

The AOK forum for health politics, practice and research.



GESUNDHEIT UND GESELLSCHAFT

What makes the world healthy?



Special issue in cooperation with GIZ

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Partners at eye level

Many governments are looking to Germany when it comes to establishing social protection systems. For **Rüdiger Krech** cooperation needs to be on an equal footing.



There are a number of good reasons for strengthening health systems worldwide such that they can better deal with crises. The first is that the human right to health can only be realised if every country in the world has an effective health system. The second is that we are all becoming more and more interdependent. After all, viruses are no respecters of national borders. Every day 8.6 million airline passengers jet off on some 100,000 flights to the farthest flung destinations on earth. Not even the best entry and exit screenings can hermetically seal off countries and continents against disease in today's globalised world. For that reason, more and more heads of state are convinced that the effectiveness of a country's health system has an equally decisive impact on the health situation in other countries and on global security and stability. This is good news, because the third reason is that, in many countries health is the largest branch of the economy even now, and makes a massive contribution to cushioning the negative impacts of financial shocks. Thus, it is only too understandable that more and more people think of an appropriate quality of healthcare and health insurance as high-priority values per se, for which governments are well advised to specify clear framework conditions.

Germany has built up very efficient structures for international cooperation in the field of social protection: the Ministry for Economic Cooperation and Development is in charge of policy steering; implementation is

in the hands of Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and the German development bank Kreditanstalt für Wiederaufbau (KfW); and additionally AOK International Consulting provides important sectoral consulting. In this way concrete project experience is fed into the steering of policy and the sectoral consulting, which is what makes it so valuable for the partner countries and the international organisations.

It is gratifying that many governments are currently looking to Germany. They wish to learn from the experience gained here and evaluate it for themselves. What fits our context, the many social and health experts who work for these governments are asking themselves, and what does not? It can only be in everyone's interests for this sectoral consulting to succeed and for the countries to find the path that is right for them. This special issue illuminates a few of these experiences from the German perspective, and shows how partnerships work today: partners cooperate on an equal footing, working with a project-based and problem-oriented approach.

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Director-General, World Health Organization (WHO), Geneva

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GLOBAL HEALTH



asia



Medicine against poverty

Social health protection is elementary for overcoming poverty and premature death. Countries like India, China and many states in Africa and Latin America want to improve the health of their populations by enlarging their social systems. How much progress they have made is described by [Jens Holst](#) and [Jean-Olivier Schmidt](#) in the following pages. The first chapter addresses countries in Asia.

The smartphone from China, the shirt from Bangladesh, asparagus from Peru and roses from Kenya – for most European citizens this global assortment has become an unquestioned part of everyday life. The living and working conditions of the people who manufacture such products can easily drop below our radar. Reports of scandals reach the Western media from time to time, about unacceptable workplaces, extreme exploitation or fires breaking out in locked textile factories, but these only represent the tip of an iceberg. The fates of workers in Chinese computer assembly plants and Asian textile factories, on African or Latin American flower farms, make one thing clear: the globalisation of social rights lags far behind the exchange of goods and services. Social benefits like pensions, unemployment benefits and social health protection, which have for many decades been standard for central Europeans, remain unattainable for a major part of the world's population. Globally, one billion persons have no access to health care. Almost half of humankind is living without effective social protection against ill health or other existential risks. This not only applies to the majority of workers in the global factories of Africa, Asia and Latin America, and those workers' families, but especially also to the many millions

of small-scale farmers, traders and craft workers without formal employment (i.e. the informal sector), who make up the majority of the population in countless countries.

Year after year, more than one hundred million people are plunged into poverty by the high costs of medical treatment. Health problems present by far the greatest risk of impoverishment worldwide. In European as well as other industrialised countries and a few emerging economies, functioning social welfare systems protect citizens from the vicious cycle of sickness and poverty. To this day, countless people around the world are still denied the right to affordable health care – which was enshrined back in 1948 in the Universal Declaration of Human Rights – despite the enormous global economic growth seen in recent decades.

