IMPLEMENTING THE SOLIDARITY PRINCIPLE THROUGH FINANCIAL EQUALISATION

JENS HOLST[24]

Abstract

To have any chance of becoming comprehensive and potentially universal, social protection requires societies to adjust unequal risks and differences in financial capacities between their members. Especially in welfare states, various equalisation mechanisms exist for balancing different social risks and unequally distributed purchasing power. These apply often, but by no means exclusively, to formal social security arrangements and are an integral part of social health protection schemes based on the principle of solidarity. Moreover, competitive health insurance markets require risk structure equalisation mechanisms in order to prevent or at least reduce risk selection.

Beyond social protection systems as such, financial compensation mechanisms can be applied in broader settings at national and international levels. This paper will present two well-established examples illustrating the operating mode and the potential of inter-regional and inter-state equalisation mechanisms, namely the Federal Financial Equalisation System in Germany and the European Regional Development Fund. It will further briefly discuss the capacity of financial adjustment schemes to play a role in global social protection.

[24] Independent consultant, in this case for medico international; expert in the fields of health financing, health systems development and social protection. Email: **drjensholst@web.de**.

Setting up global financial support and equalisation mechanisms will certainly not be an easy task and will require both political assertiveness and persuasive concepts. As McDonald (1996: 301f) stated, rightly: “The possibilities inherent in the idea of solidarity should stimulate our thought about the constitutional and structural means by which a more democratic global society can be realized”.

Principle of Solidarity

Solidarity is a quite comprehensive term that is broadly used in very different settings and with sometimes surprisingly different meanings. Solidarity is generally defined as “a unifying opinion, feeling, purpose or interest among a group of people” (yourdictionary 2012). It alludes to positive associations connected to supportive attitudes and a mode of co-existence based on mutual help. It expresses the condition of having united or common interests, purposes or sympathies that are shared among members of a group.

But solidarity calls to respond not simply to individual misfortunes; there are societal issues that call for fairer, more equitable social structures. The concept of solidarity goes beyond engaging in charitable actions and works. In international law, solidarity refers to the principle of cooperation that identifies as the goal of joint and separate state action an outcome that benefits all states (cf. McDonald 1996: 259f). Solidarity is a fundamental principle of welfare states and so-

cial protection systems, and the overall objective of solidarity is social justice. It leads to choices that will promote and protect common goods such as health, decent life and participation.

The development of welfare states and comprehensive social protection has shown that beyond all conceptual wooliness, solidarity can be operationalised far beyond voluntary charity and occasional actions of mutual support. Social protection in health has long developed the pioneering model of converting a vague concept into social right and entitlement while safeguarding fairness and sustainability. Health financing in both national health systems and social health insurance goes beyond the principle of insurance. A broad range of insurance arrangements exist, covering life, crops, fire, assets, car accidents and many other risk classes. Insurance is based on the law of large numbers, on group sharing of unforeseeable individual risks, and on prepayment of affordable amounts for preventing high and potentially catastrophic expenditures. This applies to all types of insurance, regardless of the risk covered.

Solidarity in health insurance, however, goes beyond sharing the financial risk of potential losses among a group of insurees. The principle of solidarity does not only imply risk sharing among the healthy and the ill, but also cross-subsidisation between the wealthy and the poor. It has to be stressed that the principle of solidarity is due neither to theoretical considerations nor to wishful thinking; it is implemented in daily practice through the way resource generation and allocation are organised. All types of health-system financing that define payment according to ability to pay and entitlement according to need do, in effect, operationalise solidarity. Both tax-funded national health systems and social health insurance (SHI)[25] schemes combine income-based prepayment for health with needs-driven access to health care.

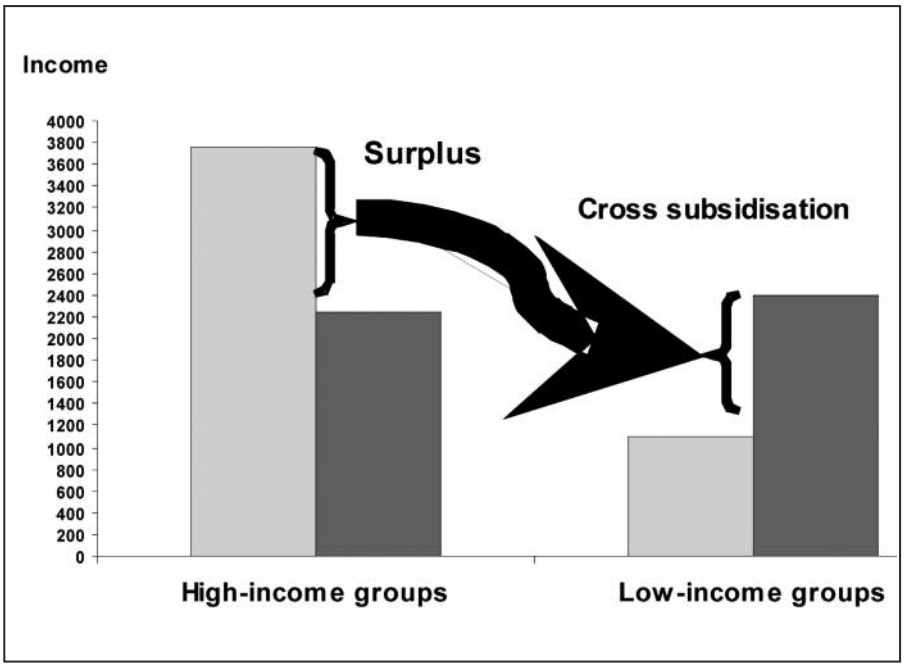
If everybody pays for health coverage according to his or her ability to pay and is entitled to the same scope of benefits whenever (s)he needs them, the solidarity principle comes into operation. The typical redistributive effects in health protection beyond the mere insurance principle – namely from the better off to the poorer members of society, from the economically active to the inactive, from younger people to the elderly and from singles and small families to larger families (if dependents are covered free of charge) – arise automatically from combining progressive resource generation with needs-driven allocation based on a unique benefit package.

To operationalise the solidarity principle effectively at society level, all members of society in need must have access to healthcare, regardless of their ability to pay. Universal healthcare systems have to ensure equal access for all to the same benefit package according to entitlements based on income-related payments and prevention of risk selection. To achieve this, tax-funded national health systems have to ensure

[25] Revising international publications on SHI and especially on SHI in developing countries reveals that many authors from World Bank, USAID, ADB and others either do not make any serious effort to define what SHI means (see e.g. Hsiao & Shaw 2007, Wagstaff 2007) or even do so erroneously. Confusion exists even among internationally recognised researchers as one might see in the abstract of a presentation held at the 2011 meeting of the International Health Economics Association. Arnab Acharya from the London School of Hygiene and Tropical Medicine and his colleagues base their systematic review on the question Do Social Health Insurance Schemes in Developing Country Settings Improve Health Outcomes and Reduce the Impoverishing Effect of Healthcare Payments for the Poorest People? A Systematic Review on a definition of SHI that is quite distant from what the concept stands for: “Social health insurance schemes are generally understood as health insurance schemes provided by governments to its citizens, especially to low and middle income populations. Recently, apart from governments, several non-government organisations at the community level provide social health insurance in developing countries. Social health insurance pools both the health risks of its members, on the one hand, and the contributions of enterprises, households and government, on the other, and is generally organized by national governments” (see also Acharya et al. 2011: fortunately this review based on wrong definitions and assumption has not yet been published in the Cochrane Database of Systematic Reviews). This type of conceptual bafflement and fogginess prevails particularly among scientists and stakeholders from other than SHI countries and reflects a mix of insufficient knowledge or even ignorance and intentional political reinterpretation.

effective and progressive tax payment and SHI systems have to achieve universal coverage. "Solidarity means that all members of society in need must have access to healthcare, regardless of their ability to pay. Solidarity is not a woolly notion about the common good. It has a specific meaning that a healthcare system is organised and managed on the basis of universal access, without risk selection, based on income related premiums and with no significant differences in the benefit package" (den Exter 2008: 698; cf. Stoltzfus Jost et al. 2006: 688). "Solidarity is neither charity nor welfare; it is an understanding among formal equals that they will refrain from actions that would significantly interfere with the realization and maintenance of common goals or interests. Solidarity requires an understanding and acceptance by every member of the community that it consciously conceives of its own interests as being inextricable from the interests of the whole" (McDonald 1996: 290).

