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The Benefits and Challenges of Social Health Insurance for Developing and Transitional Countries

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This chapter discusses the merits and drawbacks of social health insurance systems for low and middle income countries vis-à-vis other health financing options. It shows that social health insurances are based on certain principles and norms but are by no means typified by one uniform system. The elements that make up different forms of social health insurance systems provide a whole array of policy options that can be flexibly adapted to many countries.

The chapter first identifies different options of health financing and outlines the principles and values at the core of social health insurance systems. It then examines the roles of the state and the private sector in the context of social health insurance. Finally, it provides some experiences and recommendations regarding the implementation of social health insurance in low and middle income countries.

Health financing systems

Every health system has as its goal to contribute to the good health of the concerned population (WHO 2000: 23). It can achieve this best for those people it can reach and thus is more effective the higher its population coverage is. Coverage is therefore an indicator of health system performance. Linked to this is the goal of fair financing which also impacts on whether universal coverage can be attained. Unfair financing is likely to bring health care out of reach for some and universal coverage out of reach for the system. The basic functions in financing health systems are resource collection, pooling and purchasing. However, existing health systems are much more than this. They are the result of complex national, historical and

¹ The authors are indebted to Katja Bender, Jürgen Hohmann, Jens Holst and Sonja von Möller for their substantial contributions to this article, which emerged from a discussion paper on social health insurance that GTZ published on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ).

political path-dependent evolutions. They reflect inherent norms and values of the societies that have shaped them, and consequently no two systems are identical. For example, in a number of Eastern European countries the legacy of the communist era with its emphasis on curative care and abundance of hospital beds is still visible in the current setup. Similarly, many developing country health systems are modelled on those of a former colonial power. All health systems rely on the steering capacity and to some extent the financial resources of the state. Where this capacity is insufficient the private sector tends to fill the gap with health services often designed for the richer members of society. If left unchecked, this can result in the exclusion from health services of the poor and distortions to the health sector.

Generally, one can distinguish between the following sources of revenue for financing health care: general (and ear-marked) tax revenue, social (mostly mandatory) health insurance contributions, revenues raised on the basis of group or community membership, private out-of-pocket payments paid either directly for health care or into private insurance, and donor money. International comparison of health systems does show some relationship between the type of financing and expenditure in the health care but one should be cautious of over-generalisations.

The money collected from these sources is then used to pay for health care. The most straightforward options are *out-of-pocket payments* or *user fees* which exist extensively in many developing countries. In OECD countries in particular, such direct payments have been replaced to a large extent by various forms of prepayment. These include government purchasing of health care and payment through a third organisation, such as an insurance, be it a social health insurance, a community based health insurance or a commercial private insurance.

Hardly any country has implemented any of these financing systems in their purest form but most adhere to a large extent to the principles of one of them. The British *National Health Service* is often given as example of tax-financed public provision with its far-reaching integration of financing and service delivery. Sweden and Spain are in the same category. Many of the former British colonies have adopted essential elements of this system. Other countries, such as Brazil, have also put in place tax financed health systems but in a decentralised way with extensive flexibility in provider contracting. Germany was the first country to introduce a workers'

