

GTZ: HEALTH, EDUCATION, SOCIAL PROTECTION

SOCIAL PROTECTION IN HEALTH CARE

EUROPEAN ASSETS AND CONTRIBUTIONS

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LIST OF ABBREVIATIONS

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

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

The world in general and most societies are facing challenges resulting from the current structural, social and economic changes. The underlying causes include globalisation trends as well as technological, environmental, demographic, societal and political developments.

The countries of Central and Eastern Europe, the Newly Independent States, and several Asian, Latin American and African societies are undergoing profound restructuring processes. The removal of tariff and non-tariff barriers to trade, the liberalisation of capital markets, the removal of restrictions on international investment flows, contractionary monetary policies, public spending cuts, and the privatisation of public enterprises and public services, including health care services, are serious challenges for many governments. In trying to adapt to global trends and economic pressure, numerous low- and middle-income countries – particularly on the African continent – experience stagnation or even deterioration in their historically weak social protection systems, notably in the health care sector.

Considering these changes, the authors would like to initiate an international debate about the fundamental importance of improving social protection systems in low and middle-income countries, especially for the health care sector. Moreover, drawing on long-standing European experience in the field of social protection, the paper invites European decision-makers and all interested parties to take an active role in consulting and supporting partner countries in the South on how to set up or to reform their social protection systems. It is hoped that the paper will contribute to the development of a more co-ordinated and concerted European approach to technical co-operation in the field of social protection.

The paper discusses the subject area as follows:

The introduction places the topic of social protection, especially in the health care sector, into the European and international context, while chapter two summarises the current situation and the major social challenges the world faces today. These challenges can differ between countries; some are only found in specific country groups, while others occur in almost every country.

Europe is looking back on over 120 years of experience in developing and setting up social protection schemes and offers a broad range of feasible system solutions, expertise and technical know-how. The authors strongly believe that Europe's social protection systems are based on a series of intrinsic principles and values that deserve to be discussed internationally to determine whether they merit universal application. Accordingly, the paper's third chapter outlines some important assets Europe has developed in the sector of social protection, especially for the setting up of health care systems.

The fourth chapter reflects on the possible European contributions in the field of technical co-operation. It is hoped that the discussion on Europe's potential contributions to improve social protection and to combat poverty worldwide will lead into a more concerted European approach in development co-operation.

The elaboration of some conclusions (chapter five) is followed by the provision of a glossary of technical terms (chapter six) and the references on which the paper draws (chapter seven).

After years of being treated as a relatively low political priority – especially during the height of the Cold War and the beginning of the neo-liberal era – social protection and accessible health care are back on the agenda of international organisations, governments, and civil society organisations at large. It has been realised that health has essential macroeconomic benefits. On the other hand, lack of access to health care and catastrophic expenses related to ill health are critical poverty traps, even for middle-income families. The strengthening of basic social services and protection schemes is also in the global interest, because it supports policy and security. The United Nations Millennium Development Goals (MDGs) for 2015, for instance, emphasise health and education as major indicators and drivers of development and poverty reduction.¹ The International Monetary Fund (IMF) and the World Bank, the key promoters of economic globalisation and structural policies, have declared that they will pay special attention to social protection. Several deliberations of the UN Security Council and the G8 summits underline the priority status now given to health care. The World Health Organisation's document about Macroeconomics and Health has proven a close relationship between development and health (Sachs 2002). Thus, after two decades of structural adjustment policy, the focus of international co-operation has been re-oriented on a more social than purely economic approach. Sustainable social development and social protection is seen as a frame of reference for development co-operation.

The entry point to formal social protection mechanisms is often represented by the setting up of structures or systems with the aim of protecting the population against the financial risks of expensive health care (insurance function). Normally, even in very poor countries and/or in the absence of sophisticated formal social protection schemes, some type of institutionalised health care provision can be found. However, these services may not always be accessible to all population groups. Today, half of the world's population has no access to quality health care, and about 1.3 billion people lack affordable and adequate health services (Preker et al. 2002). Those population groups living in remote or rural areas, and the urban poor in particular, face the hardships of insufficient access to and provision of health care. Even the publicly owned facilities offer their services sometimes only to those who can afford the co-payments (and in many cases under-the-table money). At the same time, private institutions are established for the rich, thereby pulling out resources and trained personnel from the system of public health services. In consequence, the quality of public facilities deteriorates further and forces even the indigents to seek advice and treatment at expensive private facilities. All these factors lead to a situation where illness can easily result in the financial collapse of the household. Considering this, it is clear why in the case of introducing or reforming a social protection system; the implementation of an affordable health care system represents one of the most urgent issues. This holds especially true knowing that health care addresses a human right and a basic need of human beings – the physical capability to work and to survive. Interestingly, from an economic point of view, the health care sector offers significant growth and employment opportunities. In fact, in many countries health is one of the largest sectors of the economy.

Europe is seen as the cradle of the modern social protection systems. The first systems were developed in the 19th century in response to problems caused by increas-

¹ The Millennium Development Goals (MDGs) are a set of numerical and time-bound targets that express key elements of human development. They include halving income-poverty and hunger; achieving universal primary education and gender equality; reducing under-5 mortality by two-thirds and maternal mortality by three-quarters; reversing the spread of HIV/AIDS; and halving the proportion of people without access to safe water. These targets are to be achieved by 2015, from their level in 1990 (www.developmentgoals.org).

ing labour migration, poverty and unemployment, due to industrial and technological revolutions. Since then these early systems have spread and evolved, and generated a large variety of different social protection systems within Europe. Today, many countries rely on state-run health care systems being mainly publicly financed by taxes. The success of these schemes can be attributed to the existence of the following three prerequisites: (1) the majority of the population works in the formal sector of the economy or pays regular taxes to the government; (2) the systems to collect the taxes and to allocate the money to the different sectors (health, education, infrastructure, security etc.) is balanced and efficient; and (3) the health care infrastructure offers more or less equitable access to health care throughout the country. Many countries exhibit shortfalls in one or more of the areas mentioned above, leading to a situation where the poor segments of society do not possess access to quality health care, but may subsidise the health care of others.

This paper draws attention to some of the features of the Bismarckian model for the organisation of health care services. It is an insurance-type of social protection, which traditionally relies on the existence of a number of health insurance schemes that are attached to specific professional groups or regions. In general, the system is compulsory, at least for the poorer and middle-income sections of society. The Bismarckian system is predominantly financed by wage-related contributions of its members to a fiscally autonomous health insurance fund. The better-off pay more than the poorer population groups, but all get the same kind of benefits. The system is embedded in a country's legal framework; those who contribute are entitled to a well-defined set of benefits. According to the principle of subsidiarity, certain tasks and obligations are fulfilled by autonomous professional actors within the health care system, with the government taking on the role of a regulator and overall supervisor.

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

- Health insurance coverage of large sections of the population embodies important development and health policy objectives. It contributes to
 - equity of access,
 - adequate health care,
 - poverty alleviation,
 - and economic growth.
- Health insurance may improve access to health care services when needed, at the same time ensuring effective protection of family income and assets from the financial burden of expensive medical care.
- Health insurance schemes have an independent source of revenue. They tend to be less susceptible to budget restrictions and political rationing.
- Health insurance schemes offer immediate benefits. They are likely to gain greater acceptance than savings accounts or pension schemes that require long periods of payment before receiving the first benefits.

All over the world, the health sector faces serious challenges. The authors hope that a closer look at the European experiences and assets in social protection in the context of health care may provide fresh insights and new ideas and approaches to address current problems in this sector and also in other regions of the world. Some of the major challenges – both globally and for certain country groups – will be discussed in the next chapter.