TABLE 1: DISTRIBUTION OF GLOBAL HOUSEHOLD INCOME



Risk equalisation mechanisms for implementing solidarity

RISK (STRUCTURE) ADJUSTMENT IN HEALTH INSURANCE

Risk equalisation mechanisms are increasingly common in health-insurance markets. Risk adjustment – sometimes also called risk structure adjustment – establishes financial transfers between various insurers in order to compensate for competitive disadvantages due to differences in the risk mix of different health-insurance funds. Funds with a higher number or share of elderly, low-income and chronically ill enrolees face higher expenditures because they have more expensive customers in their risk pool. Risk structure adjustment is a common means for enhancing the fairness of health financing. In principle, risk equalisation promotes solidarity and – at least indirectly – universal coverage in multiple-player health insurance systems. Without cross-subsidising between funds with better and worse risk mixes, it will be extremely difficult to assure health protection to all citizens.

Although risk adjustment has long been present in SHI systems, the relevance of risk equalisation has dramatically increased with the implementation of market-driven concepts in social protection. Actually risk equalisation is mostly discussed in the context of introducing competitive insurance markets. Under the prevailing liberal paradigm in global health policy, competition between health insurance funds or companies has become a common denominator of health-sector reforms and is generally expected to increase efficiency and help to contain costs (e.g. Paolucci et al. 2006: 107).

Risk equalisation is typically an element in competitive health insurance systems, which are often called markets in accordance with the prevailing economic view of health care and health financing. Risk adjustment is generally considered an indispensable prerequisite for implementing competition between health-insurance funds or companies. During recent decades, practically all countries have been implementing market-driven health-sector reforms in order to achieve better performance and higher efficiency. A common approach for improving the healthcare system is to introduce measures mainly derived from micro-economic theory. Among many other aspects, this is reflected in the claim to strengthen the demand side in the health sector and to support the position of clients in the health-insurance market.

Consumer choice has become a key issue in the health sector reform debate and in health policy in general. On the one hand, the concept is in line with the Health-for-All strategy because it refers to essential demands of the primary-healthcare movement proclaimed at the Conference of Alma Ata in 1978, such as participation and empowerment. On the other hand, consumer choice is a pillar of liberal economic systems and market economies. Empowerment of both insurees and patients is usually considered a promising strategy for making healthcare systems more efficient and, lately, for containing rapidly increasing expenditure on health.

In health financing, the liberal paradigm is reflected in competition between various health-insurance funds, be they public or private. As a matter of fact, various countries with Bismarckian health insurance systems permit periodic consumer choice of the SHI provider (e.g. Belgium, Czech Republic, Germany, Israel, Netherlands, Slovakia) (van de Ven 2011: 147). Likewise, insurance companies operate in competitive markets in those countries where private health insurance is an important provider of mandatory health protection (e.g. Chile, Switzerland). Commercial health insurance companies also tend to compete with each other for their market share, but competition might vary according to the general health-sector framework e.g. in Australia, Ireland and South Africa.

The global enthusiasm for competitive arrangements in contribution-based social health protection is as evident as it is surprising. It is widely known and has been repeatedly proven that competition among health insurance providers has a series of inevitable and undesired consequences. Competitive health-insurance markets entail risk selection because health-insurance providers tend to increase revenue and reduce expenditures. The resulting market segmentation into “good risks” and “bad risks” has serious adverse effects, and impedes universal coverage unless adequate regulations and policies are in place. Risk equalisation and risk adjustment are essential for preventing the most drastic disadvantages of a competitive health insurance market, which are largely due to risk selection (cf. van de Ven 2007: 149).

The general understanding of risk adjustment in health financing refers to payments taking place between insurers to compensate for the competitive disadvantage of those insurance providers whose customers are on average older, poorer or otherwise more likely to suffer from bad health and incur higher medical expenses. Equalisation of risks takes place from insurers with low risk profiles to insurers with high risk profiles. In practical terms this means that insurers with a healthier client mix make compensation payments to those schemes that have a larger share of higher-risk beneficiaries. From a health-policy perspective this is typically done in order to encourage insurers to compete on their own merits – e.g. based on efficient contracting with providers of care and investment in quality and prevention – rather than on risk selection of their customers – i.e. insuring only healthy consumers. Moreover, without risk equalisation the other public interest policies such as open en-

FIG. 2: RISK ADJUSTMENT IN SELECTED COUNTRIES

Risk adjustment and risk sharing system 2000–2006

	Belgium	Germany	Israel	Netherlands	Switzerland
Risk adjusters in 2000	Age/gender Disability Income Employment status Mortality Family composition Social status Urbanization Preferential reimbursement (lower co-payments)	Age/gender Disability Entitlement for sick leave payments Income	Age	Age/gender Urbanization Entitlement for sickness fund membership (e.g. disability)	Age/gender Region
New risk adjusters added in 2001–2006	Diagnosis of invalidity Eligibility of social exemption Chronic illness	Registration in a certified Disease Management Programme	–	Pharmacy-based cost groups Diagnostic cost groups Being self-employed.	–
Quality of the risk adjustment system in 2006	Moderate/fair	Moderate	Low	Fair	Low
Level of ex-post cost-compensation 2000–2006	Decreased from 96% (2000) to 92.5% (2006)	Increased from 0% (2000) to 4% (2006), due to high-cost pooling	Unchanged (5%)	Decreased from 64% (2000) to 47% (2006)	Unchanged (0%)
Potential profits from risk selection in 2006[a]	In general low, but can be quite substantial for a small group of 'chronic high-cost' insured	Very high	Very high	Fair/high	Very high

Source: van de Ven et al. 2007: 164

rolment and community rating are unlikely to work, given the possibilities of de facto risk selection (e.g. based on selective marketing and neglecting the needs of undesirable consumers) (Sauter 2008, p. 5).

From a purely economic perspective, however, risk equalisation is counterproductive for applying "real" competition in health insurance markets. Nevertheless, there is general consensus that effective risk adjustment is an essential precondition for reaping the benefits of a competitive health insurance market. Without risk equalisation, the disadvantages of a competitive insurance market are very likely to outweigh the expected advantages. However, international experience suggests that in practice the implementation of even the simplest risk equalisation scheme is very complex (van de Ven et al. 2007; Armstrong et al. 2010).

Risk adjustment has the potential to reduce risk selection and prevent the most unfair excesses of competitive health-financing arrangements, but it cannot fully rule them out. Competitive health-insurance markets, whatever the level of regulation is, cannot avoid a certain risk of legal or illegal attempts by HI funds to optimise their risk mix according to the regulations in force. From the perspective of current health economics, however, health-insurance funds have financial incentives to select the predictably profitable consumers only in the case of imperfect risk adjustment. The belief is that undesired effects of health-insurance competition are due to imperfect risk adjustment and that the equalisation mechanisms have just to be brought to perfection in order to reconcile competition and solidarity (Paolucci et al. 2006: 110; van de Ven 2011: 150).