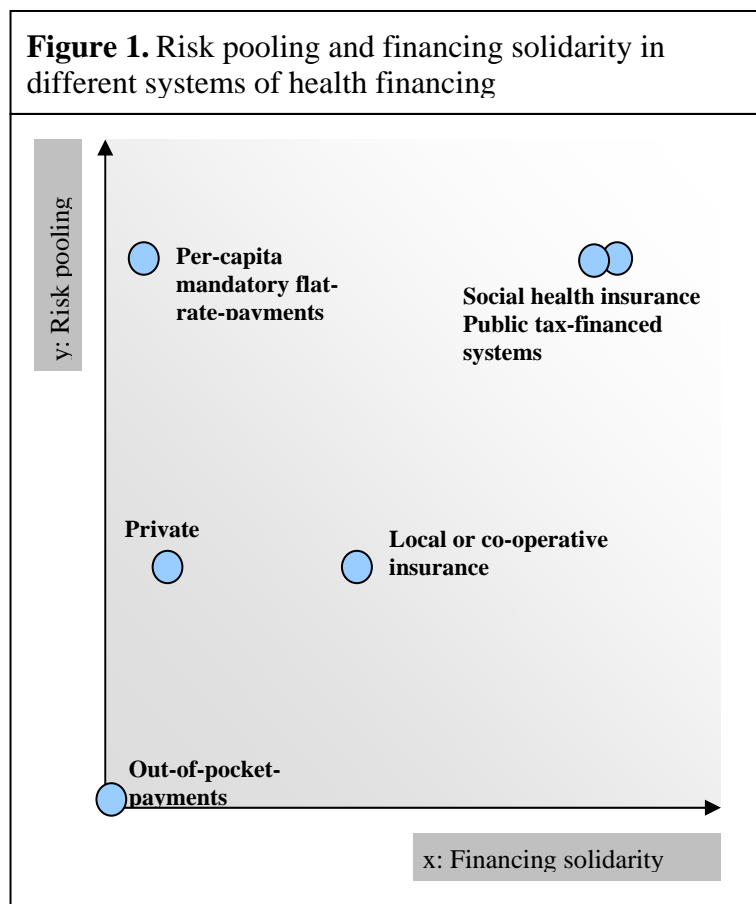
insurance with progressive contributions, which was gradually extended to provide universal coverage to the entire population. Similar comprehensive and mandatory *social health insurance systems* can be found in many European countries, such as Belgium, Austria, and France but also in Japan, South Korea and Costa Rica. Historically, this type of health financing was preceded by community based or co-operative health insurances which provided the main basis for collective protection in Europe until the mid-19th century. These forms of insurances are today found in a range of countries, including Senegal, Guinea, Rwanda, Tanzania, Paraguay, India and the Philippines. The USA epitomises the individual, private payment system where commercial health insurances are the main financing basis of the health care system. In practice, the different financing systems exist alongside one another or as hybrid types within most countries (Preker 2002: 144). For example in the USA Medicare and Medicaid co-exist with private health insurances since 1960 as publicly financed health care systems for poor and old people.

The choice between a prepayment and out-of-pocket payment has consequences for fair financing. As stated by the World Health Organization (WHO): “the most important determinant of how fairly a health system is financed [...] is the share of prepayment in total spending. Out-of-pocket payment is usually the most regressive way to pay for health, and the way that most exposes people to catastrophic financial risk (WHO 2000: 113)”. *Fair financing* is one of two crucial dimensions that facilitate universal coverage. The other one is *risk pooling*. Risk pooling is the fundamental function of an insurance and provides for its economic sustainability as well as the sharing of individual risks associated with ill health across all the insured. Basically, increasing the size of the group improves the extent of risk pooling since the consequences of an individual needing costly treatment are spread.² In a similar vein it is important to cover a wide risk mix. Health risks are spread unevenly across income groups.³ Pooling only low-income groups or those with a high risk of disease undermines the financial sustainability of any scheme as it would

² The model of an actuarial fair insurance requests that there be enough insured persons, that risks have to be independent from each other and that the probability of their occurrence must be below 1.

³ Concerning average life expectancy in all societies a clear gap between the better off and those of the lower income groups appears. Within the rather egalitarian Scandinavian societies the difference accounts for up to five years, in Germany of 7, in the USA around 20 and in many developing countries even more years. (Marmot 2004: 320).

result in either too little income or too high expenditures. To provide access to health care to all and be financially viable an optimal risk pooling can only be achieved by covering the entire population, possibly through mandatory health insurance.



Source: GTZ (2005): 9

The risk of impoverishment through ill health increases with the amount of fees and co-payments that have to be paid while using health services (Kawabata/Xu/Carrin 2002: 612). Regardless of the particular health system, a distinct correlation between the amount of out-of-pocket-payments and the share of people exposed to catastrophic expenditure in order to preserve their health can be observed (Xu et al. 2001: 115). From an economic as well as health policy point of view, payments at the point of access to care are almost always counterproductive and discriminate against those who are ill (Whitehead/Dahlgren/Evans 2001: 834; Holst 2004: 148 ff; Holst/Stierle 2005). If there is acute need of health care,

direct payments constitute generally the most ineffective form of payment while prepayment mechanisms such as health insurances promise a more effective management of resources (WHO 2000: 38, Arhin-Tenkorang 2000: 5). Solidarity-based risk pooling offers the option to redistribute horizontally between the healthy and the sick and vertically between more affluent and poorer members of society. In contrast, risk-adjusted premiums usually applied by private, for-profit insurers favour cream skinning and their logic runs counter to covering whole populations and especially the poor. As a result, in health systems based on the market principle and in health insurance systems with a strong private financing component (e.g. USA, Switzerland, Chile, Columbia, South Africa, Namibia), there are marked differences in health care access and poorer households are financially threatened from high health expenditures.⁴

In turn, micro-insurances have difficulties creating sufficiently large risk pools due to their small size and voluntary membership. Here the problem of adverse selection can become particularly acute, meaning that they attract people with “bad” – i.e. high – health risks thereby compromising the mutually supportive risk sharing between the healthy and the sick. In addition, micro-insurances tend to have neither significant financial reserves (due to low revenues) nor adequate human resources at their disposal.