2 CURRENT SITUATION AND CHALLENGES

2.1 GLOBAL COMPETITION AND FINANCIAL CONSTRAINTS

Today, the countries of the world face an increasing dependence on world markets and capital flows. At the same time as international trade is expanding, goods and capital markets are opening up to global competition. Multinational corporations are growing, and powerful business alliances are being forged around the globe. This trend is accompanied by strong political movements in favour of free trade and economic globalisation, fostered by the World Trade Organisation (WTO). Some groups of countries have already become a single market (e.g. the EU), others are about to follow.

World Merchandise Trade by Selected Region – Average Annual Percentage Change

Country group	Exports 1994-2001	Imports 1994-2001
World	5.9	6
North America (excluding Mexico)	5.7	8
Latin America	8.4	8.2
Western Europe	4.9	4.7
Asia	7	5.8

Source: WTO International Trade Statistics 2002.

The globalisation of markets implies the need of producers to reduce costs in order to maintain or improve their competitiveness. Wages and wage-related costs such as contributions to social security schemes and taxes are perceived to have a major impact on costs and, consequently, on prices – prices that have to compete on the world markets. This discussion about competition is observed for all countries, where export-oriented producers are struggling for world market shares. However, a rational analysis of the real impact of contributions on production costs, and hence on world market prices shows that, in industrialised countries at least, the scale of such an effect is overestimated.² Conversely, there is a correlation between (potential) contributions for social protection and growth in a country's national income. Since the share of wages in relation to overall production costs tends to diminish with technological change, economies with a high rate of agricultural and manufacturing production face higher relative wages and wage-related costs. This fact has to be taken into account when contribution-based social protection systems are being designed or implemented. At the same time, the poorest countries are also affected: depending on the export of agricultural products, raw materials and manufactured products such as textiles, they rely directly on the development of world markets.

Poor countries are affected in several ways:

- Growing global competition, combined with decreasing prices for raw materials, reduces their ability to pay off their external debt and to increase

² For instance, a 10 per cent increase in contribution rates for social health insurance in Germany would raise the production costs of world market products in this highly export-oriented European country by just 0.1 per cent. Nevertheless, wage-related costs play a central role in the public debate (Statistisches Bundesamt (2000). Bundesministerium für Arbeit und Sozialordnung, Arbeits- und Sozialstatistik).

internal revenue. This has an adverse effect on the availability of financial resources for urgently needed health care and social protection.

- Consequently, the value of their currencies declines and the expenses for essential imports (often to be paid in foreign currency), such as energy and drugs, increase. Their opportunities to benefit from new technologies in health care are reduced as a result.
- Additionally, many countries prefer to allocate resources to politically more important sectors such as the military. This is done to the detriment of social sectors such as education, social security in general and health care in particular.

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

Official Development Aid Figures – DAC Countries

Year	US\$ m
1990	52961
1991	56678
1992	60850
1993	56486
1994	59152
1995	58926
1996	55622
1997	48497
1998	52084
1999	56482
2000	53734
2001	52336

Source: OECD 2002. DAC-Countries: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, United States

Countries in economic transition face additional challenges and problems. On the one hand, they face structural changes as they are in the process of changing their entire economic and legal systems towards market economies; and on the other hand, they have to cope with financial restrictions as they have to meet the requirements for successful participation on global markets.

These changes raise the need to restructure their social protection systems. In many of these countries, a sharp decline in GDP imposed severe budget constraints in the early 1990s, which also had repercussions in the health sector. Many national economies are also facing structural changes in their economy. This change is observed in almost all countries; it occurs in various patterns and might involve dif-

ferent sectors within the economy. In some sectors, particularly in the industrial sector, jobs are being lost, while in others like the service sector, new jobs are being created.

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

The combination of all these factors tends to result in a further weakening of the sometimes already shaky social protection mechanisms within poor countries. Therefore, new resources for financing health care have to be generated; and reliable as well as acceptable financing and allocation mechanisms have to be developed. This has to go hand in hand with comprehensive and transparent priority-setting in health care delivery and financing. Moreover, the quality, effectiveness and efficiency of health care services have to be improved.

2.2 POPULATION GROWTH AND URBANISATION

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

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

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

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

	1960	1970	1980	1990	2000
Ghana	6 774 177.6	8 612 251.9	10 736 412.3	15 020 381.0	19 593 340
Niger	3 028 147.9	4 165 153.1	5 586 447.4	7 731 319.6	10 742 180
Nigeria	42 305 99	56 581 214	78 430 1 130	108 542 296	114 746 270
Zambia	3 141 199.4	4 189 415.8	5 738 626.4	8 138 416.1	10 419 310
Zaire	15 333 215.1	20 270 232.9	27 009 520.5	37 391 191.9	48 200 110

Population in thousands, GDP per capita in US\$ (second figure).
Source: World Bank 2002.

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

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

Urbanisation – Percentage of Urban Population

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

Source: UNDP 2002, World Population Prospects.

Urbanisation – Percentage of Urban Population

Country	1990	2000
World	44	47
Least developed countries	21	26
Excluding China & India	22	31
Less developed countries	35	40
More developed countries	74	76
Latin America & the Caribbean	71	75
South East Asia	30	38
Sub-Saharan Africa	23	33
Europe	72	73
Africa	32	37

Source: UNDP 2002, World Population Prospects.

2.3 DEMOGRAPHIC CHANGES, AGEING SOCIETIES AND CHANGING MORBIDITY PATTERNS

Overall, the world's population is ageing (see table below). Regarding the age structure of countries, however, there are major variations and differences between regions and countries. This structure is particularly accentuated by the impact of the AIDS epidemic in middle and low-income countries. In consequence, demographic projections on population size and age structure in several countries may have to be revised.

Age structure of the world's population compared to the age structure in the least developed nations 1950-2030 (percentage)

Age range/year	1950	1980	1990	2000	2030
0 to 4	13.4/16.7	12.1/17.8	12.0/17.5	10.2/16.6	7.7/12.5
5 to 14	21.0/24.4	23.0/26.9	20.4/26.9	19.9/26.7	15.5/22.9
15 to 59	57.5/53.5	56.4/50.4	58.3/50.8	59.9/52	60.3/58.2
Over 60	8.2/5.4	8.6/4.9	9.2/4.8	10.0/4.8	16.6/6.4

Source: UNDP 2002, World Population Prospects

As explained before, in all developing countries, the ageing population leads to an increase in health expenditure, since the growing percentage of elderly people induces a higher prevalence of chronic diseases and, thus, an increasing demand for health care services. This fact may stimulate a debate on how to define, or adapt, the concept of solidarity to this changing environment. Some countries are already discussing whether and how priorities in social security schemes have to be set or adjusted. Often, health insurance schemes are competing with pension schemes for scarce resources.

At the same time, the ageing of the population will result in fewer economically active and more economically inactive people in society (an increase in the dependency rate). This in turn will increase the burden on the economically active population to cater for the dependants, and could lead to attempts by this population group to lower this burden. Some experts even argue that demographic ageing, particularly in Asian developing countries, is responsible for the emergent crisis in health care.

2.4 TECHNOLOGICAL PROGRESS IN HEALTH CARE

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

Technical advances in medicine have two main impacts: on one hand, they will lead to new patterns and opportunities for prevention and treatment; on the other hand, they will raise the issues of accessibility, eligibility and prioritisation. The eventual outcome of both trends is still open, but, in the short run, new technologies will require major investments in equipment, training and restructuring.

