The GTZ-Sector Project "Elaboration and Introduction of Social Health Insurance Systems in Developing Countries" and its tool "InfoSure" – a Health Insurance Evaluation Methodology and Information System

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1. Background

In most developing and threshold countries, there is a demand for blanket-coverage health care of sufficient quality which is accessible to all social groups. However, for both the state health care services as well as private service-providers it seems difficult to meet these standards. Thus, almost half the world's population has insufficient access to health care services. The hardest hit are the poor, living in remote rural areas and people in the informal sector in the cities. At the same time, these groups are exposed to a higher than average risk of illness. Where it exists, the traditional social security network is collapsing as a result of overpopulation, rural exodus, flight from wars and natural disasters, urbanisation, slum formation and impoverishment.

The trend towards globalisation in general and the global and regional economic crises of the eighties and nineties specifically have posed severe problems to many developing nations. They had to face stagnating international commodity markets, falling prices for raw materials and rising foreign debt. The real income of many households fell dramatically, and major sections of the population became impoverished. As a result, social and health care budgets frequently have to make do with ever shrinking financial resources. In many countries, the funds which the Government provides for public health care are not even sufficient to ensure regular payment of health care workers and to supply the necessary medicines. This is compounded by the fact that the existing resources are not deployed efficiently.

This development has also led to major changes among providers of health care services and in the financing of health care:

- In many of the countries concerned, patients are required to make co-payments, even in public facilities, although often this is not legal.
- Poor performance and low quality of services in many public healthcare facilities forces even the relatively poor to consult private healthcare providers.
- Higher-income sections of the population are resorting to private services which are appearing on the market in increasing numbers. Patients pay for these healthcare services out-of-pocket, unless they are insured by some type of (classical) state social

security scheme for privileged population groups, such as state employees, employees in the formal sector or the military, or are covered by a private scheme, many of which have their headquarters in one of the industrialised nations.

As a consequence, isolated healthcare systems develop for the various population groups, making it more difficult to show solidarity with one another. At the same time, an increasing number of households remains cut off from healthcare services of acceptable quality, or they are economically ruined by disease. Furthermore, dubious, unqualified, unlicensed suppliers are common on the market. Prices and fees are not transparent.

It is only when legislators create the legal framework, define performance criteria and fees, and regulate access to the market, that a broader range of health care services can lead to an improvement in the performance and quality offered by public facilities.

Since people have had to pay more and more for health care services, in recent years there has been a proliferation of health insurance models at local authority and community level. Essentially, these are either pre-payment systems or systems which offer membership to smaller mutual aid groups which intervene in case of sickness. In pre-payment systems, savings are collected and price reductions are agreed with service-providers.
The term Mutual Health Organisation (MHO) has been coined for these models. Though they might take widely varying forms, there are still some fundamental similarities:

- Membership is voluntary.
- They are non-profit-making.
- They are small and transparent with only a few thousand members.
- They are adapted to the local cultural and technical conditions.
- They are established thanks to the initiative of communities and non governmental-organisations (NGOs) such as associations and co-operatives.

One welcome development is that the Governments of many countries are now supporting these models. Another positive trend is that the various models of insurance pave the way for developing social counterbalancing mechanisms, strengthen the position of consumers in relation to providers of health care services, and hence influence the quality of the services provided. As a rule, the insurance schemes have democratic

structures which are developed and operated with and by those concerned. However, in spite of a number of initial successes, the problems inherent in the insurance systems developed to date cannot be overlooked:

- They only cover a very small section of the population. For this reason, the possibility of genuine risk sharing among members remains extremely limited.
- In most cases, their small size restricts insurance protection to a small number of benefits. In the event of epidemics, they are often unable to cope, and consequently many patients are left on their own to pay for expensive courses of treatment.
- yet only a small number are able to cover their expenses through contributions.
- often administrative performance is poor.
- Because there is a lack of relevant statutes, there is widespread insecurity regarding the legal form, constitution, minimum requirements and consumer protection. Not least, this frequently hinders the schemes from getting loans.