In principle, public tax-financed health services as well as social health insurances offer the best options for financing health services in terms of equity and universal coverage (Weber et al. 2000: 31). Tax financed systems facilitate the inclusion of all groups of the population since citizenship or residence determine coverage. The level of fair financing depends on the degree of tax progressiveness. Social health insurance systems incorporate fair financing through progressive contributions but a considerable effort is needed to reach universal coverage. If there are several social health insurance funds competing in a

⁴ 1998 half a million of US citizens were financially insolvent due to the financial burden of medical treatment. Thus, 40% of insolvencies in the USA were caused by health spending of households (Gottlieb 2000: 1295). In Switzerland one out of 30 families falls into poverty due to health spending. This is primarily caused by the system of “per capita flat-rate-payments” for health insurance (Murray/Evans 2003, pp. 525). In Chile, where several private insurers compete with a public social fund the contribution is indeed based upon income, but on the provision side there are significant financial deficits of the insurance coverage. Private insurances are less able to foresee severe economic burdens of households due to health spending and this leads to a high risk of impoverishment for citizens being ill. The existing social insurance has to bear this risk for many Chileans. (Holst 2004: 211, 226).

country, equity is difficult to achieve. The problem can be mitigated via a risk adjustment mechanism between the funds.

Social health insurance: principles and values

Social health insurances aim to enable as many people as possible to enjoy good health by organising the funding of health care through payment according to means and providing access to health services according to need. Fairness and solidarity are determined from a societal viewpoint in contrast with a libertarian approach, which may consider it unfair to share individually raised resources for health (Saltman 2002). By adopting an inter-individual approach, based on equity and solidarity, social health insurance includes among its objectives overcoming the exclusion from health services of poor or otherwise disadvantaged groups. A feature distinguishing social health insurances from tax-financed systems is their greater flexibility in combining public interest with market mechanisms. Many developing and transitional countries suffer from an inefficient, centralistic setup with a ministry regulating as well as managing the entire public health system. Separating regulation and political steering from financing and provision offers many improvements and social health insurances are well suited to manage the lower tier of such systems. However, there are also underlying societal values which influence system development in a country. The following sections highlight some important assets of Europe's long history of social protection in health.

Solidarity

Solidarity is the crucial ethical and economic foundation for risk pooling and redistribution. Mature social insurance systems operate according to the solidarity principle mentioned above: contribution according to means, benefits according to needs. Social health insurances redistribute from the healthy to the sick (risk solidarity) and from the rich to the poor (income solidarity). Likewise, the younger pay for the elderly and small families subsidize large families. Within the health system, insurances strengthen the demand-side (patients) to offer the same access to all. If necessary, subsidies (from government or donors) for the poorest can supplement individuals' income based contributions. This can be of particular use

during the introduction of social health insurances, as well as in times of economic recession to maintain their financial viability (Carrin 2002).

Plurality of functions and organisations

In many developing and transitional countries health system reforms have been implemented with the aim to boost efficiency. Introducing increased competition and separating regulation, financing and provision functions has been at the top of the agenda. In contrast with more monolithic setups, social health insurances allow a high degree of fine-tuning. Apart from collecting and administering contributions, they may be asked to define service packages, accreditate providers, control service delivery, negotiate remuneration mechanisms and prices. They can flexibly and selectively contract with hospitals as well as physicians and health provision networks. They can negotiate differentiated contracts and conditions with public, private and non-profit service providers. Large funds representing many members have a better bargaining position for volume discounts and other cost-reductions or for quality assurance of health services. Within the system there are many options of provider payment to balance incentives for quality, quantity and cost control. Overall, social health insurances can be an important instrument to organise health system processes efficiently and productively (Wagstaff/Claeson 2004: 93 ff).

At the same time social health insurances can offer freedom of choice to their members and promote competition between health care providers. Competition can just as well be implemented between social health insurers, provided that they are effectively regulated and that there is a risk adjustment mechanism.