The predominant trend in health-policy debates is consciously or unconsciously casting doubt on the priority goal of social health insurance, namely to provide access to affordable health-care coverage to a certain group or, better still, the whole population. In the prevailing market-driven debate it should not be ignored that there is essentially no need for risk adjustment in non-competitive health-insurance systems. Although concepts and solutions provided by "modern" health economics might appear fashionable and even seem to hold out the promise of solving global health problems, they are associated with high risks of detrimental impacts on essential health-policy goals such as the right to health, universal coverage and solidarity.

Financial equalisation mechanisms at national level

The Federal Republic of Germany (FRG) (formerly often called West Germany) was founded in 1949 as a federal state comprising the Federation and a series of federated states known as the "Länder" (singular Land) or, more completely, Bundesländer.[26] Due to the unification of the FRG with the former German Democratic Republic (often referred to as East Germany) in 1990, the total number of partly sovereign constituent states of the extended Federal Republic of Germany is now 16. Federalism is established in Germany's Basic Law: "The constitutional order in the Länder must conform to the principles of a republican, democratic and social state governed by the rule of law, within the meaning of this Basic Law. In each Land, county and municipality the people shall be represented by a body chosen in general, direct, free, equal and secret elections" (Deutscher Bundestag 2010: 31: Art 28 (1)).

Decentralised political power and decision-making is taken as a constant in the German Constitution and defines essential elements of the political framework conditions. But to be effective and sustainable, decentralisation and federalism require adequate distribution of power, including a delegation of power towards the decentralised levels for the performance of those tasks transferred from central to regional and local governments. At the same time, corresponding financial resources have to be available at the decentralised levels. In order to fulfil their tasks under constitutional law, the Länder need both sufficient means at their disposal, and free and independent control over such resources.

The legal settings of the Federal Republic and its constituent states established by the German Basic Constitutional Law Art. 28 on "Land constitutions – Autonomy of municipalities" (Deutscher Bundestag 2010: 31) have to be considered and applied in the perspective of another noteworthy specification of the German Constitution: Art. 20 (1) specifies that the federal states have a responsibility to ensure social equity both among individuals and provinces. The basic idea behind this is to create and maintain equal living conditions for the entire population all over the country, irrespective of the region they live in. To achieve this ambitious goal, Germany's constitution guarantees the Federation and Länder appropriate levels of funding and determines the respective procedural regulations.

At the core of this constitutional duty, the Federal Republic of Germany has implemented a financial equalisation system between the Federal Government and the Länder, which aims at balancing living standards across the country, and might be combined with structural policy measures to raise living standards in

[26] Although the FRG comprised 11 Länder during the first half century of its existence, it was created in 1949 with 12 Länder: On the one hand, today's federal state of Baden-Württemberg still consisted of the three Länder Baden, Württemberg-Baden and Württemberg-Hohenzollern, which decided to merge in 1952. On the other hand, the Saarland was a French-occupied territory separated from Germany until 1956; when the inhabitants were offered independence in a plebiscite in 1955, they instead voted to become part of West Germany.

those areas (Deutscher Bundestag 2010: Art. 107 (2)).

ARTICLE 107
[Distribution of tax revenue – Financial equalisation among the Länder – Supplementary grants]

(1) Revenue from Land taxes and the Land share of revenue from income and corporation taxes shall accrue to the individual Länder to the extent that such taxes are collected by finance authorities within their respective territories (local revenue). Details regarding the delimitation as well as the manner and scope of allotment of local revenue from corporation and wage taxes shall be regulated by a federal law requiring the consent of the Bundesrat. This law may also provide for the delimitation and allotment of local revenue from other taxes. The Land share of revenue from the turnover tax shall accrue to the individual Länder on a per capita basis; a federal law requiring the consent of the Bundesrat may provide for the grant of supplementary shares not exceeding one quarter of a Land share to Länder whose per capita income from Land taxes, from income and corporation taxes and from taxes under Article 106b ranks below the average of all the Länder combined; with respect to the tax on the acquisition of real estate, the capacity to generate revenue shall be considered.

(2) Such law shall ensure a reasonable equalisation of the disparate financial capacities of the Länder, with due regard for the financial capacities and needs of municipalities (associations of municipalities). It shall specify the conditions governing the claims of Länder entitled to equalisation payments and the liabilities of Länder required to make them as well as the criteria for determining the amounts of such payments. It may also provide for grants to be made by the Federation to financially weak Länder from its own funds to assist them in meeting their general financial needs (supplementary grants) (BMJ 2010).

Source: Deutscher Bundestag 2010: 98f

The quite elaborate financial equalisation scheme ensures both vertical and horizontal redistribution of pooled national revenue: firstly, the entire tax revenue is distributed to the two levels of government (Federation and Länder) and municipalities receive a supplementary grant of revenue. Secondly, the total amount of taxes raised at state level is allocated among the 16 Länder. And thirdly, the financial equalisation of the Länder defines net flows from rich to poor regions according to the difference between a Land's per-capita revenue and the average fiscal capacity per inhabitant. For the fine-tuning of financial equalisation between wealthier and poorer Länder, a linear-progressive schedule (60 % - 95 %) is applied: the more a Land's revenue exceeds the national average, the higher the percentage of its relative surplus funds that have to be transferred to the equalisation system; and the further a Land's revenue falls below the national average, the higher the percentage of its relative deficit that will be refunded by the financial adjustment scheme. In addition to the Länder equalisation mechanism as such, uncommitted federal grants complement financial adjustment among the Länder in order to provide poor Länder with additional resources; uncommitted grants from the Federation are available as general supplementary federal funds for general purposes and supplementary federal grants for special needs (BMF 2010: 1).

All procedural regulations assuring that wealthier federal states make adjustment payments to poorer Länder as well as all details of the individual stages are established by ordinary law.

Furthermore, up to 25 % of VAT income accruing to the Länder is used for additional ex-ante financial equalisation between wealthier and poorer federal states according to linear-progressive topping-up: the lower the VAT income of a Land, the higher the relative equalisation. It is worth mentioning that financial adjustment only partially compensates the differences in revenue generation among federal states in order to safe-

TABLE 1: EQUALISATION OF THE DIFFERENCES IN FINANCIAL CAPACITY BY APPLYING THE SYSTEM OF FINANCIAL EQUALISATION AMONG THE LÄNDER AND THE GENERAL SUPPLEMENTARY FEDERAL GRANTS

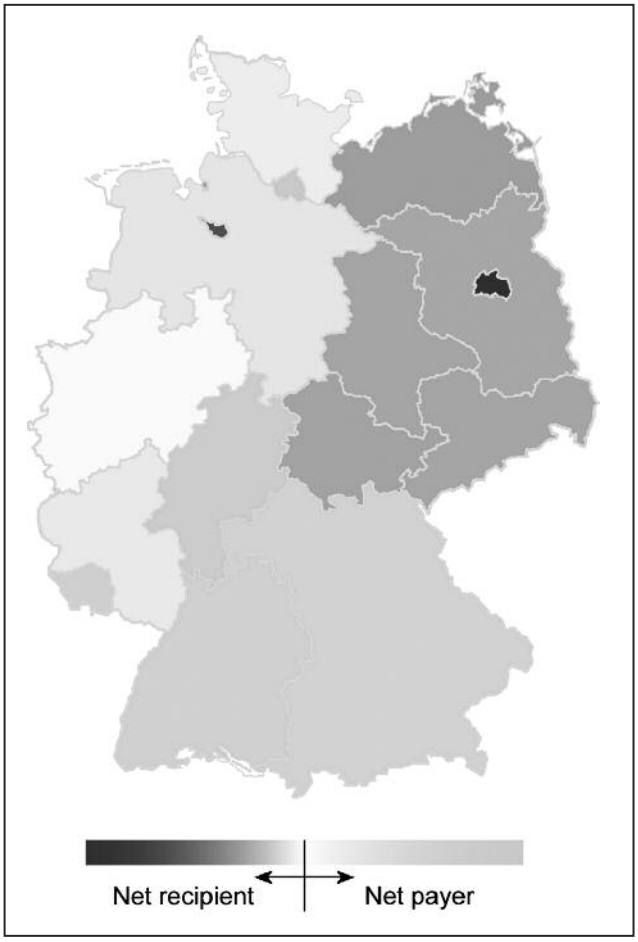
Financial capacity per inhabitant before financial equalisation among the Länder as a % of the average financial capacity per inhabitant	Financial capacity per inhabitant after financial equalisation among the Länder as a % of the average financial capacity per inhabitant	Financial capacity per inhabitant after financial equalisation among the Länder and the supplementary federal grants as a % of the average financial capacity per inhabitant
70	91	97 1/2
80	93 1/2	98
90	96	98 1/2
100	100	
110	104	
120	106 1/2	
130	109	