Universal social protection boosts the economy. At least since the publication of the 2010 World Health Report by the World Health Organisation (WHO), universal health coverage has been at the very top of the global agenda. With the support of international development organisations and partners, the countries of the global South are attempting to provide their



“A top-down approach does not work at all”

Karin Dobberschütz is responsible for AOK International Consulting at KomPart Verlags GmbH. She seconds experts from the German public health insurer AOK to support the development of health insurance schemes in other countries.

G+G: How well does German health insurance fit into other countries?

Dobberschütz: We are definitely not selling the German model, but consulting within an existing social health insurance system. We are called upon when problems crop up, mainly in connection with financing issues. Then the AOK consultants travel to the country for one or two weeks, where they analyse the situation in situ and deliver their recommendations.

G+G: What must the consultants bring to this job?

Dobberschütz: They have to know the German health system like the back of their hand, and ideally be well-informed about alternative systems as well. Armed with knowledge about the cornerstones of a functioning social protection system, AOK staff go to other countries and look at why something is unstable and where adjustments must be made. Particularly in developing countries our experts are dealing with professionals who, more often than not, have studied at elite universities. It is vital to be able to talk to them as equals – a top-down approach is no use at all. We only offer our know-how, which decision-makers can then put to use in line with the country's policies.

G+G: What is the level of interest among AOK employees in going abroad?

Dobberschütz: That depends very much on the country and the inquired qualification profile. Some competences are more common within the internationally interested AOK experts than others. In total about 100 AOK staff members from all over Germany are registered in our database as having an interest in an international assignment.

G+G: And the AOK releases its employees without question?

Dobberschütz: The experts normally take care of the arrangements themselves, and in most cases it works out by mutual agreement. The AOK also benefits from it: the assignments are one form of human resources development. The employees are dealing with their professional subject area in a different context, finding new solutions which may subsequently come to bear in Germany, too. This is a fruitful exchange in every way.

G+G: Who finances this work?

Dobberschütz: What the consultants do is paid for by the commissioning international organisations such as Deutsche Gesellschaft für Internationale Zusammenarbeit, the WHO, the World Bank and the European Union. For the period of the foreign assignment, the experts are contracted by us. Coordinating the information, concluding the contracts, organising the travel, providing the requisite insurance and accounting for everything afterwards is the role of AOK International Consulting.

More Information: www.kompart.de/international

citizens with effective protection against the financial risks of ill health and to give them access to appropriate medical care. Almost all developing and newly-industrialising countries have flagged up the objective of universal health coverage, underpinned by the knowledge that health is a vital economic factor. Today, health is no longer treated as a mere cost factor but as an investment in economic development and growth.

Widespread lack of resources and know-how. In many countries the health sector is already the largest and most dynamic branch of the economy. Global health expenditures amount to more than four billion euros. Rich countries account for the bulk of this, but even in newly-industrialising and a few developing countries, sums on that scale bring economic interests into play. The expansion of health care systems poses the unavoidable challenge of establishing robust and sustainable health financing systems. In the countries of the South, sizeable investments in high-tech medicine are not possible without broad-scale public spending; otherwise the majority of the population would remain excluded from appropriate care.

The exclusion of poorer population groups from access to health care can only be overcome by comprehensive social protection – as is demonstrated by the history of European welfare states. Nowadays this is also the accepted wisdom in organisations like the World Bank and the International Monetary Fund, which until recently considered economic development to be the ultimate cure-all. In the international community, today, unanimity prevails across political camps that universal health coverage must be given special significance in the context of development cooperation. But for all the agreement on fundamental objectives, in many places implementation is proving to be extremely difficult because of a lack of resources, know-how and, not infrequently, political will.

