link between beneficiaries and national health insurance corporation	++	++	+++	+	Good conceptual framework. Promising steps, but questions remain: e.g. is PhilHealth attractive enough to enrol new members? Necessity remains to attract more members to become a success. Quality of health services provided will prove to be a crucial determinant.
IN	Social security fund administered by insurances for NGOs; joint committee board for supervision	++	+	+++	+++	Promising examples of the partner-agent model and targeting the poor. Problems with capacity and financial sustainability of the schemes
TZ	Competence centres –> social insurance and community health funds– > informal economy	+	na	+++	++	Introduced in several poor countries. Evaluation? Successful instrument so far?
PY	Small-scale security funds – public social security fund	+++	+	+++	+++	Much remains to be done in order to link up the schemes.
CL	Public and private funds – no link	+++	++	++	+++	No linkages between public and private funds. Lack of equity between the schemes. Risk adjustment as a necessary remedy.
VN	National HI-scheme and private HI-schemes – NGOs for the poor	+++	+++	++	++	Good concept but how to enforce it? Organisational capacity. Top-down approach
LA	Still segmented insurance schemes	++	++	+	-	No linking up so far, but schemes are existent and built upon compatible mechanisms

weak + to +++ strong; na= not applicable;
GR= Governmental role; **RP**=Risk pooling; **IE**= Informal economy targeted; **PP**= Pro-poor-targeted

Table 8 regroups the country cases in this study alongside some crucial dimensions which have to be considered: what systems are being linked up? What is the role of the government in the establishment of links between institutions and actors? Is the

respective approach strengthening solidarity (degree of risk pooling)? Are poor people targeted on an individual basis or is the scheme designed for the informal economy (the two categories, though overlapping, are not necessarily the same)? In addition, the linkages could be considered alongside many more dimensions, such as comprehensiveness and coherence of the social protection system, sustainability, enhancement of the quality of services provided, degree of public-private partnership, empowerment of the poor, etc. However, these dimensions, though important, will not be considered here due to a lack of data.

Table 8 shows the great variety and different effects of linking-up approaches, and the different problems they are struggling with. The main question now is whether it is possible to draw general conclusions and recommendation for establishing linkages or are there too many idiosyncrasies making each experience unique in its way and thus ruling out generalisations? Are there tendencies and patterns which emerge out of the case studies upon which it is possible to make policy recommendations?

First of all: the countries are very divergent in cultural, socio-economic and politico-institutional respects, so caution should be exercised over applying off-the-shelf solutions to complex issues. This general caveat – a truism anyway – put to one side, the linkage mechanisms outlined above are all too different and the data set too scanty to enable any generalisation. Nonetheless, it is possible to draw some conclusions and to state that something has been learnt from all these approaches because there are some points common to all the countries depicted in this paper.

1. The political will exists in very different parts of the world and under different circumstances to invest effort in the extension of social protection. All strategies are directed towards the prominent objective of universal coverage.
2. In many countries this extension is seen as being achievable with the help of innovative approaches and there have been some successful early strategies and promising steps in this direction.
3. These innovative approaches are centred on linkages between systems of social protection. Where social protection is organised in too many sub-systems, problems with coverage persist and there is usually a great deal of overlap and inefficiency.
4. Widespread poverty is not an insurmountable impediment in the quest to improve the performance of social protection systems in developing countries. Examples such as CHIC in Tanzania show that quality of services can be improved in an efficient and relatively low-cost manner.
5. Just as important as the economic background, if not more so, is the notion of solidarity within a country; e.g. in this sample Chile is the country with the highest GDP per capita, but still faces problems of equity. However, the case of the Mennonite health insurance scheme in Paraguay shows that solidarity can be implemented in a culture where risk pooling between the rich and the poor is not common.
6. The linkages show that a great variety of interactions between many organisations can be implemented successfully:
    a. Expand formal social security systems

       The examples of India, Chile, the Philippines and Vietnam have demonstrated that governments often entrust public institutions with the responsibility of implementing pro-poor programmes or managing social

funds. The Life Insurance Corporation of India administers the social security fund, which targets poor people in urban and rural communities. FONASA in Chile demonstrates best practice in linking and managing both the contribution-based health insurance system and the tax-based welfare system of the government. Similar experience is known from VSS in Vietnam and PhilHealth in the Philippines.