Source: BMF 2010: 5

guard fiscal autonomy and sovereignty of decentralised bodies. The reference point of financial equalisation among the Länder is per-capita tax revenue defined as the state tax receipts plus 64 % of the sum the of municipal tax receipts. This allows wealthier municipalities in a poor Land to reduce their net financial adjustment benefits. Moreover, financial equalisation takes into account higher per-capita resource requirements of city states and sparsely populated Länder. The overall redistribution effects of the financial equalisation system in Germany are quite considerable. In 2009, direct adjustment among the Länder according to financial equalisation amounted to € 7 billion, supplementary federal grants to € 12.8 billion and the VAT ex-ante adjustment € 6.6 billion.

In view of the current challenge of how to implement an international framework for global social protection, it has to be pointed out that all procedural regulations assuring that wealthier federal states make adjustment payments to poorer Länder as well as all details of the individual stages are equally established by ordinary law.

FIG. 3: FINANCIAL EQUALISATION IN THE FEDERAL REPUBLIC OF GERMANY



Source: Wikipedia

Financial equalisation mechanisms at international level

Of course, unequal regional income and living conditions are not restricted to national states. They are also present and often much more pronounced in supranational institutions such as free-trade agreements and economic associations. There is even some evidence that they tend to increase regional inequality and disparities within communities and countries (Perry et al. 2006: 136f) unless proactive political frameworks and supportive action are implemented.

The former European Economic Community (EEC) and current European Union (EU), as the oldest and certainly most developed full-scale trade agreement in the world, provides some compelling examples for the need to focus on inter-regional differences regarding living standards. Compensating the socio-economic and income differences in the regions was a basic political concept of the EU from the very beginning. With the intention of reducing existing disparities between development levels of the various regions and overcoming the backwardness of least-favoured regions and islands including rural areas, the EU has set up a series of structural funds and compensation mechanisms that are worth considering in more detail. Funds under the Cohesion policy are complemented by other specific funds whose objective is to contribute to the regional development within the EU. The need for financial equalisation and adjustment between regions has usually been largest when new Member States accede to the community. This was especially the case after the inclusion of three Southern European countries in 1981 (Greece) and 1986 (Portugal and Spain) and again after the waves of Eastern European enlargement in 2004 (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, Slovenia and Cyprus) and in 2007 (Bulgaria and Romania). For the implementation of its policy to create more equal conditions all over the community regions and to adjust living standards, the EU provides two types of funds. In addition to structural funds aiming at improving infrastructure and investing in physical development, namely the European Regional Development Fund (ERDF) and the European Social Fund (ESF), the EU has set up so-called cohesion funds as essential tools of the EU's regional policy. Together with the Common Agricultural Policy (CAP), structural funds and cohesion funds make up the great bulk of EU funding, and the majority of total EU spending.

EUROPEAN FUND FOR REGIONAL DEVELOPMENT (EFRD)

The European Regional Development Fund (ERDF) addresses regional development, economic change, enhanced competitiveness and territorial cooperation throughout the EU. Funding priorities of this support programme include modernising economic structures, creating sustainable jobs and economic growth, facilitating research and innovation, implementing environmental protection and ensuring risk prevention. Particularly in the least-developed EU regions, the ERDF also plays an important role in infrastructure investment. For achieving their objectives EFRD funds are mainly intended for economic promotion in the following areas:

- Productive investment for creating or ensuring jobs
- Infrastructure
- Local development initiatives and support of the activity of smaller and medium-sized companies
- Promote economic and social cohesion by correcting the main regional imbalances and participating in the development and conversion of regions
- Provide assistance for cross-border, transnational and inter-regional cooperation under

Objectives 1 and 2:

Convergence Objective (formerly Objective 1): Promote the development and structural adjustment of regions whose development is lagging behind;

Regional Competitiveness and Employment Objective (formerly Objective 2): Support the economic and social conversion of areas experiencing structural difficulties Territorial Cooperation Objective (formerly Objective 3):

TABLE 2: COMMITMENT APPROPRIATIONS FROM THE STRUCTURAL FUNDS FOR 2000-06 IN MILLION € (1999 PRICES), EXCLUDING COMMUNITY INITIATIVES AND INNOVATIVE ACTIONS

Member State	Objectives					FIFG (Non-Objective 1)	Total
	1	Transitional support Objective 1	2	Transitional support Objective 2	3		
Belgium	0	625	368	65	737	34	1,829
Denmark	0	0	156	27	365	197	745
Germany	19,229	729	2,984	526	4,581	107	28,156
Greece	20,961	0	0	0	0	0	20,961
Spain	37,744	352	2,553	98	2,140	200	43,087
France	3,254	551	5,437	613	4,714	225	14,794
Ireland (2)	1,315	1,773	0	0	0	0	3,088
Italy	21,935	187	2,145	377	3,744	96	28,484
Luxemburg	0	0	34	6	38	0	78
Netherlands	0	123	676	119	1,686	31	2,635
Austria	261	0	578	102	528	4	1,473
Portugal	16,124	2,905	0	0	0	0	19,029
Finland	913	0	459	30	403	31	1,836
Sweden (3)	722	0	354	52	720	60	1,908
UK (2)	5,085	1,166	3,989	706	4,568	121	15,635
EUR 15	**127,543**	**8,411**	**19,733**	**2,721**	**24,224**	**1,106**	**183,738**

Source: CEC 2001: 14

The Convergence Objective covers regions whose GDP per capita is below 75 % of the EU average. It aims at accelerating the economic development of low-productivity and low-income regions throughout the EU. The Convergence Objective is financed by funds from the ERDF, the ESF and the Cohesion Fund. Prioritised areas are human and physical capital, innovation, knowledge society, environment and administrative efficiency. The budget allocated to this objective is current € 283.3 billion.

The Regional Competitiveness and Employment Objective is applicable to all regions of the EU territory, except those already covered by the Convergence Objective. It aims at reinforcing regional competitiveness, employment and attractiveness and focuses mainly on innovation, promotion of entrepreneurship and environmental protection. The funding of currently € 55 billion is provided from the ERDF and the ESF.

- Last but not least the territorial Cooperation Objective builds upon the Interreg initiatives[27] of previous years, which were originally planned to be fully incorporated into the main objectives of the structural funds. Financed by the ERDF with a budget of € 8.7 billion, its aim is to promote cross-border cooperation between European regions, as well as the development of common solutions for issues such as urban, rural and coastal development, shared resource management or improved transport links.