Private health market is expanding. In many developing and emerging countries, the state was traditionally responsible for regulation, financing and service provision. Now its role is undergoing a shift, whereby it creates the statutory framework and monitors that the purchasers, service providers and other parties involved comply with the rules. Hence the German model is of interest to many countries, not only because of its social health insurance system but also because its structure clearly assigns roles and responsibilities to the various actors. Subsidiarity and regulated processes of negotiation between different stakeholder groups within a framework of self-governance are organisational principles that resonate with other countries. This approach allows the integration of private providers, which can be powerful players in many countries, into a publicly organised health system and shows how the sometimes very rigid separation of public and private provision can be relaxed. In many countries of the South a rapidly expanding private health market is emerging, particularly for inpatient care. The growing middle class is placing higher expectations upon health care than most public facilities can meet. Often, however, private services are subject to neither volume control nor social protection coverage.

The second megatrend is the requirement that all people should have access to needed health services at affordable prices. The experience of the welfare states in the North proves that this must be financed predominantly from taxes or social insurance contributions. Even if many finance ministers still do not really believe it, such an investment pays off; it fosters economic growth and could provide a firm footing for an economic upturn, in India and China, for example.

India and China are breaking new ground. One person in three on this planet is either Indian or Chinese. For all the differences between the countries on the Ganges and the Yellow River, they have several features in common. Both countries lay claim not just to regional but to global leadership. Nonetheless, these new global players are under enormous domestic policy pressure due to social disparities and growing internal tensions. Whereas in the 1990s their attention was focused mainly on economic system reforms, they are now increasingly addressing social policy issues.

One relevant area is the health system. Following on from their longstanding autonomous medical traditions (traditional Chinese medicine and Ayurvedic medicine), both countries can only look back at a short history of Western-influenced curative care and social protection. The rural majority of the population has previously been excluded from appropriate care and comprehensive social protection. Private health services expose the rapidly growing urban population to steeply rising and in some cases barely affordable costs. To get a grip on these challenges, both countries are breaking new ground.

Following its independence in 1948, India had developed a system of public healthcare modelled on the tax-financed British National Health Service. Within this system, the state was responsible for financing and providing health services. However, the system always suffered from an extremely sparse allocation of tax resources: the public health ratio never exceeded one per cent of gross national product, even though consistent, strong economic growth since the end of the 1990s would certainly have created room for manoeuvre in fiscal policy. Based on such minimal public resources it is impossible to ensure the provision of satisfactory medical care. Usually the population had no choice but to pay the costs of treatment out of their own pockets – if and only if they could afford to do so.

India's health indicators to date are wholly unacceptable for a country with such a strong economy: one Indian woman in every 250 dies during pregnancy or childbirth. In parts of India, infant malnutrition or undernutrition are as high as in the poorest countries of Africa. Together with the extremely unequal distribution of income – the number of people living below the poverty line in India is higher than the number of all poor persons in sub-Saharan Africa, yet at the same time it has the most millionaires in the world – the lack of public care raises doubts in many people's minds about the Indian state. One consequence is domestic terrorism, which the former prime minister, Manmohan Singh, cited as the country's biggest security problem. The Indian state in fact has no control over one-third of its territory, because people reject the state monopoly on force or local opposition leaders rebel against it.

Doing good while doing business. In the process of catching up in social policy, since 2008 the Indian government had made efforts to improve social health protection for the country's more than 300 million poor people having to live on the equivalent of less than one euro a day. With support from Deutsche Gesellschaft für Internationale Zusammenarbeit and the World Bank, in the meantime almost all Indian states are setting up a health insurance scheme known as RSBY (Rashtriya Swasthya Bima Yojana, meaning National Health Insurance). RSBY makes it possible for poor Indians to access medical care free of charge. To this end, the Indian state had to accomplish a revolutionary change of roles: instead of acting as the service provider itself, it commissions the purchasing of medical services in the public and private sector via public as well as private insurance schemes. Profit-oriented health insurers submit bids in response to invitations to tender from the states. If their bid is accepted, they register the citizens listed on the national poverty register and, in return for an annual administration fee, payable by the members, of around 40 eurocents, supply them with health insurance cards equipped with biometric data. The card entitles the insured individuals to take up medical treatment in private as well as public hospitals. The reimbursement of costs is limited to a maximum of 30,000 rupees (about 400 euros) per year. In addition, RSBY covers transport costs of up to 1,000 rupees (13 euros) – which is a most significant benefit in such a large coun-