Even today, the question of allocation already arises. Should new technologies be available to everyone or only to those who can pay for them? Currently the gap is still widening between possible therapies on the one hand and their availability to the poor on the other; poor people only benefit to a very limited extent from medical advances.

2.5 POVERTY AND UNEQUAL ACCESS TO HEALTH

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

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

Improvements in people’s health status lead to increased individual productivity, increased life expectancy and higher quality of life. On the one hand, the health care system has only a minor impact on a population’s health status. On the other hand, the infrastructure and provision needed to achieve even those limited gains in health status require enormous investments and resources. Yet numerous countries are unable to generate and sustain these resources themselves. They depend on external assistance and the solidarity of the better-off nations.

However, international assistance in most of the least-developed countries covers less than two per cent of total health care expenditure. An exception is sub-Saharan Africa, where external aid represents more than 10 per cent of total health care expenditure. The recent tendency of international donors towards concerted activities and financing seems to be an effective strategy to face the major challenges arising in the poorest of the poor countries. Especially, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) offers opportunities to lower the burden of disease through the promotion of national programmes.

Aid flows per capita, US\$ 2000

	1990	2000
East Asia and the Pacific Region	6	5
Eastern Europe and Central Asia	19	23
Latin America and Caribbean	12	8
Middle East and North Africa	45	15
South Asia	5	3
Sub Saharan Africa	40	20
Low income countries	15	9
Middle income countries	13	8

Source: World Bank, 2002.

As outlined above, one of the major challenges in the health sector of developing countries is the maintenance, improvement and extension of existing health care systems. However, it is not only developing countries that face the problem of insufficient and inequitable access to modern and well-performing health care systems. In transition countries and industrialised countries, there are population groups, such as the urban poor, ethnic minorities and migrant workers, facing severe difficulties in accessing adequate health care services.

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

2.6 *INEFFICIENT AND INEFFECTIVE HEALTH CARE SYSTEMS*

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

This argument fails to notice that I) there is no absolute, but only relative efficiency, and that II) effectiveness is the degree of achievement of predetermined and agreed objectives (which may differ from country to country). Moreover, important factors contributing to the efficiency and effectiveness of health care systems, such as good governance, transparency, rule of law, civic participation, responsiveness and quality of services are neglected. For its World Health Report 2000, WHO developed a conceptual framework and accompanying criteria and indicators designed to measure and compare the performance of different health care systems. The report generated an intensely lively political and scientific debate,

particularly with respect to its perceived methodological weaknesses and inherent value judgements. The report did however invite the scientific community to reassess its viewpoints and positions and offered some new approaches to the evaluation of health care systems (see WHO report, 2000). The more recent World Health Report 2003 has built on this approach, but gives more emphasis to the issues of fair financing and pro-equity health care systems (see particularly Chapter 7 of the WHO report, 2003). Most of the described principles and criteria for an equitable health care system have been operationalised in European social policy.

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

- Inefficient and insufficient resource generation;
- Inappropriate resource allocation and planning mechanisms, e.g. input orientation instead of output- and outcome orientation,
- Centralisation of decision-making and lack of civic and political (community) participation,
- Excessive bureaucracy and high administrative costs.
- Lack of private initiative and an unwillingness to assume local responsibility according to the subsidiarity principle, and to provide a counterbalance to centralisation trends
- Imbalance between public and private responsibilities,
- Lack of equipment, materials and consumables, inadequate maintenance systems,
- Insufficient standard-setting, supervision and regulation;
- Services which lack responsiveness to their clients, and neglect of quality of care,
- Selective and inequitable coverage of services;
- Very limited, insufficient benefit packages or benefit packages that sometimes include unnecessary, inefficient or non-effective (sometimes even harmful) services and products;
- Monopolies and over-pricing, especially in the drug sector;
- Insufficient remuneration of staff and providers, leading to low morale and motivation, increased corruption and “under-the-table payments”, “brain drain “ etc;

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

2.7 COUNTRY-SPECIFIC CHALLENGES

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

Health indicators — World averages 2000

Country group	Life expectancy at birth	Infant mortality rate	Fertility rate	Public Health expenditure as percentage of GDP 1990 – 97
East Asia and the Pacific Region	69	35	2.1	1.8
Europe and Central Asia	68	31	1.6	3.9
Latin America and the Caribbean	70	29	2.6	2.6
Middle East and North Africa	68	45	3,4	2.3
South Asia	62	72	3.3	0.8
Sub-Saharan Africa	47	106	5.2	1.7
Low and middle income countries	64	62	2,9	1.8
High income countries	78	5	1.7	6.0
World	67	57	2.7	2.5

Source: World Bank 2002.

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

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

The health-related problems of these countries are those associated with long life expectancy, unhealthy lifestyles and environmental hazards. Cardiovascular diseases, cancer, mental and neurological disorders, degenerative and chronic diseases and conditions predominate.

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

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

- Strike an appropriate balance between the principles of solidarity³ and subsidiarity⁴

³ **Solidarity**, as understood in Germany and, more generally, in Europe, is the ethical platform of joint efforts among people of economically different initial positions directed towards achieving a common socio-economic goal to reduce social friction. Everyone in the solidarity system should have access to the same quality of care and the same comprehensive benefit package, on equal terms. No family should be financially burdened by illness, and a family’s contribution should be based strictly on the family’s ability to pay and be completely unrelated to the size of the family or its health status.

⁴ **Subsidiarity**: This principle, perhaps best described as supplementary subordination, implies that tasks and obligations should always be fulfilled by the lowest possible level within society capable of shouldering the burden and/or solving the problem. This principle implies that the government should step in as a regulator of private affairs only if the private system fails to own up to shared social goals. It also implies that the government should direct its monetary subsidies and other form of assistance mainly to those individuals in society who cannot help

- Extend social protection coverage to previously excluded and possibly marginalised population groups;
- Provide state-of-the-art treatment (including therapies made possible by the latest technological advances) for all serious medical conditions to all citizens/insured on equal terms;
- Guarantee long-term care for the growing proportion of the population that is ageing;
- Bear the financial burden that such care implies; and finally;
- Contain costs, taking into account the pressures of world-wide competition.

The **second pattern** is found in the transition countries of Central and Eastern Europe. For many decades, these countries have pursued strategies in health care that have been distinct from the western, industrialised countries, e.g. physician and hospital bed ratios had been higher than those in the rest of Europe. Despite the setting up of a large medical sector, the epidemiological and environmental situation compares unfavourably with that of the rest of Europe. In fact, life expectancy in those countries is roughly five to seven years shorter than in Western Europe and is actually declining in some countries.

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

Many of these countries have been undergoing major reforms to re-orient their health care sectors towards insurance-based systems with an emphasis on preventive and primary care. Public services have been replaced in many instances by private health care provision. However, the change of system and new priorities has not necessarily resulted in better access to health care and improved health indicators; in many cases the instabilities caused by the transition process have rather caused people's health status to deteriorate.

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

- Respond more effectively to the changing epidemiological situation, and revise negative trends in morbidity, mortality and life expectancy;
- Combat environmental health threats and unhealthy life styles;
- Fight poverty, and economic, social and political exclusion as well as corruption and nepotism;
- Determine the objectives and activities in regard to health system and financing reforms on the basis of evidence;
- Assess the potentials and opportunities for reforms realistically, and give support to comprehensible and transparent policy making;

themselves (Reinhardt, 1993). According to the Catholic social doctrine, subsidiarity also means the delegation of decision-making responsibilities to regional and local bodies. This became a dominant principle of the European unification process, and it is anchored in the social protection and other welfare policies in the European countries.⁴

- Respect the principles of good governance, transparency and political participation of all stakeholders, and ensure law enforcement;
- Counterbalance the predominance and sometimes selfish interests of medical, paramedical and pharmaceutical professionals while safeguarding a decent and appropriate remuneration of health workers;
- Take existing inequities regarding accessibility and use of health care services into account;
- Balance private and public responsibility in health matters as well as social objectives and private involvement in health care provision (development of a social market economy);
- Build up the capacity for and update the know-how regarding modern diagnostics and treatment procedures, including quality management and assurance;
- Replace bureaucratic, centralised structures and procedures with a decentralised management system adapted to the requirements of the country.