These factors notwithstanding, these small-scale insurance systems have been at the centre of interest for several years, not only because they offer ways of countering the seemingly chronic lack of funding in the health care sector in many developing nations, but also because often they are based on participatory approaches, and can therefore contribute towards democratisation processes and can help strengthen the establishment of civil societies.

2. Project goal and policy significance

The project intends to encourage decision-makers in selected partner countries to apply strategies and methods to set up socially-balanced health care systems which improve sustainable access especially for the poorer members of the population.

In pursue of the project goal:

?? Strategies and methods should be developed to foster a socially-acceptable (poverty-orientated) form of co-operation between private and public funding agencies (financing and provision of services) in the health care systems of the partner countries.

?? Partner countries should be extensively advised on the social effectiveness of the strategies and methods developed, taking account of their countries' specific socio-economic, cultural and political circumstances.

?? Fora and association structures for the insurance and service-providers' institutions should be established, to promote an effective exchange of expertise and experience between those concerned and to represent the latter at political level.

?? In selected pilot regions with local insurance institutions in place, the coverage of the low-income population should be expanded.

The project intends to support sectoral reforms of the health care systems with a view to strengthen the element of solidarity in the financing of health care.

Organising and supporting social health care systems is one of the core tasks of the state. This includes the design of framework legislation to actively promote the creation of private and individual initiatives, to guarantee and finance the provision of health care and to grant appropriate scope for action and legal security. The aim is blanket-coverage health care which is equally accessible to all sections of the population, sufficiently high in quality and affordable under the prevailing situation, technically adjusted to circumstances, but nevertheless sustainable. The economic crises which illness causes in the budgets of families and individuals can thus be alleviated. The project aims to facilitate a comprehensive approach to combating poverty.
The development of decentralised structures, democratically organised and based on the principle of solidarity, are among the tasks which are to be undertaken as a matter of priority. Establishing lasting social health care systems will only be

possible by linking existing public and private demand and supply structures. The project targets the overall population of the countries and regions receiving the consultancy services, in particular the weaker groups, such as women, children and the poor. Introducing health care funding concepts based on the principle of solidarity at local, regional and national level leads, on the one hand, to better funding of health care services, and hence creates the foundation for improving the quality of supply. On the other hand, it also relieves the burden on private households, in particular by alleviating acute funding emergencies in the event of a family member falling ill.

3. Structure of the project

At GTZ headquarters the sectoral project is managed by the "Division for Health, Education, Nutrition & Emergency Aid" in co-operation with the "Division for Economic and Social Policy, Law and Administration". Furthermore, in this field the GTZ is co-operating with various scientific and specialised institutions. This represents a means to increase the quality and effectiveness of the German contribution. In this context the following goals are central:

Experience from countries and systems which have been working with health insurance models for many years and/or decades is put to good use. Here, the projects conducted in the Philippines, India, Guinea, Madagascar, Côte d'Ivoire, Uganda, Chile, Venezuela and El Salvador represent sources for analysis. The GTZ also is supporting measures to improve the funding of the health care system in a series of countries with economies in transition.

Experience gathered with the establishment of health insurance schemes in developing nations is exchanged.

In providing consultancy services to institutions, co-operation efforts aim at expanding the institutions' range of benefits and services, pooling resources, avoiding duplication of effort and achieving synergistic effects. Resources from a variety of sources are combined in order to place health insurance projects on a broader financial and technical footing. A pool of experts with different areas of expertise from various countries and institutions is created.

The sectoral project cultivates co-operation with social insurance funding agencies in Germany and Western Europe. The creative exchange of experts, in particular with the largest German health insurance funding agency, the General Local Health Insurance Fund (AOK), is to be expanded further.