World Risk Report 2013

High co-payments are harmful to health

The World Risk Report 2013 of the Alliance "Development Works" (Bread for the World, Christoffel-Blindenmission (CBM), Kindernothilfe (KNH), medico international, Misereor, terre des hommes and Welthungerhilfe) is dedicated to the headline theme of health and medical care. It comes to the following conclusions:

The health systems in many countries are inadequately financed. In 2011, per-capita health expenditure in the USA at around 8,600 US dollars was more than 500 times as high as in Ethiopia, at 16.61 US dollars. For 49 countries with very low per-capita income, the World Health Organisation (WHO) assesses the basic requirement for preventive health measures and medical care to be 60 US dollars per capita per annum. Equally dramatic is the share of total per-capita health expenditure that the population in many countries have to pay out of their own pockets, because it is not reimbursable by any health insurance scheme or state-provided system. In Myanmar direct payments account for 80.7 per cent and in Guatemala 53.4 per cent of health expenditures – as opposed to only 5.3 per cent in Cuba. As soon as out-of-pocket payments exceed a 20 per cent share, according to the WHO, it has catastrophic impacts on those affected. In countries where per-capita health expenditures are low and the out-of-pocket share is high, healthy life expectancy tends to be lower.

Source: www.worldriskreport.org



try as India. Health insurance costs vary from state to state but public-sector expenditure amounts to an average of 10 euros per insured person per year. This is the amount the insurance schemes bill to the state. The successful model is explained by Anil Swarup, former leader of RSBY: “We let the market forces operate under state direction.” This is what makes the programme successful: within a few years, 36 million people were issued with an RSBY insurance card. Since family members are covered, some 150 million people now benefit from health insurance cover.

Incentives for undesired volume expansion. So far RSBY only reimburses the costs of inpatient treatment; coverage of outpatient services has not yet been resolved. The hospitals receive a flat fee of about eight euros per patient for day-clinic care and almost 16 euros for emergency treatments. The agreed prices for surgical interventions range from 16 up to 470 euros. Clearly, the monetary value of the entitlement to services on the insurance card can soon be used up. But for all the limitations of its health insurance protection: RSBY is a very promising beginning.

The employees in the huge informal sector (small-scale farmers, craft workers, traders) have an interest in RSBY and are evidently willing to pay contributions themselves for health insurance. Other countries are monitoring the Indian system of social health protection, which relieves the state of its sole responsibility. However, the public sector still needs to gather experience on effective methods of steering and regulating market forces. The reimbursement of costs by a health insurance scheme for Indians who were previously uninsured is creating economic incentives for undesired volume expansion by hospital providers. For instance, the Indian press reported on cases of non-medically-indicated hysterectomies in a few clinics.

CHINA

It does not matter whether a cat is white or black, if it catches mice it is a good cat. Under the pragmatic leadership of Deng Xiaoping (1976 to 1997), in the 1980s China introduced fundamental reforms, some of which applied to the health system. In the 1980s China gave up the system of free basic health care for the population, developed by Mao Zedong. Irrespective of their ability to pay, citizens since then had to pay for medical treatments. This presented huge difficulties, especially for the rural population.

Chinese health policy in recent years saw a host of successive reforms, many of which caused new problems and necessitated yet more reforms. During this period China was following a middle course between public health care and commercial private insurance. From 2003 the government introduced the “New Rural Cooperative Health Care Scheme” to enable the poor population in the countryside to have better access to medical care. The costs of this insurance programme are around 24 US dollars per person per year. The lion’s share is borne by central government and the relevant provincial government. To date, 832 million persons have been enrolled. Membership is voluntary but local officials exert a certain pressure on the population to

join the insurance scheme. The system sets financial incentives to attend local health care facilities by reimbursing the bulk of the costs, around two-thirds, for making use of community clinics. If patients go to a specialist hospital in the city, the insurance only reimburses about one-third of the bill. Nevertheless, the quality and range of services in local facilities are often so poor that many people prefer to attend special clinics. Admittedly, the cooperative protection scheme has contributed to a slight decline in direct payments for treatment. But it is still the case that the poorer and therefore needier population often has to refrain from using health services for financial reasons. The targets of the reforms have only partially been achieved.