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

Many of these countries have made considerable progress in building up a health care infrastructure focussing on primary and essential health care. Their past efforts have been rewarded by declining infant and maternal mortality rates, increasing life expectancy at birth and diminishing fertility rates.

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

- Respond to current – and newly emerging – needs, demands and expectations within the limited resources available especially these of an ageing society,
- Improve the quality of care,
- Develop solidarity mechanisms to distribute the limited funds in such a way that universal coverage can be achieved, particularly to provide essential health services to the rural and urban poor,
- Sustain the achievements and maintain the benefits that their health care systems have already established.

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

The outlook regarding health matters in this pattern is particularly distressing. These countries face critical and most difficult situations, but have only very limited financial and human resources at their disposal to develop their health sectors. Their rapidly growing populations live to a large extent in extreme poverty, and in deplorable and hazardous environmental conditions with regard to hygiene, health and clean water. Their most urgent health needs cannot be met by health care systems alone. Economic development as well as political, fiscal, social and economic reforms is also necessary.

Infectious and parasitic diseases, acute respiratory tract illnesses, malnutrition and the spread of HIV/AIDS contribute to a large extent to high morbidity and mortality.

Policy-makers in least-developed countries face three main challenges. They need to:

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

In this context it seems worth mentioning that in many of these countries, large and inappropriate portions of the state budget are spent on military and security purposes, even in the apparent absence of external aggressors. And for a long time, so-called structural adjustment enforced by the World Bank and International Monetary Fund (IMF) induced palpable deprivation in a large part of the population in many developing countries.

3 EUROPEAN ASSETS IN SOCIAL PROTECTION: PRESENTING EIGHT UNDERLYING PRINCIPLES

This chapter examines European experiences and assets in view of the challenges stated in chapter two. Europe looks back on a wide pool of expertise in the field of social protection and social security developed over a time span of more than a century. Therefore the contribution Europe can offer to the international debate regarding social protection in health goes far beyond technical matters. The experience comprises political and ethical foundations, conceptual knowledge as well as the practical know-how to reinforce the principles in day to day life. The debate on social protection, with a special focus on the health care sector, is largely dominated by issues such as:

- The ethical platform of political choices, i.e. the value base of social protection in the cultural context of a specific country
- The balance between shared social goals, public involvement and private (individual) aspirations and preferences regarding financing, allocation and provision of services
- The trade-off between equity, solidarity, effectiveness and efficiency
- The setting up of responsive and appropriate organisational arrangements, taking into account the different roles and interests of all stakeholders including the role of the state and the public institutions
- The possibilities for catering for the indigent and the disadvantaged
- The generation and sustainability of sufficient financial resources
- The prevention of fraud and moral hazard on the user as well as on the supplier side.

The following eight European assets illustrate the richness that European systems exhibit regarding the political, conceptual, procedural and technical aspects of social protection in health.

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

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

- In economic terms, solidarity mechanisms – particularly those implemented in social security schemes – contribute to the stabilisation of demand, to growth of the internal market and to (human) capital formation.⁵
- In social terms, solidarity mechanisms contribute to poverty alleviation, to a more equitable and just society, to security, social harmony and social cohesion.

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

- One day, “net payers” may become beneficiaries;
- Those who do not need any form of mutual support because of their comfortable economic position benefit from a stable and peaceful en-

⁵ Through its resource-generating and redistributing effects.

vironment that threatens neither their way of life, nor the overall cohesion of society.

Despite Europe's pluralism and variety of structural approaches, mutual support and solidarity has become a basic value at all levels of society, although it may appear in many different forms and solutions:

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

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

The underlying principles of these funds are:

- Partnership: the institution of partnerships on all levels of implementation, with special consideration given to local partners and sector wide approaches (SWAp).⁶
- “Subsidiarity”: in this case meaning that countries must first try to solve their problems using local and national means and capacities before the EU may step in.
- Co-financing: European solidarity funding should be used only to complement national funding and not to replace it. This principle aims mainly at achieving financial sustainability.⁷

3.2 THE SECOND ASSET: UNIVERSAL COVERAGE – HEALTH FOR ALL

A key question that all European countries have successfully answered over time is how national health systems can ensure universal coverage. Universal coverage is defined as access to promotional, preventive, curative and rehabilitative health interventions for all at an affordable cost. The extension of social protection in health is a key strategy for overcoming the financial barriers that restrict access to health care services and prevent people from becoming impoverished due to catastrophic health expenditures. This strategy involves a move towards enhanced risk-sharing and risk-pooling, thereby increasing the amount of prepayment and reducing the reliance on out-of-pocket payments. Besides protecting people from the direct costs of illness, health financing through collective arrangements provides financial resources to diagnose, prevent and treat illness and promote better health. Several options for establishing universal coverage exist, which can be classified into two broad strategies: tax-funded health financing and social health insurance. Both options are prominent in Western Europe, and usually refer to the two “model systems”, namely the “Beveridge” and the “Bismarck” approaches.

The European experience shows that different strategies can be applied in order to achieve and extend social protection in health. They depend mainly on the basic definition of entitlement and coverage and can evolve in parallel, depending on historical conditions and the socio-political environment. There is no major difference, in terms of universal access, between health care systems based on general tax revenues and those financed by compulsory insurance. In the first case, people are entitled to health benefits through citizenship or residence; in the latter case entitlement is defined by mandatory contributions from workers, employers, and the self-employed, with a greater or lesser level of subsidy from the government.

For any universal system of social protection, the design of an adequate legal framework is a crucial precondition. Furthermore, public confidence in social protection schemes is a key factor for success. For confidence to exist, good governance and transparency are essential. State legislative and executive bodies have a priority role in facilitation, promotion and extension of coverage. In most cases universality has been achieved gradually, and the extension of coverage took several decades. Generally, it is easier for any administration to assess incomes and draw contributions from workers and employers. How-

⁶ For an explanation of SWAp please refer to the definition later in this paper.

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

ever, there are also means of enrolling other groups of the population. This is very much dependent on the cultural context and pre-existing solidarity mechanisms.

In general, the extension of social protection prevents external health costs while minimising social exclusion and marginalisation of certain population groups. At the same time, universal coverage is of the utmost importance for social cohesion and fairness in society. In Western Europe, the general understanding of fairness is collective and need-based; it refers to mutual support and equity between society members. This notion is directly antithetical to the politically-fanned belief in the United States that social programs are in fact individual savings accounts.⁸ All prepayment methods of health care financing improve with the involvement of higher numbers of insured members, because the larger the risk pooling, the better the distribution of individual expenditures. However, in order to achieve a high degree of fairness in health financing, pooling has to include different risk groups and socio-economic strata in order to guarantee an effective redistribution in the society. Thus, the inclusion of the whole population dramatically improves the insurance scheme's capacity to cover the needs of all beneficiaries and to operationalise overall solidarity and redistribution. Moreover, most Europeans neither perceive paying tax for health care nor obligatory contributions to social security schemes as a limitation of their individual freedom. On the contrary, guaranteed access to essential social services, including health, seems to justify affiliation, thus contributing to a high level of acceptance of social protection schemes.