b. Linking up with reliable market mechanisms

The introduction of borrowed principles and mechanisms from the commercial insurance market is also very promising. Group discounts, which are offered to organised groups in the Philippines, are a common practice amongst private insurers. The Tanzania CHIC approach is based on a franchising model, known from many international food and beverage chains (i.e. McDonald's, Starbucks). Slightly adjusted mass products for the majority of the population produce economies of scale.

c. Simplify and standardise insurance products

The comparability of social security products and administrative procedures offered for different target groups has many advantages. Economies of scale have just been mentioned. Equally important is the efficiency gain on the provider side in terms of manageability of different systems. Incompatible mechanisms for handling payment procedures, medical records, referrals could overburden the administrative capacity of providers. Therefore, Laos shows how to deal with similar modi operandi in all three social security systems.

d. Reach out to the informal sector via organised groups or NGOs.

Civil society organisations can play a crucial role in enrolling large groups from the informal sector. Group contracts combined with incentives and advantages for all parties involved (i.e. the organised group, the member and the insurance organisation) are a promising approach. The country profiles have shown that Vietnam, the Philippines, Paraguay, Tanzania and India have faith in collaborating with NGOs and other groups, for instance cooperatives. If the organised group is managed well, they will even be in a position to take over administrative functions from the insurance corporation.

e. Effectively target families and households as the smallest group entity

Household and/or family coverage is a common approach in social security systems. Protecting all dependants via membership of the head of the household puts a strong emphasis on solidarity. However, family coverage has a serious financial impact on the viability of a scheme. The revenues generated by contributing members have to cover the expenses of all beneficiaries. The larger the average family size in a health insurance scheme, the more the contributing member has to pay. This is one reason why family membership is not always introduced from the very beginning or is levied with additional contributions per beneficiary. Laos has successfully implemented family coverage in its social security system, whereas the CBHI in Laos face financial problems due to large family sizes and the corresponding high utilisation rate of services. Family membership is also part of the

Chilean FONASA system. Vietnam, on the other hand, promotes family coverage with discounts.

f. Government programmes – an effective way to target the poor

Government commitment is very important for reaching the poor (and the poorest of the poor). The poor can be given free health cards or vouchers and cash for benefits. Vietnam opted to a large extent for this allocation method. All other countries pursue strategies of direct targeting of the poor, be it through tax-funded welfare programmes, social or equity funds. It has comparative advantages and is more consistent with social insurance schemes than providing free health care services for the poor. However, finding the right targeting method and ensuring sustainability are common issues of concern. Nonetheless, government – with the help of donor money – has an important role to play if the coverage is intended to be for the whole population. In India, for instance the Government recognises the role of the state in protecting the poor. The requirement that insurance companies have to conduct 15% of their business in rural areas has boosted the extension of health insurance coverage.

g. Enforcement of mandatory membership

Law is by nature a powerful tool of government that can help to introduce risk pooling and financial sharing. A social security law which stipulates mandatory membership is a prerequisite for attaining universal coverage. Most countries in this study passed respective laws. However, in many countries the law has not been fully implemented or effectively enforced. Laos and Vietnam are two examples that stipulate mandatory coverage of private sector employees by law, but due to non-enforcement both countries cover only a third of the target group.

3.2 Summing up and looking ahead

The examples are all too recent to know much about their success in terms of poverty reduction, real diminishment of health problems, prolongation of life expectancy and effects on national economies. But they seem conceptually sound enough to be able to meet the challenges and to fulfil promises of a better future for the beneficiaries of the schemes. The main challenges – *beyond* financial sustainability – will consist in the acceptance of the idea of solidarity in these societies. The lessons learnt show that generalisations can be drawn which can be of interest for future projects in other countries. However, experiences are so diverse that one needs to adapt the specific linkage mechanisms carefully to the country context. While bearing such caveats in mind, one can conclude that on the way towards realising the appeal in Article 22 of the Universal Declaration of Human Rights, linking-up approaches are viable solutions to the problem of attaining ever-expanding coverage of the population.