Medical savings accounts for serious illnesses. Health care in cities is different than in the countryside. Besides the basic medical insurance for informally working and needy urban dwellers, China provides a health insurance scheme for which employees and employers share the levies: employees pay two per cent of their salary and employers six per cent of the wage bill. Despite shared and income-related financing, however, this cannot be called a social health insurance scheme. Part of the contributions flow into an individual savings account which families can draw upon in case of need. These “medical savings accounts” for health care enjoy great popularity in a few Asian countries and are also found in the USA. Medical savings accounts of this kind provide very inadequate coverage of the actual treatment costs in the case of serious or recurrent chronic diseases. Above all, they make no provision for spreading the financial risks of ill health across many shoulders. Every family builds up savings on its own behalf, and can only spend its savings balance itself. The savings accounts can be scrutinised in vain for any sign of social risk sharing or the principle of solidarity. At the same time, this system is only intended for serious illnesses. Visits to the doctor have to be paid out-of-pocket in any case. Although there is a tax-financed solidarity fund, its subsidies are limited to 40 per cent of treatment costs.

Ageing is becoming the greatest challenge. One, as yet unsolved, problem is the lack of social protection for China’s approximately 200 million internal migrant workers. They most of all are exposed to an especially high risk of ill health due to unhealthy working conditions, social uprooting and constant fear of job-loss as well as other social conditions. But rigid bureaucratic regulations prevent this growing population group from being officially registered in the cities in order to benefit from medical care. At the beginning of 2016, the Chinese government announced that it would partly lift the existing urban-rural divide and merge the rural cooperative medical care system with the urban basic medical insurance. Mainly migrant workers will benefit from the merger and the adaptation of benefits.

Overall, social protection and health care for China’s population are worse today than under the conditions of the former socialist command economy. Despite its much better baseline health indicators compared to India, China will be facing a further problem in the near future. After many years of the one-

Country survey: health and society in figures



asia

OECD average (2013)

(Countries of the Organization for Economic Cooperation and Development)

| | |
|---|--------------|
| Per-capita income (2014) ³⁾ | 38,867 \$ |
| Health expenditures ³⁾ | 8.9 % of GDP |
| Life expectancy ³⁾ | 80.5 years |
| Infant mortality/1,000 births ³⁾ | 3.8 |
| Maternal mortality/100,000 births ³⁾ | 8 |



India

China

Thailand

Vietnam

Philippines

| | India | China | Thailand | Vietnam | Philippines |
|--|-------------------------|-----------------------------|-------------------------|------------------|---------------------|
| Population figure (2014) ¹⁾ | 1.295 billion | 1.364 billion | 67.73 million | 90.73 million | 99.14 million |
| System of government ⁴⁾ | parliamentary democracy | socialist people's republic | constitutional monarchy | one-party system | presidential system |
| Literacy rate (2015) ²⁾ | 71.2 % | 96.4 % | 96.7 % | 94.5 % | 96.3 % |
| Gross domestic product (GDP) (2014) ¹⁾ | 2.05 trillion \$ | 10.35 trillion \$ | 404.8 billion \$ | 186.2 billion \$ | 284.8 billion \$ |
| Per-capita income (2014) ¹⁾ | 1,570 \$ | 7,400 \$ | 5,780 \$ | 1,890 \$ | 3,500 \$ |
| Health expenditures (2013) ²⁾ | 4 % of GDP | 5.6 % of GDP | 4.6 % of GDP | 6 % of GDP | 4.4 % of GDP |
| Life expectancy (2013) ¹⁾ | 67.7 years | 75.4 years | 74.2 years | 75.8 years | 68.1 years |
| Infant mortality/1,000 births (2015) ²⁾ | 41.81 | 12.44 | 9.63 | 18.39 | 22.34 |
| Maternal mortality/100,000 births (2015) ²⁾ | 174 | 27 | 20 | 54 | 114 |

Sources: ¹⁾ worldbank.org, ²⁾ CIA World Factbook, ³⁾ stats.oecd.org, ⁴⁾ auswaertiges-amt.de



child policy, the age pyramid has broadened considerably towards the apex. It seems uncertain whether mere economic growth can compensate for the consequences of demographic change. Ensuring and financing health care for its rapidly ageing population may soon become China's greatest social policy challenge.