Self-administration and participation

Continental European social insurance institutions are an example of public institutions that are neither owned nor run by the state. They are independent from the government, administer themselves and have the authority to negotiate autonomously with service providers. Endorsed with this authority they manage the public resources for health care generated by the (compulsory) contributions of their members. Social health insurances are subject to public law, they are neither allowed to run into debts nor to generate profits but they are not classified as charitable organisations. The state is thus free to concentrate on policy making while the health financing

system enjoys a large degree of political, organisational and especially financial autonomy. Health care funds are thus better protected against misuse for short-term gains or for political interests than in a state-run system, if sufficiently controlled. However, prerequisites for successfully functioning social health insurance systems are transparency and participation. First and foremost, health insurers must be accountable to their members and have to disclose their finances transparently. Since all their incomes are to be used for one purpose only (funding the health care of their members) this can be achieved more easily than with a tax-financed system. Participation and internal control can be ensured by an elected board⁵ which follows neither the shareholder-value logic nor the will of political majorities.

Decentralisation and subsidiarity

Decision making within social service systems is best done by those involved in running it. Decentralised organisations tend to be more flexible and responsive than centralised ones, as long responsibilities are clearly assigned and coupled with appropriate financial autonomy. The principle of subsidiarity embodies this delegation of authority and responsibility to the lowest possible level. In practice, subsidiarity strengthens the responsibility and self-control not only of administrative bodies but also of civil society and individuals (Weber et al. 2004: 26). The subsidiarity principle can also be applied when social health insurances deal with other interest groups, such as providers or patient associations. Negotiations about e.g. remuneration of services can thereby take into account the local or regional situation.⁶

State and private sector in the health market

The responsibility for ensuring the availability of health services ultimately lies with the state. To this end it can make use of private enterprise but

⁵ However, there is no guarantee that a social health insurance will foster transparency and (democratic) control. For example, the electoral process in Germany for the supervisory boards in social insurances is very obscure so that the turnout at the election is very low.

⁶ The responsible ministry intervenes only in those cases where the negotiating partners do not reach an agreement or if their agreement runs counter existing rules.

relying purely on market forces will not achieve universal access to health care. This is because the health sector is inherently prone to market failures such as adverse selection, moral hazard and information asymmetry. Competition can be useful for increased efficiency and better quality of services. It also brings the users the freedom to choose the insurer and/or the provider of their choice. It is an incentive to organise health services and insurance packages according to the needs of patients. Because of the separation of insurer and service provider in social health insurance systems, competition can be implemented within either section and can be extended to public or private entities or between them. There are, however, very important caveats to consider pertaining to the above mentioned market failure threats. In particular, risk selection by insurers can aggravate differences between rich and poor. Freedom of choice can be severely limited in the case of acute illness. Lack of knowledge about medical procedure makes it profoundly difficult for the patient to make informed choices. There are mechanisms to deal with these issues, such as outlawing insurer's refusal to insure someone, risk structure adjustment, quality standards and control.

In short, the health sector needs to be governed by effective and robust regulation to take advantage of the efficiency gains of private enterprise and market forces. Social health insurances, with their modular design, offer many points at which these can be introduced. In fact, the historical experience of social health insurances shows that a coexistence of public and private structures both in financing and in service delivery leads to quality care and high consumer satisfaction. A social health insurance system allows for "more market" than a national health service, but less "cream-skimming" compared to private health insurance.

Social health insurances in developing countries

Every system of social protection must take into account the societal norms and values and a blueprint of a universally applicable social health insurance standard does not exist. The elements and mechanisms of social health insurances can be picked, matched and adjusted flexibly to the different circumstances and be introduced gradually. In developing and transitional countries, where poverty and lack of access to health care are

extremely acute problems, implementing equitable financing mechanisms and insuring against catastrophic health expenditures should be given high priority in national policy making (Gsänger 2003). In the absence of such mechanisms the poor may be forced to resort to unsustainable survival strategies, such as selling what little assets they may have or taking their children out of school to work and earn money. Protecting the poor against risks in combination with investments in education and infrastructure is a more cost-effective strategy to reduce poverty. In some cases direct cash transfers are a necessary complementary instrument to extend social protection to those that are most difficult to reach with insurance services (Zeller/Sharma 1998: 26). Although private (for-profit) insurance is available in most countries, it is naturally targeted at the well-to-do. This lack of solidarity can be mitigated, although not eliminated, through mandatory contracting obligations or risk adjustment mechanisms.