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

It is often argued that solidarity and mutual support reduce individual initiative and responsibility. This is the reason why the principle of subsidiarity (see glossary) forms an integral part of European policy. In particular, subsidiarity counteracts the potentially negative effects of formal, solidarity mechanisms. In practice, it strengthens responsibility, accountability, and self-reliance not only of lower or decentralised levels of public administration, services and local governments, but also of civil society organisations, communities, households and individuals. In Europe this principle applies in the following cases:

- Only those issues that demand joint efforts and promise some form of synergy at a central intervention level are regulated and managed on the EU level. Increasingly, regions and provinces within EU member states achieve more responsibility along with opportunities to influence the central EU-level. Decentralisation of power to lower administrative and bureaucratic levels is also gaining significance. At the household and individual level, policies increasingly aim to support self-help initiatives instead of simply providing allowances or financial resources. This ap-

⁸ The US "actuarial" fairness concept leads most Americans to assume that fairness means that they should get out exactly what they put in, with interest, and that somebody's money should never be used to pay for someone else's care: that would be considered as unfair. Putting the priority on actuarial fairness, a business strategy for gaining market share, pursues an ideology that is actually anti-redistributive and a method of organising mutual aid by fragmenting communities into ever-smaller, more homogeneous groups (Stone 1993. p. 308ff).

proach is particularly important for the labour market, but it is also relevant to the health care sector.

- The delegation of responsibilities and functions from the state to non-state institutions is an essential part of the European concept.
 - The economy of the social sector, the **“social economy” is one of the largest sectors in terms of economic importance as well as in terms of participation.** It includes all civil society organisations (CSO) that are based on non-profit and participatory ideas, such as associations, mutual health organisations, workers’ friendly societies and co-operatives. These organisations, including charity organisations and religious organisations, have been playing an important role in the health sector in Europe. They have taken over functions and tasks that, in other contexts, are assumed by the state. These include:
 - provision of all kind of preventive, curative, rehabilitative and long-term care,
 - organisation of the financing of health care (mutual health organisations (“mutualités”), social health insurance schemes, social assistance funds),
 - advocacy and voicing of patients’ and health workers’ interests and rights, provision of continuous and specialist training and organisation of information, education and communication (IEC) activities as well as awareness-raising campaigns, etc.

All these activities tend not only to reduce the burden of the state regarding its obligations, but also to generate new employment and, thus, contribute to economic growth. In line with the principle of subsidiarity, some EU member states (e.g. Germany) have delegated a number of the above mentioned tasks to **autonomous, non-profit and decentralised bodies, governed by public law**. These bodies assume – on behalf of the state – important functions, such as assuring adequate financing of health care (“sickness funds”), provision of health care (“association of panel doctors”), specialist training, and implementation and supervision of the code of conduct of medical doctors (“medical board”). They have been granted self-governing status, which equals autonomous administration, financial sovereignty and self-sufficiency and democratic control by elected representatives of the members (employers and insured employees). Collectively, they have the right and duty to enter into contracts with the other actors in the system. Thus, the implementation of the public laws governing the health care sector has been left to the actors of the system themselves – at least to a large extent. The reasoning behind this set-up is that stakeholders of the sector show the greatest interest in, and know best how to tackle issues and solve problems concerning, their field of work.

In summary, the civil society organisations of the “social economy” and the self-governed bodies – representing actors and stakeholders of the health care system – play a vital role in European societies. By doing so, the internal cohesion of society is strengthened, and accountability and responsibility of actors is fostered. Thus, beneficiaries, actors and stakeholders directly contribute to the maintenance and further development of the welfare state.

3.4 THE FOURTH ASSET: COMPETITIVE MARKETS AND SOCIAL PROTECTION

In terms of GDP, the European Union is the largest internal market in the world. Europe is the biggest exporter and importer of goods worldwide. Moreover, its member states run comprehensive (and expensive) social protection and health care systems that cover practically the entire population.

High employment rates and decent, regular income generation are means of achieving and maintaining social protection in their own right. To a certain extent, these features contribute to securing social stability and social peace. This is important since a country's competitive position in world markets is not determined by labour costs, or product prices, alone. Europe tries to achieve the right balance between labour costs and the competitiveness of its economies on the one hand, and the costs and benefits of its social protection schemes on the other. It is not easy to reconcile the principle of solidarity ("sharing and caring") with the rules of the market ("winner takes all"). In Europe as elsewhere, the question of achieving the right balance between the two competing requirements is the subject of constant debate. However, Europeans (still) consider the health care sector – though an integral part of the economy – as a sector that should be guided and regulated by the state⁹ thereby securing the social (not market-driven) distribution of health benefits.

So far, the European experience has proven that it is possible and advantageous to link comprehensive social protection with elements of free markets. Accordingly, the European concept of a **social market economy** combines private ownership, freedom to enter into contracts, and competitive rights along with societal responsibility. Ultimately, this has led to increased productivity, innovation and success in world markets. Hence, the European example shows that "social protection" favours market development in the long run (see section 3.1. "The First Asset").

3.5 THE FIFTH ASSET: MULTIPLE OPTIONS WITHIN THE PUBLIC-PRIVATE-MIX

Privatisation is one of the most fiercely debated issues worldwide. In the narrow sense, privatisation refers to a particular form of ownership of capital. Private is everything else not owned by the public (be it the central state, local governments, or publicly capitalised, but autonomously managed entities).¹⁰ In the broader sense, privatisation refers to the shifting of capital and/or responsibilities from the public to the private sector.

Sometimes, however, the concept of privatisation, and that of the public-private mix, is discussed only in ideological terms and in its narrow, mostly

⁹ The USA, considered a country without broad social protection, also runs a broad network of social protection mechanisms, which are, however, less comprehensive and less "generous" than any of the European ones. Examples: pensioners over 65 and low-income earners benefit from in-kind health care benefits. Wage earners are entitled to sickness benefits, and most employees are entitled to unemployment benefits. Pension schemes exist, covering disabled persons and surviving dependents.

¹⁰ However, there is the important distinction between for-profit and not-for-profit ownership. For-profit status indicates that private individuals have put up the business capital, and expect to keep any accrued earnings. Not-for-profit describes an umbrella category for different organisational formats (civil society organisations, such as churches, charities, various associations, unions) where no group of individuals has contributed risk capital on which they expect to earn profit (Stierle, 1998).

neo-liberal, interpretation.¹¹ Whilst holding on to the fundamental principles of universal coverage, solidarity and equity, Europe has set up a firm regulatory framework for the private actors in the social sector, proving its economic and social reality to be adaptable to change. It has not limited itself to a simplistic “either-or” view but has developed a large number of models that integrate private elements on the financing as well as the provision side. Some of the many examples include:

- The trusts within the British National Health Service represent a type of self-governance of public facilities, which goes far beyond the traditional concept of a public service administration organisation.
- The German social health insurance carriers (“statutory sickness funds”) and their federal associations are non-profit, self-governed and autonomous institutions with a legal mandate and ruled by public law (cf. page 27).
- In France, mutual health organisations (“mutualités”) and “Institutions de Prévoyance” provide social services that traditionally would be organised by state agencies, including the “Sécurité Sociale” of public servants.
- In many European Member States, prices and terms of health care provision are (often collectively) negotiated between health care providers and financing agencies, which may be either private, civil society, semi-public, public, for-profit or not-for-profit organisations.