[27] Interreg initiatives are designed to stimulate cooperation between EU Member States in order to diminish the influence of national borders in favour of equal economic, social and cultural development throughout of the European Union. Interreg aims at strengthening economic and social cohesion in the European Union by promoting balanced development through cross-border, trans-national and inter-regional cooperation. One of the approaches is to place special emphasis on integrating remote regions with those that share external borders with the countries applying for EU membership.

EUROPEAN SOCIAL FUND (ESF)

The European Social Fund (ESF) is one of the EU structural funds, set up to reduce differences in prosperity and living standards across EU Member States and regions, and therefore promoting economic and social cohesion. The European Social Fund (ESF) focuses on four key areas: adaptability of work force and enterprises, access to employment and participation in labour markets, social inclusion through combating discrimination and facilitating access to the labour market for disadvantaged people, and partnership for reform in the fields of employment and inclusion.

The ESF is devoted to promoting employment in the EU. It helps Member States make Europe's workforce and companies better equipped to face new, global challenges. In short:

- Funding is spread across the Member States and regions, in particular those where economic development is less advanced.

- It is a key element of the EU's 2020 strategy for Growth and Jobs targeted at improving the lives of EU citizens by giving them better skills and better job prospects.

- Over the period 2007-2013 some €75 billion will be distributed to the EU Member States and regions to achieve its goals.

The EU Member States and regions manage ESF funds, to deal with the diverse employment challenges they face. This section gives access to Member State ESF operational programmes, their priorities, their funding and their successes.

EUROPEAN COHESION FUND (ECF)

The Cohesion Fund as a core element of EU regional policy comprises a set of financial tools set up to implement the Cohesion policy, also referred to as the Regional policy of the European

Union. They aim to reduce regional disparities in terms of income, wealth and opportunities. Europe's poorer regions receive most of the support, but all European regions are eligible for funding under the policy's various funds and programmes. The Cohesion Fund contributes to interventions in the field of the environment and trans-European transport networks. It applies to Member States with a per-capita gross national income (GNI) of less than 90 % of the EU average. As such, it covers all 12 new Member States (Bulgaria, Cyprus, the Czech Republic, Estonia, Greece, Hungary, Latvia, Lithuania, Malta, Poland, Portugal, Romania, Slovakia and Slovenia) as well as Greece and Portugal. Spain is also still eligible for the Cohesion Fund, but on a transitional "phasing out" basis.

The European Cohesion policy pursues the objective of reducing economic as well as social shortfalls and stabilising national and regional economies. Activities financed under the ECF comprise trans-European infrastructure and environmental projects, and may also relate to transport, e.g. energy efficiency, use of renewable energy, developing rail transport, supporting inter-modality, strengthening public transport, etc..

The role of international financial equalisation schemes for GSP

LIMITED USE OF RISK ADJUSTMENT SCHEMES

Risk equalisation is typically an instrument for regulating competitive health-insurance markets and lacks relevance for non-competitive arrangements. Hence risk equalisation mechanisms are unlikely to play a role for global social protection since it is not about national health-financing schemes – either tax-borne or contribution-based – competing with each other. On the one hand, each country's risk mix is predetermined and not subject to selection. On the other hand, risk adjustment requires reliable and comparable data for ensuring a minimum of adequate compensation and of course a reference currency. The often-applied purchasing power parity, expressed in international dollars, is certainly insufficient for establishing a fair calculation basis due to the wide variability of healthcare provision costs.

A risk-adjustment approach to global social protection will require realistic and operable concepts for calculating the overall "risk" of poorer countries compared to wealthier societies. Compensation payments based on a country's health risk would first of all need reliable data on morbidity and mortality, in terms of potential years of life lost (PYLL), disability-adjusted life years (DALY) and quality-adjusted life years (QALY). Moreover, the availability, capacity and quality of healthcare facilities, health professionals, drugs and other core items of healthcare provision would have to be assessed in order to define the need. These data would have to be cross-checked with indicators of social health protection and healthcare funding in a country. All this would have to be calculated on the basis of internationally comparable reference scales, taking into account the large variability of costs and prices payable for healthcare. All in all it will be extremely difficult to establish reliable and fair mechanisms for cross-border comparisons, which are indispensable for adjusting risks between different countries.

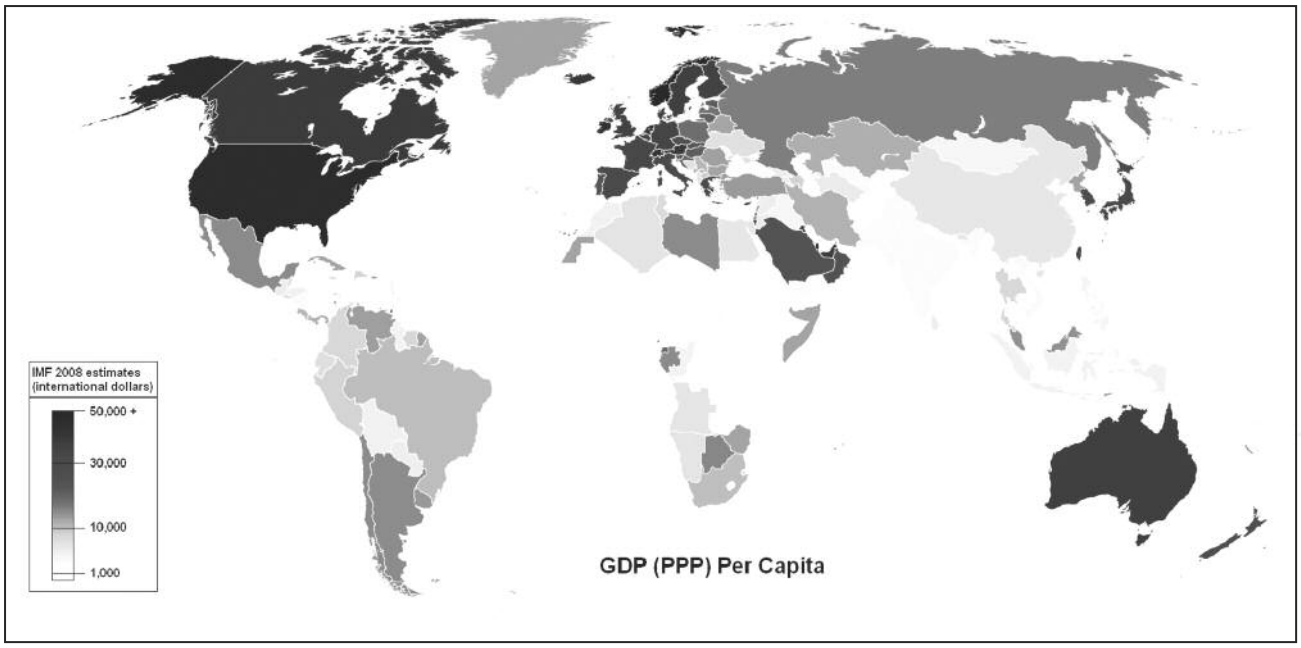
THE POTENTIAL OF NATIONAL EQUALISATION SYSTEMS FOR GLOBAL SCHEMES

National financial adjustment systems such as the Länderfinanzausgleich in Germany provide some enlightening lessons learned that can enrich the discussion about international social protection funds. They have certainly a potential for making global social protection possible, for enhancing equity with regards to global health financing and for implementing the principle of solidarity at international and global levels. Applying the principles of national equalisation me-

chanisms worldwide, however, requires a series of adaptations. Any implementation of financial adjustment among nations that vary considerably with regards to economic and social development and living standards has to take into account extremely different levels of national income, revenue and available resources.

achieved by applying linear progressive transfers where all countries pay according to the difference their per-capita GDP shows from international average. However, redistribution could be even more effective if a mechanism of more progressive adjustment is applied such as equalisation scheme between the German Länder

FIG. 4: PER-CAPITA GROSS NATIONAL INCOME IN PURCHASING-POWER PARITY



Source: Wikipedia 2012a (based on IMF 2008)

A rather practical approach would be to base adjustment payments on countries' GDP and use the average world GDP as reference scale for defining adjustment payments from wealthier to poorer nations. Countries might either be grouped in GDP brackets (as shown in Fig. 4 above) or individually categorised according to their relative position to the global mean per-capita GDP.