Health insurances in poorer countries face the challenges of low contributive capacities and relatively few people being in formal employment. These people are however the most vulnerable to high out-of-pocket payments, which typically constitute the biggest share of health expenditures in poor countries (Arhin-Tenkorang 2000; Holst 2004: 130 ff). To cope with possible illness, even the poorest often try to save a part of their income (Agyemang-Gyau 1998; Zeller/Sharma 1998; Arhin-Tenkorang 2000; Baraldes/Carreras 2003), especially younger people and those with some level of education (Jütting 2001). Unsurprisingly, willingness to pay does come with the expectation to obtain a higher quality of services (Okello/Feeley 2004; Gerlter/Hammer 1997).

In most of the cases, the introduction of a universal health insurance system will necessitate extra funding from other sources than contributions, especially during its initial phase. These may include a variable tax-financed share or funds from external donors (Carrin 2002). Social health insurance allows for a combination of contribution based financing and tax (or donor) subsidies, which can then be used to fund particular public health or preventative interventions (e.g. immunisations, HIV/AIDS, etc.) and to finance the protection of the poor. The necessary resources depend on the range and complexity of the benefit package. Countries have to consider epidemiological priorities as well as overall financial capacity of the insurance fund. Prioritising a basic service package can produce significant health improvements of the disadvantaged population

(Bobadilla et al. 1994: 659 ff; Ensor et al. 2002: 253 ff). Thus, social health insurances may be used as transaction mechanisms for channelling targeted, outcome-oriented funds efficiently. Generally, social health insurances provide more flexibility than purely state-financed health services and guarantee better equity than private insurance companies (Holst 2004c: 101; Holst/Laaser/Hohmann 2004: 281).

An increasing demand for innovative concepts and expertise in social policy can be observed within international development cooperation, especially in the area of solidarity based health financing. Many countries from all over the world are debating or implementing forms of social health insurance, e.g. Cambodia, Ghana, India, Indonesia, Kenya, Kyrgyzstan, the Philippines, Romania, Syria, Tanzania, Vietnam or Yemen. Others, such as Chile, Costa Rica, Mexico or South Korea can already look back at many years of experience in this field. Multilateral organisations (e.g. World Bank, WHO, ILO, EU) are also putting social protection on the international development agenda (e.g. the resolution on social health insurance of the World Health Assembly in May 2005) and offering their support. WHO, ILO and GTZ (Deutsche Gesellschaft für Technische Zusammenarbeit) have founded an international consortium on social protection in health to support countries and give technical advice in particular on health financing, of which social health insurance is an important mechanism.⁷

Key elements for successful implementation

It is generally not possible to introduce a social health insurance system without the broad support of the population and the political establishment. Major changes in the health sector are often met with resistance from entrenched interest groups. The population may be sceptical about promises of improvements. Political will and persistence as well as a realistic assessment of the problems and opportunities are necessary to succeed. Introducing social health insurances is likely to require structural

⁷ The consortium also organized an International Conference on Health Insurance in Developing Countries from 5 to 7 December 2005 in Berlin. The conference recommendation and the presenters' contributions can be retrieved from the website <http://www.shi-conference.de>

changes such as the decentralisation of resources and responsibilities. *Good governance* standards and the ability to steer processes are as important as ensuring that any new structures are equipped with the necessary skills and resources to fulfil their new tasks. Historical experiences from Continental Europe suggest gradual expansion and making use of existing organisational structures can facilitate health insurance implementation greatly. Social health insurances have often started with covering only a part of the population and then continuously extended the protection to other regions and societal groups until reaching universal or near universal coverage. In Germany, guilds first organised some form of health risk protection on a larger scale, greatly helped by the fact that membership and payment structures were already in place. Communal authorities, professional associations, cooperatives or social structures at the community level are well placed to provide protection from health risks for their members and put in place initial insurance mechanisms.

The degree and the pace of the introduction of a social health insurance depend on the general economic situation of a country and especially the structure of its labour market. The major challenge for many developing countries is to extend coverage to the informal sector. The larger the proportion of workers that are in the informal sector the more complex it is to define the amount of contributions and how to collect them. Therefore many countries start by creating a social health insurance for the formal sector first and expand coverage at a later time. To achieve this, different strategies may be employed. One is to gradually increase coverage by a single insurance system to further groups of the population. If this increase is from richer to poorer groups it would have to coincide with an increase in contributions or subsidies. Another option is to start different insurance mechanisms for different groups (e.g. salary deductions for the formal sector, community-based health insurance for the informal sector, etc.) and link these up via risk-equalisation, reinsurance or other pooling mechanisms. Such linkages may also be pursued with other insurances (sickness, accident, ageing, unemployment, crop- or credit shortfall, liability insurance, etc.) and instruments of social protection (cash transfers, basic pensions, aid to handicapped people, etc.)