Other health insurance partners are the Belgian health insurance association (ANMC) and the international health insurance association (AIM) in Brussels. On the academic side, the sectoral project works together with the Institute of Tropical Medicine in Antwerp (ITG) and the Centre for Development Research (ZEF) in Bonn. Together with the German Foundation for International Development (DSE) several seminars have been planned and conducted on the topics " development of health insurance concepts" and "health care funding" in Germany, the Philippines, Guinea and Thailand.

At international level, the project co-operates with the International Labour Organisation (ILO), in particular with the Social Security Section's STEP ("Strategies and Tools against Exclusion

and Poverty") project as well as with the corresponding departments at the World Health Organisation (WHO).

To date, the sectoral project has been analysing experience with health insurance schemes in many developing and threshold countries, taking particular account of community-based health insurance schemes. To facilitate analysis and evaluation pro??cess, a standardised evaluation method consisting of a questionnaire and appropriate database software has been designed. The knowledge gained with every single analysis is fed into the policy advice services to support the partners in planning and introducing health insurance systems..

Furthermore, strategy papers for Western Africa and Latin America have been drafted, which discuss the potential and the limits of social insurance systems against the background of the prevailing economic and cultural circumstances.

4. Methodological approach

The sectoral project attempts to integrate both the vertical as well as the horizontal levels in the consultancy approaches.

The **vertical approach** refers to all state and supra-state levels which should be taken on board for the design of a feasible concept. These include:

Local level (micro level)

The users or customers of a health insurance scheme i.e. the project's target group, are found at local level. Some of the main advisory services rendered here are feasibility studies, financial viability studies, start-up assistance for the implementation of concepts, and training of local experts.

It is of particular importance that the health insurance schemes should not be an alien body in the population, but should be incorporated in local structures, for example via participatory (democratic) decision-making mechanisms, linking into existing communities, taking account of local circumstances and the special needs of women and children (family insurance).

Regional level (meso level)

The regional level is the first level at which networks can be established and the local systems strengthened by political means. To facilitate this, effective association structures are needed which can provide qualified advice and services, such as negotiations with service-providers or finding suitable reinsurance partners. Such an association structure can help insurance systems to retain their local character, and hence are better accepted, whilst having the advantages offered by large organisations.

National level (macro level)

It is at national level that the cornerstones of a country's health policy are agreed, including co-ordination with international development partners (e.g. SWAP). Ideally, health insurance projects should help implement decisions of institutions at national level while receiving support from others at this level. It is solely at the national level that concepts for the nation-wide promotion of local health insurance schemes can be developed. It is also at national level that the statutory framework is regulated.

International level

At international level, consultancy services can support the establishment of international health insurance projects, and promote an exchange of experience with other countries in a similar situation, in addition to co-ordination with international aid organisations.

The **horizontal approach** attempts to include various sectors, specifically:

The public sector

In many developing nations, public authorities are the main funding agencies and organisers of health facilities, especially for the poorer population groups. It is therefore necessary to avoid governments adapting the view that their influence on and control of the health care system is jeopardised by the development of health insurance schemes. Rather, there should be close co-operation between the state institutions and any other initiatives. Furthermore, the services provided by state facilities can also be the subject of insurance schemes.

The NGO sector

NGOs are important funding agencies and promoters of health facilities. As a rule, they attempt to fund themselves by charging fees which cover their costs, but they frequently take the financial means available to their patients into account. The need for NGOs to finance themselves has been growing in recent years because of reduced financial support from the industrialised countries. NGOs represent important potential contractual partners in health insurance projects. In many cases, NGO hospitals or health centres have initiated health insurance projects. However, the challenge presented to these initiatives, lies in the transition of these service-provider-operated systems into self-administered health insurance schemes.

The private sector

In many developing countries private health care services are in the pro??cess of taking over a growing market share. Here, "private services" cover a broad spectrum of providers and products:

?? small private traders (traders in non-authorised medicinal products) and traditional healers,
?? public servants earning additional income, for instance as private doctors,
?? licensed private clinics, health centres, laboratories, chemists, etc.,
?? private insurance companies, and
?? private enterprises which fund health care services for their employees.