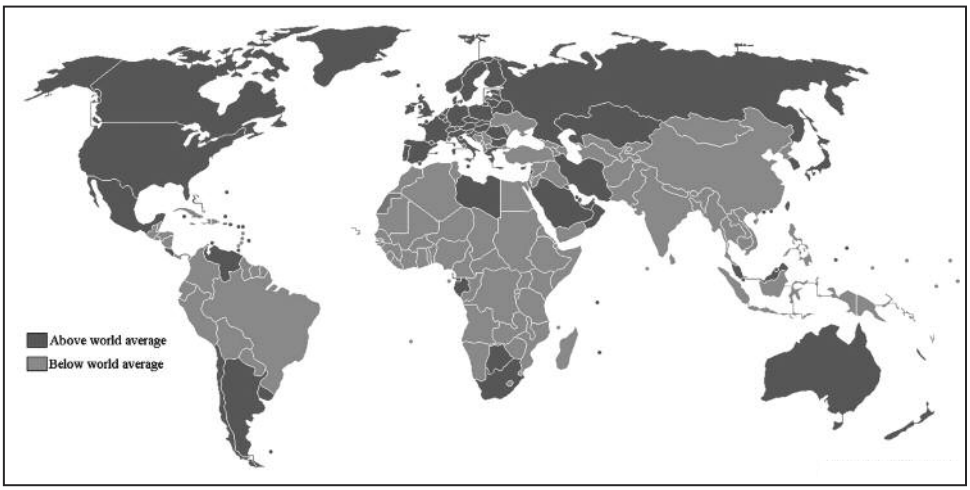
If financial compensation for global social protection is arranged this way, countries whose GDP is above the worldwide average will become net payers and those below global mean GDP will be net receivers of resources earmarked for health care and social health protection. Internation global redistribution can certainly be

(see Table 1): the richer a country or the further above average its per-capita GDP, the higher its share of the surplus to be paid to the global fund; and the lower a country's mean income or the further below average its per-capita GDP, the higher its share of the difference to be equalised. The second option will certainly be politically more challenging to implement but is much more promising to contribute to balancing the blatant worldwide inequity in health financing.

Additional challenges arise because regardless of the adjustment scheme to be set up, any kind of financial equalisation mechanism will need to be continuously updated. Even a cursory comparison of the charts above and below illustrates some relevant changes within only two years.

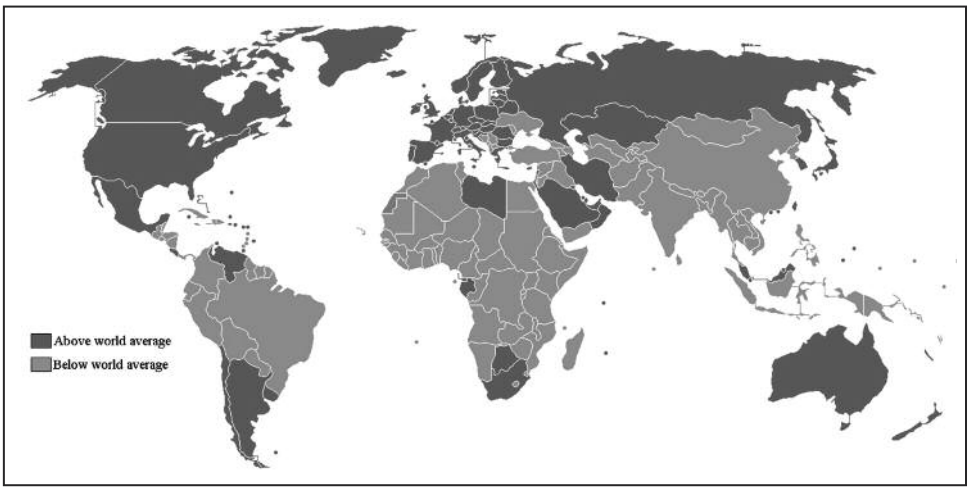
While Brazil and Turkey as well as Serbia-Montenegro and Macedonia have increased their GDP above the worldwide average and hence shifted from net recipients to net payers, South Africa has lagged behind global income development and would have converted from being a net payer to a net recipient of global social protection funds.

FIG. 5: AVERAGE GDP PPP PER CAPITA 2008



Source: Wikipedia 2012b (based on CIA Fact World Book 2008)

FIG. 6: AVERAGE GDP PPP PER CAPITA 2010



Source: Wikipedia 2012c (based on CIA Fact World Book 2010)

However, setting up global financial equalisation systems to cover healthcare costs and achieving universal coverage will face a series of political hurdles and technical challenges. On the one hand such an adjustment mechanism will have to deal with extreme variations of GDP between the countries worldwide. By way of example Liechtenstein and Luxembourg with a GNP of $145,747.58 (in 2008) and $81,278.63 (in 2010) per capita, respectively, are very different from Brazil ($11,503.01) and Indonesia ($4,348.44) and extremely remote from Zimbabwe ($349.61) and the Democratic Republic of Congo ($347.45), the two countries with the lowest national products worldwide (Nationmaster 2012).

Trans-national financial equalisation and risk compensation will have to apply all regulations, but additional framework conditions have to be met to make such an adjustment fund viable, reliable, transparent and credible. But over and above requirements within national states or between countries of comparable living standards such as member states of trade agreements, financial adjustment for social protection at global level will need further arrangements and definitions in order to be functional and operational. At global level, for the implementation of worldwide social protection based on international financial equalisation, the most important challenges will be to find a way to define adequate and fair currency and exchange rates that ensure international comparability of both national and household purchasing power and gain a high level of acceptance among all countries participating in global social protection. At the same time some general benchmarks will be indispensable for establishing the comparability of

different countries in order to define potentials and needs for providing universal health coverage; this might either happen by defining a "standard" level of healthcare provision in terms of scope, quality and accessibility, or, by determining a consistent share of GDP to be spent on social health protection by all countries.

The challenges to be overcome and the issues to be clarified at country level are certainly no less complex and difficult to accomplish. Since financial compensation for financing social protection will have to rely on public and especially on government resources, tax systems have to be effective, reliable and progressive in order to achieve global equity and equal burden sharing (cf. Gebauer: The Need to Institutionalise Solidarity for Health in this reader, pp. 14-23). This is closely linked to the ability of national governments to enforce public and fiscal policies, to implement adequate taxation and to ensure transparent use of public resources. Thus, governance, control of funds, transparency, and the reliability of governments and civil society are indispensable requirements for setting up adjustment schemes within a system of global social protection.

Last but not least, European experiences with regional development funds illustrate the need to not focus exclusively on nation states but also on sub-regions. A global social protection fund will face specific challenges to address regional differences that exist within countries because such an approach might easily come into conflict with national sovereignty and self-determination of countries.

SUPRANATIONAL DEVELOPMENT AND ADJUSTMENT FUNDS AS A MODEL FOR A GLOBAL FUND FOR SOCIAL HEALTH PROTECTION

International support funds for development and equalisation of different economic and income conditions represent an important approach of free-trade agreements for overcoming economic constraints and fostering development. The above-mentioned funds implemented in the European Union (ECF, EFRD and ESF) are good examples for this type of supranational supportive funds and show that financial adjustment is feasible, at least within economic or political blocks. And they show that the principle of solidarity can be applied at international level.