Another important factor for the design of a social health insurance is the level of income and its distribution within the population. Social health insurances can increase the funds available to the health system as a whole

if the population agrees to pay corresponding contributions. Indeed, the higher the revenue from contributions is, the more likely poor families can be included in the coverage through cross-subsidisation from higher to lower income groups. However, the fundamental financial mechanism of social health insurance is to bring a large share of out-of-pocket payments into prepayment, thereby reducing the likelihood of catastrophic spending among its members. This works whether the sums involved are large or small (albeit more effectively in high income settings). It is therefore not so much the question of whether a population can afford social health insurance, but rather how much they are willing to spend on health. Social health insurance then offers an option to pool those funds based on equity and solidarity.

While political commitment and leadership are required for most policy reforms, the nature of social health insurance means that there should be an ongoing involvement of and critical dialogue with as many stakeholders as possible. Social health insurance is in part about sharing responsibility and encouraging the participation of its members. The social partners (employers, employees, government) as well as representatives of other social groups (e.g. the informal sector, the poor), health service providers and insurers need to agree to play their part in a new health financing system (ILO 2001: 94 ff). The state must be an honest broker of interests and a promoter of fair financing in health. It is necessary to find a consensus on the extent of which solidarity is reflected in the health financing system. A social health insurance can only cover everyone, if either the state or the other members agree to pay contributions high enough to cross-subsidise the poor. It may mean that members of existing insurance setups are asked to contribute more for fewer benefits. This is a normative and not a technical decision. How to include - and pay for - the poorest part of society is a question that needs to be acknowledged and tackled from the start. If it is not, there is a risk of excluding those that need cover the most, while providing health insurance for the rest (Bärnighausen/Sauerborn 2002: 1567).

Involvement of stakeholders will also serve to engage productively with criticism or opposition to social health insurance systems. The formal sector may view health insurance contributions as a direct negative impact on profits or incomes. Private health insurers may feel that their business model is threatened by compulsory insurance. In this respect it is important

to compare the costs with those that a lack of health insurance may incur. This includes higher sick leave rates and higher costs to companies to look after the health of their employees. For the employees it means higher out-of-pocket spending with potentially disastrous consequences. Involving companies in health insurance contributions also serves to illustrate the importance of health for a workforce and may help to improve social standards or health promotion at work. Private companies offering health insurance focus mostly on the higher earning population. These potential customers will typically be willing to spend more money on their health than social health insurances is able to pay for in low income countries. There is thus considerable scope for private firms to offer top-up insurance packages. Furthermore, their expertise and experience in the insurance business may open up mutually beneficial cooperation opportunities, such as subcontracting administrative or actuarial tasks to them.

The quality of health services covered by a health insurance plays a decisive role in bringing about its acceptance among the population and a willingness of members to pay contributions in advance. The introduction of social health insurance offers an opportunity to control quality through accreditation standards and to offer remuneration that gives incentives to improve quality. At the same time, the health insurance must be equipped to process claims and pay service providers promptly and fairly as to avoid the emergence of "under the table" payments.

An innovative and interesting approach to improve the functioning of health insurances is to set up competence centres to offer technical support to insurances. Such a centre can provide ongoing support and capacity building to several insurance entities, whether they are branches of one national system or part of a network of local community-based insurances. To overcome shortages of skilled personnel, some technical or managerial functions (e.g. developing insurance products and quality standards, contracting providers, accounting, monitoring, pooling funds, and training) may also be transferred to such a centre.

All in all it is certainly a delicate and complex task to introduce social health insurances in any country. These challenges need to be balanced with the advantages, such as flexibility, modularity and a design that is inherently based on solidarity. In order to improve the health status of populations, countries can follow many different pathways. Social health insurance makes the inclusion of the disadvantaged an implicit and

normative choice in the aspiration for universal coverage. A society that has found itself in agreement with this may want to consider pursuing social health insurance as some developing and transitional countries have already done. The success is dependent on many variables, some have been described above.

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