THAILAND

In Thailand the history of social health protection began in the mid-1970s with the introduction of a health insurance card for poor and needy people. From 1980 the country set up social health insurance schemes for public servants (the Civil Servant Medical Benefit Scheme, CSMBS) and for private sector employees (the Social Security Scheme, SSS). These were augmented in 1983 by a tax-subsidised health insurance scheme for the informal sector.

The decisive reforms on the way to universal health coverage were introduced in Thailand's Constitution of 1997, which accords all citizens an equal right to health care. What is remarkable about this is the country's resolution to take comprehensive social policy measures amid the Asian crisis and despite economic stagnation – in stark contrast to the Chinese logic of expenditure limitation. A decisive role was played by the Thai Rak Thai party (TRT), which had made the introduction of universal health coverage the centrepiece of its campaign and had to back its words with action following the election victory in 2001. With the health reform of 2002, the TRT government along with the two social health insurance schemes for those in formal employment introduced a third tax-financed pillar for the informal sector and indigents. This offered all Thais relatively compre-

hensive medical care for a low co-payment of 30 baht (about 80 cents); very poor persons were exempted from this user fee.

Model for Southeast Asia. Today, in fact, the Thai population has far better access to health services than people in the neighbouring countries of Cambodia, Laos or Myanmar. Following stepwise expansion of the service package to encompass more complex services, even including heart surgery, all Thais today can take advantage of the same treatment options, irrespective of their income. Nevertheless, when it comes to the scope of services and especially the payment of doctors and hospitals, certain differences exist between the social insurance schemes for formal employees and the former 30-baht system, today called the Universal Coverage System. Over time, the Thai health-financing system has become renowned as a model in Southeast Asia. Equally, the extension of social protection to the entire population here was accomplished within a short period of time. The decisive factors were political will and interest in a thorough upgrade of health care as an essential prerequisite for sustainable economic growth.

PHILIPPINES

The Philippines can look back on almost half a century of social health protection. The National Health Insurance Program (NHIP) was brought into being at the end of the 1960s. Following the model of the former colonial power, the USA, the country's own NHIP scheme, generally called Medicare, provided social protection via the workplace for employees in the formal sector. In the course of its health reform, the government created the Philippine Health Insurance Corporation (PhilHealth) in 1995. It was no longer open solely to civil servants and those formally employed by private companies. Apart from contributions, PhilHealth also received tax funding to provide coverage for poor and destitute people. And the Individual Paying Program (IPP) was aimed at the large number of Filipinos who earned their living as small-scale farmers, traders, self-employed craft workers or in other occupations without formal employment. Since then, all PhilHealth beneficiaries have had access to the same package of benefits, irrespective of whether they are paying a wage-scaled contribution or a flat fee as informal workers, or whether their contributions are publicly paid in full.

Membership cards as an election instrument. So much for the theory; things look somewhat different in practice. Time after time, the tax-financed programme for the poor degenerates into an election campaign instrument. Before parliamentary and governorship elections, the established candidates are fond of buying votes with PhilHealth membership cards. The share of the population with health insurance cover regularly rises to over 80 per cent in election periods. Since the cards are only valid for one year, again and again the Philippines fall short of the goal of universal health coverage before very long.

At the same time, only a minority of Filipinos in informal employment have taken up PhilHealth's offer of voluntary

Sustainable Development Goals – health reloaded

How much does the world want justice and health?