A global fund for social health protection might take up some lessons learned from existing cross-border equalisation systems. The very reason for such a fund is to organise needs-driven financial transfers for improving health coverage; resources channelled through a global social protection fund have be earmarked for both health care delivery and universal health coverage because it will certainly be insufficient to set up additional health facilities and employ more personnel if additional funds provided by international solidarity funds are not used likewise for strengthening health systems.

As for global equalisation schemes, countries have to be classified in order to define them as net payers and net receivers. Such a classification has to adequately reflect the economic development and situation of participating countries. Various strategies might be applied for defining a country's ability to pay and need to receive equalisation funding. Of course the method described above for international equalisation systems is also suitable for global funds, and payable resources can be determined according the relative position of countries with regard to average global GDP. But other, simpler financing mechanisms might also be applied as long as they safeguard the principle of solidarity and make countries pay according to their economic and financial capacities. In any case payments have to be mandatory for wealthier countries.

Naturally there are still many questions to be answered and challenges to be overcome for setting up a global compensation fund for uni-

versal health protection. One of the main problems will be to find strategies to establish an international equalisation fund in a way that allows making resource generation compulsory, reliable and sustainable. Payment of contributions has to be mandatory for all net payers, and the fulfilment of financial commitments has to be legally enforceable. On the part of recipient countries, the challenges are no less daunting. A major hurdle will be to find objective, effective and internationally accepted mechanisms for assessing the "health need" of all countries that shall or want to benefit from a global social protection fund. Moreover, all recipient countries will be required to assure that the resources they receive from such a fund are exclusively used for promoting universal health coverage. In this regard the GFTAM provides a series of interesting strategies that have meanwhile proven to be efficient in making governments accountable for the earmarked funds they receive and in enhancing transparency and governance at country level (cf. Ooms: Fiscal Space and the Importance of Long Term Reliability of International Co-financing in this reader; pp. 135-139).

POTENTIAL ROLE FOR TRADE AGREEMENTS FOR GLOBAL EQUALISATION IN SOCIAL PROTECTION

There is abundant evidence for the close relationship between good health and economic growth (Sachs 2001). Health and social protection are crucial for economic development as well as for international trade. However, free-trade agreements tend to underestimate the huge potential of social cohesion and social justice for the economic development of regions and countries. This is partly attributable to the fact that free-trade agreements are mostly designed under a simplistic macro-economic growth theory. Moreover, international regulation for promoting social protection in trade and economic relations is widely underdeveloped because they are not yet priority of the World Trade Organisation (WTO) and existent ILO conventions are often insufficient for trans-nationalised economies.

In the globalised world multinational free-trade agreements are becoming increasingly important and deploy considerable dynamics. Besides the European Union, the North-American Free Trade Association (NAFTA) and the Common Southern Market (MERCOSUR) have been established; other agreements such as the ASEAN Economic Community, the Central-American Free Trade Association (CAFTA), the Common Market for East and Southern Africa (COMESA), the East African Community (EAC) and others are emerging. Economic and trade integration generally advances under the rules of business and tends to be much faster for traditional trade items and services, and usually much slower amongst social goods and services. In 2006, WHO member states urged their governments at the 59th World Health Assembly to ensure that trade and health interests are better coordinated and more appropriately balanced (WHO 2006: 37f).

Despite the longstanding priority setting on purely economic rather than social objectives in global economy, free-trade agreements have a potential for contributing to social protection that should not be underestimated (cf. Holst 2009: 85ff). Experiences from the EU, but also from MERCOSUR and other emerging agreements, show that the latter can play an important role in internationalising and potentially globalising social protection. Even relevant differences in design, structure, financing, coverage and regulation of health systems in member states do not necessarily prevent them from implementing common block-wide social health strategies and policies (ibid.: 90f). Member states of free-trade agreements offer rather smaller inequalities with regards to their economic, social and development conditions compared to the global level. Moreover, social protection can build upon existing economic and financial arrangements set up for managing and facilitating trade and

economic exchange. And, last but not least, free-trade agreements have better possibilities than other international bodies to enforce social protection requirements and require member states to fulfil their obligations. This is certainly also true for emerging agreements, as expressed by Snyman-Ferreira & Ferreira (2010: 622): "The principle of solidarity is also recognised in the Constitutive Act of the African Union (2000). As such all member states of the Union are legally bound to act in the broader interest of the Union and should therefore refrain in the harmonisation process from promoting their own interests at the expense of other states. In fact, a stronger state like South Africa should use its power not to dominate but to guide and assist weaker participating states in the harmonisation process". ■

REFERENCES

African Union (2002). Constitutive Act of the African Union. AU, Addis Ababa (http://www.africa-union.org/root/au/aboutau/constitutive_act_en.htm).

Board of Healthcare Funders (2003). BHF Position Paper on Health Care Reforms. BHF, Rosebank (http://www.bhfglobal.com/files/position_paper.pdf).

Bundesministerium der Finanzen (BMF) (2010). The Federal Financial Equalisation System in Germany. Federal Republic of Germany, Berlin (http://www.bundesfinanzministerium.de/nn_4480/DE/BMF__Startseite/Service/Downloads/Abt__V/The_20Federal_20Financial_20Equalisation_20System_20in_20Germany,templateId=raw,property=publicationFile.pdf).

Bundesministerium der Justiz (2010). Basic Law for the Federal Republic of Germany in the revised version published in the Federal Law Gazette Part III, classification number 100-1, as last amended by the Act of 21 July 2010 (Federal Law Gazette I p. 944). Federal Republic of Germany, Berlin (http://www.gesetze-im-internet.de/englisch_gg/englisch_gg.html).

Bundesrepublik Deutschland Grundgesetz (n. y.). Das Finanzwesen. Artikel 107. Bonn. (http://www.bundesfinanzministerium.de/nn_4480/DE/BMF__Startseite/Service/Downloads/Downloads__allgemein/Artikel__107__Grundgesetz,templateId=raw,property=publicationFile.pdf).

Commission of the European Communities (CEC) (2001). Report from the Commission. Twelfth annual report on the Structural Funds (2000). COM(2001) 539 final, CEC, Brussels, 03.10.2001 (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2001:0539:FIN:EN:PDF).

den Exter, André (2006). Claiming Access to Health Care in the Netherlands under International Treaty Law. Presentation on the 16th World Congress on Medical Law, Toulouse, August 7-11, 2006, World Association of Medical Law. Congress Reader: 667-679 (http://193.175.234.83/bioethics/16th_World_Congress_on_Medical_Law/ARTICLES/pdf/161.pdf).

den Exter, André (2008). Access to Health Care in the Netherlands: The Influence of (European) Treaty Law. Med Law 27 (3): 569-595 (http://onlinelibrary.wiley.com/doi/10.1111/j.1748-720X.2005.tb00537.x/pdf).

Deutscher Bundestag (2010). Basic Law for the Federal Republic of Germany. Translated by Christian Tomuschat & David Currie. Print version as at October 2010. Bundestag, Berlin (https://www.btg-bestellservice.de/pdf/80201000.pdf).

Economic and Social Policy Component (). Sustainable Economic Development. Vietnamese Economic Reform, Socialist Versus Social Orientation – A Policy Debate. GTZ, Hanoi (http://www2.gtz.de/ wbf/4tDx9kw63gma/VN_economic_reforms_socialistvs_social_orientation.pdf).