In general, assuming that they are properly monitored and regulated, market mechanisms and private ownership of services seem rather well adapted and beneficial to health care provision. In contrast, financing – i.e. resource generation¹² – and allocation of funds seem to require much more direct public intervention and/or public regulation.

In consequence, all European systems apply – in one way or another – the principle of solidarity for the whole population. And all of them have implemented some mechanisms to counteract market failures such as adverse selection, cream skimming and risk selection. It is a broadly shared opinion in European societies that universal and equitable access to quality health care cannot be achieved by the market alone. The rules of the market would automatically marginalise those parts of society that are too weak or simply not attractive in economic terms, thereby intensifying social cleavages. This stance requires a strong state that has the capacity to regulate and supervise a privately administrated system, and to regularly update the legal framework governing this system.

¹¹ It is often argued that privatisation would pave the way for (more) competition and efficient behaviour of organisations from which the users would benefit. However, this does not always hold true. Privatisation is not necessarily linked to the process of competition. In the case of a monopoly, there is no competition, although resources are privately owned. In contrast, it is perfectly feasible for competition (i.e. a market) to be introduced in a set of publicly owned organisations, including publicly owned health care services (Stierle, 1998).

¹² Mostly through some form of compulsory membership and/or contributions, and through broad risk-pooling.

3.6 THE SIXTH ASSET: SUSTAINABILITY

The European experience demonstrates that political, financial and technical sustainability has rarely been achieved through simplistic approaches, through force or cohesion. Rather, sustainability is a matter of:

- Involvement and participation of a broad spectrum of actors, stakeholders and beneficiaries,
- Respect for smaller communities and minorities,¹³
- Flexibility and tolerance,
- Mutual support,
- Transparency,¹⁴ and
- Courage to search for new solutions, which may have been inspired by existing models and may need adaptation for other economic and social contexts.

One important lesson from European experience is that neither health care nor social protection systems were initially designed as such. They are rather the result of continuous complex processes affected by numerous and interdependent historical, political, cultural, social and economical factors. In its present form, the European Union, and its various institutions and instruments, are the result of very adaptive and flexible processes. The basis and the heart of this successful evolution are a set of agreed values and guiding principles that draw on the historical experiences of EU member states: these include mutual respect, a desire for peace, democracy and political participation, freedom of movement, a social market economy, social protection, the willingness to co-operate, and the protection of minorities. In most instances, the different speeds of decision-making, different priorities and different economic capabilities of member states have been respected.

3.7 THE SEVENTH ASSET: VARIETY, COORDINATION, CONVERGENCE

European health care and social protection systems exhibit most of the approaches and elements that are debated worldwide. The available options are reflected in almost all areas of health care financing and provision, including the institutional set-up: European health care systems are either (predominantly) state-run and tax-funded (Denmark, Greece, Ireland, Portugal, Sweden, Spain, UK), insurance-based (Austria, Belgium, Germany, France, Luxembourg, the Netherlands), or mixed systems (Italy). Among the social health insurance schemes, some are very pluralistic (Germany and the Netherlands), and some are run by a few organisations only (Spain, Italy).

- **Membership versus citizenship:** Some systems base entitlement to benefits on citizenship (tax-based systems) and others on membership (contribution-based systems). In the latter case, some systems focus partly on voluntary membership (Ireland), while others combine compulsory health insurance membership (for the majority of the

¹³ An example is where voting rules within European institutions do not always correlate to the population size of member states.

¹⁴ Examples are the early publications of political plans and objectives to give stakeholders and the public the opportunity to comment and react.

- population) with the option for the richer groups within society to opt-out and obtain private health insurance (Germany, Netherlands).
- **Financing:** The Nordic and Anglo-Saxon systems are mostly financed through general taxation (sometimes combined with some form of user fees or co-payments). Most systems in Continental Europe (e. g. Austria, Belgium, Germany, France, Netherlands) are predominantly contribution-financed; some are organised by regions but financed through contributions (Spain), and others combine all factors (Italy).
 - **Benefit packages:** Countries with rather restricted (basic) packages (Greece, Portugal, Spain) coexist with other countries providing relatively comprehensive and “generous” packages (Netherlands, Germany). In between these positions, countries such as Denmark and the UK offer medium standard packages. Accordingly, complementary and supplementary benefit packages are of varying importance. In Ireland, for instance, the better-off are covered only for inpatient care, whereas the package for the poorer members of society includes primary care, too.
 - **Purchaser-provider split:** In several countries, purchasers and providers of health care services belong to the same body or organisation (e. g. Spain, UK). In other cases, financing and provision of health care are secured by distinct and sometimes numerous organisations. Purchasers (health insurance organisations) negotiate with providers (panel doctors and accredited hospitals) the range, quality and price of health care services, thus building up contractual relationships (e. g. Germany, Netherlands). Interestingly, various and quite distinct forms of contracting and provider payment mechanisms exist.

The great variety of systems within Europe requires co-ordination at the EU level. Harmonisation and convergence are a continuous challenge for the European integration process. However, so far, there are no plans to impose uniformity on the systems. Rather, close co-ordination is implemented with respect to the following areas:

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

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

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

Moreover, the principle of portability does not apply only to beneficiaries, but also to health care providers. Many diplomas and other exams are mutually

recognised throughout Europe. Licensing and registration of products (e. g. drugs) in one member state is valid in the entire Union.

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

However, the concept of convergence plays an increasingly important role in European policy. The concept aims to reconcile future developments within the European Union in such a way that gradually agreed objectives will be achieved. The ultimate goal is to achieve equal (or at least comparable) levels of socio-economic standards and, if appropriate, common regulations.

3.8 THE EIGHTH ASSET: TRADITION AND INNOVATION

Due to historical experiences, most European citizens do not oppose the more “coercive” elements of social protection, such as compulsory membership of statutory health insurance funds and compulsory contributions. Reasons for that include trust in the system, ethical considerations and a feeling of safety. In many cases, it is just tradition or sheer habit,¹⁵ certainly combined with an experience of reliability and effective social protection. However, tradition may also lead to inertia, which in turn may impede development and progress. In view of the rapidly changing environment and the challenges mentioned above, changes and adjustments are necessary to sustain the acquired assets. Innovations and political reforms of social protection schemes are constantly discussed in Europe, and if necessary adopted. Currently, the following issues receive particular attention:

- The counterbalance to an ageing society with respect to the social protection of people in need of long term and nursing care,
- The improvement of medical and social rehabilitation in order to reduce the strain on social protection mechanisms,
- The increase in flexibility of social protection mechanisms and, thus, the improvement of responsiveness to individual demands and conditions,
- The strengthening of individual responsibility regarding small risks while safeguarding the protection against great risks. This goes along with increased user fees or co-payments.
- The further development of risk equalisation mechanisms between funds (e. g. Germany, Netherlands),
- The combination of different financing mechanism (taxes, insurance contributions, co-payments) in order to compensate the loss in revenues due to economic shortfalls caused by the decreasing share of wages in relation to total national income, the increasing proportion of economically inactive citizens due to the ageing population and high unemployment, and sluggish economic development.
- The attempt to make the provision of health care services more cost-effective, e.g. through managed care, disease management programmes, and closer links between inpatient and outpatient facilities.

¹⁵ In Germany, 62 % of the insured do not know the rate of their contribution to social health insurance (which is automatically deducted from their monthly salary). Source: Deutsches Ärzteblatt. 2002. 99, Heft 1-2, page C1.

In general, health care reforms take place through incremental modifications and process-oriented approaches rather than radical changes of the systems as a whole. While there is broad agreement on the underlying fundamental principles that should guide the sector, the stakeholders and partners are also aware of the need for adjustments. This can include far-reaching changes of the legislative and administrative arrangements for social protection. It has been estimated that in Germany alone, for instance, about 2000 amendments of the health care laws have been passed during the last 20 years.