Apart from the first group, many of the providers listed above offer higher quality than, for instance, state providers. However, most are not affordable for the deprived population groups.

Advisory services should examine possible synergies between the private sector and local health insurance projects. This implies transfer of knowledge, for example agreeing on fixed rates which in part can be paid by the health insurance scheme, up to and including statutorily fixed transfer payments (taxation) of private facilities.

For all levels, advisory services should focus especially on ensuring that the meas-

ures are adapted to the local political, cultural and economic circumstances. All activities undertaken and all measures proposed aim to primarily benefit the target group, i.e. the poor population. It is possible to positively influence the development of the healthcare system by accompanying economic, financial, tax, budget, social and legal policy measures.

The sectoral project envisages local subsidies for basic and further training of employees of, in some cases, recently established health insurance organisations and associations. These should have the objective to implement promising concepts that are in accordance with the project's agenda. Local subsidies should serve to promote the independence and responsibility of the organisations and create trust.

In developing proposals for consultancy purposes in partner countries the project tries to integrate lessons learned from the Western European healthcare funding concepts (Bismarck and Beveridge systems). In Europe, the Beveridge model represents tax-based funding of the health care services, the Bismarck model is based on the principle of financing health care services via comprehensive obligatory insurance. Neither one nor the other model should be transferred to the partner countries since there is limited scope for the application of the Western European health care funding concepts in other parts of the world. It is necessary to take full account of local circumstances such as the existence of only a small formal employment sector and /or wide gaps in the economic performance of the population, with extreme irregularities in the income earned by the impoverished members of the population. Often, the infrastructure in terms of health care facilities, communication and transport offers scope for improvement.

The project's advisory services aim to take the economic, cultural and political structures of a country into consideration. As the latter are subject to change the advice modules are developed in response to a specific need for advice and in an application-orientated manner.

5. InfoSure – the project's Health Insurance Evaluation Methodology and Information System

The evaluation methodology focuses on the structured, in-depth analysis of small-scale / community-based health insurance schemes.
It consists of a comprehensive **questionnaire**, including explanations and a glossary of terms, and a corresponding **database software**.
The **questionnaire** allows the respective health insurance scheme to be described as a standardised, detailed case study. It is composed of four main parts:

a) a qualitative part with open questions
b) a coded multiple choice part
c) a statistical part for quantitative data
d) a section for information on the people and institutions involved in the scheme to be analysed.

The questionnaire represents a comprehensive list of topics concerning all aspects of the organisation and running of a health insurance scheme. In regard to contents the parts are overlapping.
The topics covered by the questionnaire:

- set up of the scheme
- membership
- financing
- benefit packages offered
- risk management
- services other than health benefits provided by the scheme
- statutory framework
- administration
- the provision of health care
- the role of providers
- payment of providers
- the role of the state
- envisioned reforms / plans for the future

The **database software** product

- enables the collection of the case studies in a standardised format
- allows the performance of meta-analyses and comparative studies at a later stage
- allows the easy retrieval of data
- will be accessible via Internet to perform the analyses and tasks described above.

The database software product consists of four main elements:

- an entry module enabling direct entry of the collected data
- the database itself
- an enquiry module facilitating grouping and analysis of the data collected
- a module permitting editorial changes to be made by the system administrators.

Working with the tool – methodological approach:

?? Performance of semi-structured interviews with the parties concerned, i.e. stakeholders, enrolees, providers, etc.

by a team of 2 consultants

a) a local expert
b) a staff member of the GTZ project team.

?? The data is entered into the software product
?? the analysis of data is performed
?? a report on the findings/ main features is elaborated
?? the knowledge gained is fed into the consultancy activities.

At a later stage:

- a database on insurance schemes exists
- performance of comparative analyses etc. are possible
- data and analyses are accessible via Internet.

For more information please visit InfoSure's Webpage at http://www.infosure.org.
In spring 2001 the methodology InfoSure was published and is now available in a print and software package.

Copies can be ordered at

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