European Commission (1999). Commission Decision of 1 July 1999 fixing an indicative allocation by Member State of the commitment appropriations for Objective 1 of the Structural Funds for the period 2000 to 2006 (notified under document number C(1999) 1769). (1999/501/EC). L 194/49, Official Journal of the European Communities, 27.7.1999, Brussels (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:1999:194:0049:0049:EN:PDF).

European Commission (2010). European Social Fund. EC, Brussels (http://ec.europa.eu/esf/home.jsp?langId=en).

European Union (2012). European Regional Development Fund (ERDF) (2007-2013). Summaries of EU legislation, Brussels, (http://europa.eu/legislation_summaries/regional_policy/provisions_and_instruments/g24234_en.htm).

Ferreira, Gerrit; Ferreira-Snyman, Magdalena Petronella (2010). The Harmonisation of Laws within the African Union and the Viability of Legal Pluralism as an Alternative. Journal of Contemporary Roman-Dutch Law 73: 608-628 (http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1905454; http://poseidon01.ssrn.com/delivery.php?ID=202110105020066074017092102000124000020086089012039042073005093074073105073070070088018007127038053121097003094064076001007097042071071006015067122066103095003016019008017043123029107085072002002005124006&EXT=pdf).

Herbst, Jeffrey (1990). The structural adjustment of politics in Africa. World Development 18 (7), pp. 949-958.

The Federal Institute for Research on Building, Urban Affairs and Spatial Development (n. y.). The importance of the social security system for regional equalisation policy. Results. Bundesinstitut für Bau-, Stadt- und Raumforschung, Bonn (http://www.bbsr.bund.de/nn_62854/BBSR/EN/RP/GeneralDepartmentalResearch/SpatialPlaning/SocialSecurity/03__Results.html).

McLeod, Heather; Grobler, Pieter (2008). Risk Equalization and Risk Selection in South Africa. Paper prepared for the RAN meeting in 2008, Dublin (http://www.hmcleod.moonfruit.com/cgi-bin/download.cgi).

McDonald, Ronaldt (1996). Solidarity in the Practice and Discourse of Public International Law. Pace International Law Review 8 (2): 259-302 (http://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1289&context=pilr).

Nationmaster (2012). Economy Statistics > GDP (per capita) (most recent) by country. Nationmaster, Woolwich (http://www.nationmaster.com/red/ graph/eco_ gdp_percap-economy-gdp-per-capita&b_printable=1).

Paolucci, Francesco; Stoelwinder, Just (2011). Risk-equalisation in health insurance markets: Models and international experience. Australian Center for Health Research, Melbourne (http://www.achr.com.au/ pdfs/Risk%20Equalisation%20-%20Stowelwinder%20and%20Paolucci%20-%20Final%20paper.pdf).

Paolucci, Francesco; den Exter, Andre; van de Ven, Wynand (2006). Solidarity in competitive health insurance markets: analysing the relevant EC legal framework. Health Econ Policy Law 1 (2): 107-126. DOI: http://dx.doi.org/10.1017/S1744133105000137 (http://journals.cambridge.org/download.php?file=%2FHEP%2FHEP1_02%2FS1744133105000137a.pdf&code=41eaccfee77a8c609a5cdd4ecca8b84c).

Parkin, Neil; McLeod, Heather (2011). Risk Equalisation Methodologies: An International Perspective. CARE Monograph No. 3, Centre for Actuarial Research (CARE), University of Cape Town (http://ihea2011.abstractsubmit.org/sessions/39).

Perry, Guillermo; Arias, Omar; López, Humberto; Maloney, William; Servén, Luis (2006). Poverty Reduction and Growth: Virtuous and Vicious Circles. World Bank, Washington DC (http://siteresources.worldbank.org/EXTLACOFFICEOFCE/Resources/870892-1139877599088/virtuous_circles1_complete.pdf).

Sachs, Jeffrey (ed.) (2001). Macroeconomics and Health: Investing in Health for Economic Developing. WHO, Geneva (http://whqlibdoc.who.int/publications/2001/924154550x.pdf).

Sauter, Wolf (2008). Risk Equalisation in Health Insurance and the New Standard for Public Service Compensation in the Context of State Aid and Services of General Economic Interest Under EU Law. TILEC Discussion Paper 2008-042, Tilburg University (http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1310673; http://www.nza.nl/104107/230942/Research-paper-'Risk-equalisation-in-health-insurance'-2008-11.pdf).

Schneider, Udo; Ulrich, Volker, Wille, Eberhard (2008). Risk Adjustment in Health Insurance Markets in US, Germany, Netherlands and Switzerland. CESIfo DICE Report 3/2008, Ifo-Institut, München (http://www.cesifo-group.de/portal/pls/portal/docs/1/1193078.PDF).

Söderlund, Neil; Khosa, Solan (1997). The Potential Role of Risk Equalization Mechanisms in Health Insurance: The Case of South Africa. Health Pol Plann 12 (4), pp. 341-353 (http://heapol.oxfordjournals.org/content/12/4/341.full.pdf).

Stoltzfus Jost, Timothy; Dawson, Diane; den Exter, André (2006). The Role of Competition in Health Care: A Western European Perspective. J Health Polit Pol Law 31 (3): 687-703. DOI 10.1215/03616878-2005-014 (http://jhppl.dukejournals.org/content/31/3/687.full.pdf+html; http://content.ebscohost.com/pdf18_21/pdf/2006/HPP/01Jun06/21145588.pdf?T=P&P=AN&K=21145588&S=R&D=buh&EbscoContent=dGJyMNXb4kSep7M4v%2BvIOLCmr0qeprRSsqe4SLKWxWXS&ContentCustomer=dGJyMPGotki0p7JJuePfgeyx44Dt6fIA).

van de Ven, Wynand (2007). A comparison of the Risk Equalization systems and the policy context of 5 European countries. IAAHS Cape Town (http://www.actuaries.org/IAAHS/Colloquia/Cape_Town/van_de_Ven.pdf).

van de Ven, Wynand; Beck, Konstantin; van de Voorde, Carine; Wasem, Jürgen; Zmora, Irit (2007). Risk adjustment and risk selection in Europe: six years later. Health Pol 83 (2), pp. 162-179.

van de Ven, Wynand (2011). What to Do? Risk adjustment and risk equalization: what needs to be done? Health Econ Pol Law 6 (1), pp. 147-156 (http://journals.cambridge.org/action/displayFulltext?type=1&pdftype=1&fid=8011210&jid=HEP&volumeId=6&issueId=01&aid=8011208).

Wikipedia (2012a). GDP PPP Per Capita IMF 2008. Wikipedia, The Free Encyclopedia, Wikimedia Foundation Inc., San Francisco. 16 Aug 2012 Web (http://en.wikipedia.org/wiki/File:GDP_PPP_Per_Capita_IMF_2008.png).

Wikipedia (2012b). List of countries by GDP (nominal) per capita. Wikipedia, The Free Encyclopedia, Wikimedia Foundation Inc., San Francisco. 16 Aug 2012 Web (http://commons.wikimedia.org/wiki/File%3AAverage_GDP_PPP_per_capita.PNG).

Wikipedia (2012c). Average GDP PPP per capita 2010. Wikipedia, The Free Encyclopedia, Wikimedia Foundation Inc., San Francisco. 16 Aug 2012 Web (http://en.wikipedia.org/wiki/File:Average_GDP_PPP_per_capita_2010.svg).

World Health Organization (WHO) (2006). Resolutions. 59th World Health Assembly. WHO, Geneva (http://apps.who.int/gb/ebwha/pdf_files/WHA59-REC1/e/Resolutions-en.pdf).

yourdictionary (2012). Solidarity. Burlingham (http://www.yourdictionary.com/solidarity).