The reasons for favouring the incremental process approach over that of radical system change are the following:

- **Cultural rationale:** Despite the fact that most European citizens pay relatively high taxes and social contributions, large (public) support exists for maintaining collective social protection arrangements. In Europe, it is the norm that prosperous societies organise solidarity to balance unequal market opportunities to a certain extent. Incremental and small system-changes can maintain social protection for all members of society, and counterbalance the adverse impact of global markets.
- **Economic imperatives:** Solidarity-based social protection represents a cost item for individual enterprises that is becoming increasingly important due to the globalisation and the predominance of short-term rent seeking.¹⁶ For the nation as a whole, however, it has to be regarded as an investment. A system of sheer profit maximisation and deteriorating employment conditions leads to a lack of demand and decreased savings as well as to inequality in the distribution of wealth. In Europe, social cohesion can be considered a determining factor for achieving macro-economic stability and creating an investment-friendly environment within a national economy.
- **Political and social reasons:** Poverty and social exclusion are a threat to democracy. The continued existence of a democratic system based on the concept of a market economy is highly dependent on the legitimacy of the social order and on its acceptance within society. Effective social protection schemes have turned out to be one major pillar of political stability in democratic societies. During the last few decades, all European governments have re-focused their interventions in the field of social protection towards improving the flexibility and efficiency of their systems and, increasingly, towards introducing market elements. At the same time, however, governments have intensified their efforts to improve education, infrastructure and social cohesion. Hence, the incremental approaches to apply mechanisms of the (free) market while maintaining social responsibility through public and state intervention and control: the “invisible hand” is complemented by an “invisible handshake”,¹⁷ or the “visible hand”¹⁸.

¹⁶ Compare footnote 10.

¹⁷ Handy, C.: Beyond Certainty: The changing Worlds of Organisations, London, 1996.

¹⁸ Donaldson, C. and Gerard, K.: Economics of Health Care Financing: the Visible Hand. London: The Macmillan Press. 1993

- ***Institutional legacy***: Owing to the long history of European health care systems and the democratic processes in all European countries, there are many interest groups who strongly defend their members' interests. These groups (e. g. the pharmaceutical industry, medical doctor associations, hospital associations, health insurance funds, employers' associations, trade unions, non-profit organisations etc.) play a powerful role in the political process. It has become very difficult for governments to achieve a compromise between the different interests in the large health care market. Since most of the reforms nowadays have to address the question of how to curb health care expenditure, there is a fierce distributional battle amongst various stakeholders. The political compromise usually results in an incremental reform rather than a radical overhaul of the entire system.

4 EUROPEAN CONTRIBUTIONS TO GLOBAL DEVELOPMENT

4.1 EUROPE'S INTEREST IN THE PROMOTION OF SOCIAL PROTECTION

The assets associated with European social protection systems as previously described may be used to guide and facilitate European activities in international co-operation. The question about the motivations and interests of European decision-makers and citizens in promoting the European view on social protection arises sooner or later.

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

1. There is a desire to share the experience that universal coverage, solidarity and mutual support can contribute to economic and social stability. In a world where borders are losing their importance, stability is a public good which benefits everybody.
2. The process of globalisation reinforces the political, economic and social interdependence of the different regions of the world. It also points out the importance of mutual responsibility. Therefore the adverse effects of poverty in the South should be taken seriously by the industrialised countries of the North.

In the short run, exploitation and the acceptance of social hardships and poverty may lead to high profits, but only a small, privileged group benefits in the respective country. To sustain high profit rates, inhumane conditions for workers and their families mostly continue to exist. Considering the ethical values that European societies claim, Europe should condemn such practises as "social dumping" and seek to prevent them with all force permitted under international law.

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

4.2 PRINCIPLES TO GUIDE EUROPEAN CO-OPERATION POLICY

As described in chapter three, the European assets have developed in response to emergent challenges in the field of social protection. This justifies some reflection on the possibilities for sharing the knowledge gained and the experience gathered in the context of European co-operation policy. The authors consider that three types of assets may be shared with the international community, namely:

- Principles and concepts, specifically those dealing with universal coverage, solidarity, subsidiarity, equity, equality and poverty reduction,
- Procedural and political approaches,
- System techniques.

1. Principles and concepts

Solidarity and universal coverage are two of the key values practised and promoted in Europe. They are also guiding principles in international co-operation. In practice, solidarity means providing support and assistance in different ways to those who are in greatest need, and universality implies the extension of social protection to the whole population, without any exclusion of certain population groups. The goal is to promote social, political and economic development.

The combination of solidarity and subsidiarity is a particular European asset which compliments the social assistance approach for the very needy through decentralised decision-making and responsiveness.

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

These principles are an important part of the success-stories of European “models”, and thus may serve as the foundation of co-operation with and support for countries and communities in need. Moreover, the long-term European experience with social protection offers a series of successful and sustainable strategies that allow for an effective operationalisation of mutual help, solidarity and social justice.

2. Political approaches and procedures

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

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

These two concerns are in contrast to each other and may best be reconciled through positive experience, participation and targeted dialogue.

3. System techniques

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

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

4.3 THE ACTORS

International co-operation is not simply a matter for governments and bilateral agreements. Europe possesses a large variety of organisations that actually contribute, or could contribute, to international co-operation. Basically, four types of organisations exist:

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

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

4.4 POTENTIAL FIELDS OF ACTIVITY

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

- Adapting current social security arrangements to the requirements of the “information society”, and
- Supporting social integration and reduction of poverty and social exclusion.

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

Technical co-operation is only one possibility amongst others to support and assist low and middle income countries. However, the following suggestions focus on technical co-operation, since the authors of this paper are mainly acquainted with this area. On the following pages, the authors present some examples of how the European Commission and the EU member states could offer support to strengthen effective and equitable social protection in health care worldwide. They will underline how European assets could be used in the most effective and efficient manner and how synergies could be produced

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

- **Policy consultation and dialogue:** When their underlying political and social values are taken into account, European assets in the field of social protection and health care have a relevance that extends far beyond mere “national models.” Policy dialogue should always draw on these overarching principles, and focus less on specific advantages, or disadvantages of one particular European “system” or “model”. Rather, the policy objective is to set up efficient, effective, equitable and sustainable social protection systems, adapted to local contexts and needs. In principle, it is of no importance what kind of European national system represents the starting point for further considerations. Therefore, the intention of implementing particular national technical features and/or structural elements should not form the “hidden agenda” of technical co-operation.
- **Co-operation and co-ordination on the European level** with regard to planned (national) programmes, activities and priorities, including the exchange of experiences among European and bilateral donor agencies. One particular approach, which could complement bilateral technical co-operation and which is a “typical European” feature, is the *sector wide approach*.¹⁹
- Strengthening of the **co-operation between developing countries and the EU**, and facilitating the **debate on structural and policy options:** the large variety of social protection schemes and experiences in Europe exhibits the different *strengths and weaknesses* of their respective systems. Partners and beneficiaries of technical co-operation could particularly benefit from an open, knowledgeable and professional debate. This could be achieved through:
 - a) Support for the participation of partners in relevant conferences, workshops, seminars and training courses,
 - b) Provision of access to Internet-based information and discussion.²⁰

Box 2: Strengths and Weaknesses of System Elements

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

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

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

¹⁹ Cassels, Andrew: A Guide to Sector Wide Approaches for Health Development. WHO 1997

²⁰ The Internet will become a major source of information for developing countries. Training courses always should include modules on how to use new information and communication technologies.

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

- a) Finance regional conferences, seminars or workshops,
- b) Finance training courses,
- c) Provide training by experts from similar/comparable countries,
- d) Provide access to information on countries facing similar challenges, e. g. via an Internet-based resource pool,
- e) Develop and finance twinning projects between developing countries,²¹ for example by:
 - Focusing on developing countries exhibiting similar political, socio-economic and/or cultural features,
 - Extending the twinning projects to CSOs and NGOs and *non-acquis communautaire* issues²². (This may include health care providers, health insurance carriers, associations, self-help groups, etc.)
 - Providing training to European twinning partners, e. g. language courses, country studies and/or workshops on locally and regionally available know-how,
 - Facilitating communication and exchange between twinning partners through meetings, conferences, etc. (including provision and use of new information and communication technologies).
- Supporting the internal dialogue structure within partner countries through community development and empowerment of disadvantaged population groups, communication and information activities, promotion of political, social and cultural participation, fostering gender equality, etc.
- Supporting the development of **quality standards, quality assurance activities and quality management systems**, such as
 - a) Elaboration of standards and benchmarks for social protection schemes, including health care financing matters,
 - b) Elaboration of standards and benchmarks for project implementation and consultancies,
 - c) Providing incentives for successful project implementation and/or well-performing schemes (with respect to target achievement),
 - d) Development of quality management systems adapted to local circumstances,
 - e) Providing adequate training and support services to local staff of projects and/or schemes (regular updating of skills and know-how, provision of an expert-pool, online support, and hotlines).
 - f) Creation of adequate mechanisms and structures to deal with complaints and suggestions from clients, customers and staff,

²¹ Similar to the twinning model practised with PHARE countries.

²² “*Acquis communautaire*” means the assets commonly acquired within the EU.

- g) Establishing regular and standardised client and staff satisfaction surveys.
- o Development and/or strengthening of adequate **information sources** and decision-oriented **monitoring systems**, including
 - a) A **know-how resource database** drawing on European technical and policy expertise and practice.²³ This database could also be helpful in the process of political consultation and policy dialogue.
 - b) A **resource (project) database** drawing on experience gathered in development projects and from different schemes in partner countries.²⁴
 - c) A **success indicator database**, measuring the successful implementation of technical co-operation projects, and their impact on the target groups. It could be used by the EU and partner countries. Indicators might include measures of health status, poverty, and access to health care, gender equity and economic evaluation techniques.
 - d) Long term **monitoring** and SWOT²⁵ analysis of social protection schemes and project implementation, including
 - development of a standardised evaluation methodology,
 - identification of factors determining the performance of schemes (e. g. requirements for implementation, social, cultural and economic factors, etc.),
 - identification of “best practices”, to be fed into the know-how- and project database.

²³ It could be built on the experiences gained by MISSOC. Experience gathered in projects and in schemes of partner countries could gradually be incorporated, cf. b).

²⁴ This database could be built on the experiences gathered by databases such as SHARED (developed by GTZ for the Commission), InfoSure (GTZ) or HEARD (DSE). The possibility of merging this database with the proposed know-how resource database should be explored.

²⁵ Strengths, weaknesses, opportunities, threats.

5 CONCLUSIONS: INNOVATION, QUALITY AND RESPONSIBILITY

This paper summarises the current status of social protection in the field of healthcare worldwide, and reflects upon the challenges this sector is facing. It is addressed to decision-makers and all other interested parties, in Europe and elsewhere. Its purpose is to initiate an international debate on how to pursue the setting up of appropriate social protection systems in the health-care sector in low and middle-income countries. In doing so, the paper relies on the long-standing European experience in this field and elaborates on the rich assets Europe can contribute to the debate.

The authors would once again stress the fact that European social protection systems have largely proved to be adaptable to change. This makes them worth analysing in an attempt to find solutions for shortfalls or emergent crises in this sector worldwide. Furthermore, the authors firmly believe that it is the set of fundamentals underlying the European systems which makes these experiences and assets worth examining, sharing and discussing with other actors in the field. The universal principles the system embodies simplify the adaptation of its elements to circumstances and needs found in other parts of the world.

Concerning international technical co-operation in particular, the authors want to point out the fact that Europe, as well as being able to contribute substantial technical know-how in the field, can also draw on principles and lessons learned that should enrich any debate on the future of social protection. This paper argues strongly that the achievement of effective and equitable risk protection in health care involves much more than simply deploying financial inputs or addressing sheer technical considerations. Social protection is, first and foremost, a matter of shared social values and objectives, and of adequate social and political processes. Of course, sufficient financial resources have to be available, but systemic and structural deficiencies have to be tackled as well. Thorough attention has to be given to the following issues:

- Clarification of the value base,
- Agreement on guiding principles, such as solidarity, universality, subsidiarity, and responsiveness to needs,
- Co-operation, co-ordination and twinning,
- Balancing of power and interests,
- Encouraging active and open participation of stakeholders,
- Priority and standard setting,
- Establishment of information systems,
- Monitoring social processes, technical procedures and quality,
- Creating an open-minded environment that not only facilitates the exchange of ideas and information, but also the debate on strengths and weaknesses of different systems and reform options.

Developing processes to address these issues forms an integral part of the work of every effective and innovative organisation. Having this in mind, the authors think that support for innovative processes and their monitoring could represent one of the main targets in technical co-operation.

At this point, the question arises, who should be responsible for tackling the issues mentioned above? In this respect two different types of actors can be identified. On one hand there are the donors and technical co-operation agen-

cies, on the other there are the beneficiaries, the nations, institutions or the users.

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

On the beneficiary side it will therefore be important to develop full ownership for the planning, implementation, monitoring and evaluation procedures – even in the presence of strong technical assistance. If schemes are to be effective, then universality, reliability, responsiveness, participation, effective anti-corruption policies, public information, and transparency are all crucial. This is the case regardless of the type of scheme that is envisaged – state-run schemes, para-statal/quasi-public social protection carriers, private organisations and/or mixed systems.

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

6 GLOSSARY OF TECHNICAL TERMS

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

Equity:

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

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

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

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

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

Poverty:

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

Poverty does not merely mean that people have low incomes but also that they have to contend with limited opportunities and inadequate means of playing a part in political and economic life, and are therefore excluded from decision-making. At the same time, their human dignity is not respected, their human rights are abused, they lack access to resources and they are particularly exposed to the risks and burdens of disease, regardless of which country and society they live in.

Social Protection:

Social protection includes the entire system of mechanisms to protect citizens against the risks of sickness, natural disaster, accident, old age, unemployment and occupational hazards. Forms of social protection comprise traditional, informal and formal arrangements. These include families, solidarity-based groups (voluntary membership and/or self-help), co-operatives, (compulsory) membership-based systems of social security (such as social health insurance), private insurance (for-profit, or not-for-profit), and government-based forms of social security as well as social assistance.

Social Security:

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

Solidarity:

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

Subsidiarity:

This concept implies that tasks and obligations should always be fulfilled by the lowest possible level within society that is capable of shouldering the burden and/or solving the problem. The subsidiarity principle decrees that the government should step in as a regulator of private affairs only if the private system fails to achieve shared social goals.²⁶ It also implies that government should direct its monetary subsidies and other form of assistance mainly to those individuals in society who cannot help themselves (Reinhardt, 1993).

²⁶ Federal Ministry for Economic Cooperation and Development (2001): Poverty Reduction – a Global Responsibility. Program of Action 2015: The German Government's Contribution Towards Halving Extreme Poverty Worldwide

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