In September 2015 the United Nations adopted the Sustainable Development Goals. Under this agenda, by 2030 the member countries undertake to have made global progress in a total of 17 areas, for which they have set themselves 169 targets. In comparison to the Millennium Goals which were valid up to the end of 2015, the Sustainable Development Goals (SDG) relate not only to developing countries but to all countries. The top goal on the list remains that of overcoming world poverty. Health defines top-level goal number 3, which is broken down into nine targets, including reducing maternal mortality to less than 70 per 100,000 live births and neonatal mortality to twelve per 1000 births. Halting the spread of HIV/aids, tuberculosis and malaria remains an important target. The fact that many countries did not attain the Millennium Goals by the end of 2015 and that far too many women are still dying in pregnancy and childbirth – in Afghanistan, for example, over a lifetime one in 32 women will die in connection with a birth – can be attributed in no small part to the high cost of medical care. Furthermore, now as ever, catastrophically high medical expenses still pose the most important risk of poverty worldwide. Therefore universal social health protection also has its place among the global community's Sustainable Development Goals.

Jens Holst/Jean-Olivier Schmidt

health insurance. Even a contribution of 1,200 pesos (22 euros) per year is beyond the means of many. For better-situated self-employed persons, however, the range and care quality of the PhilHealth benefits are not good enough. They prefer to use private sector services. For many years the public health insurance scheme has therefore tried to offer low-cost group tariffs for cooperatives and other organisations in order to increase the number of informally employed members. But here, too, success has been modest at most. The last change of government awakened new hope for an improvement in social health protection. The Philippines are under growing pressure to achieve the objective of universal health coverage, originally targeted for 2010. For a long time PhilHealth prioritised real estate and financial investments instead of taking care of the core tasks of health insurance. More than half of its accountability report from 2009 deals with rates of return, real estate revenues and capital yields; data on services and service expenditures are missing entirely.

VIETNAM

Other countries in Southern Asia are also working on the establishment of social protection systems. Laos and Cambodia, for example, are still caught up in the early stages of this process and are limiting themselves to basic questions of organisation. Vietnam, on the other hand, offers most citizens social protection via a social health insurance scheme. This comprises 25 groups of beneficiaries, including public and private sector employees, pensioners, school pupils and students, ethnic minorities and poor persons. Contributions are dependent on purchasing power and amount to 4.5 per cent of disposable income or of the statutory minimum wage. For indigents and lower-income households, the state covers all or part of the payment. The main focus of ongoing reform projects is on the remuneration of service providers and on expenditure limitation. In future, primary care health facilities will receive capitation fees for the beneficiaries registered with them. Specialist doctors and hospitals will be remunerated only partly by means of fee for service; these will increasingly be replaced by case payments calculated on a population basis, followed by a complete switch of hospital financing to diagnosis-related groups (DRG). By progressively replacing fee-for-service remuneration the country intends to put a brake on service expansion and expenditure increases. Health for all should remain affordable.

Solidarity-based financing is indispensable. Despite the diversity of the countries in Asia, the experience of the past fifteen years impressively shows how they are making use of the economic upturn to address growing inequalities by means of social policy. Politicians can use health for self-promotion at election time. For all the cultural and societal differences, there seems to be agreement that broad risk sharing and solidarity-based financing are indispensable for health systems. The greatest challenges at present are how to include the huge informal sector and how to regulate private providers. Particularly on this last point, the countries might also benefit from German experience. ■

The authors: Experts in social protection worldwide



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More developed countries can support the others, technically and financially."

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2



GESUNDHEIT GLOBAL

afrika



Social systems promote growth

In a number of African countries, society is stabilising and the economy is growing. These countries want to expand their health care services. But social protection for the entire population is still a long way off. The second chapter is a situation report from South Africa, Kenya, Rwanda and Ghana.

Africa usually crops up in the media as a trouble spot and a disaster-prone region. The continent is widely associated with images of misery: civil wars, drought, famine and other disasters, poverty, AIDS orphans and refugees in boats on the Mediterranean – a ravaged continent. Contrary to all preconceptions, the “Black Continent” is far from being as homogenous as it may seem from a northern and central European perspective. In several countries the conditions have changed considerably in the last ten years, and there are signs of hope in many places. Nowhere is the economy growing as rapidly as in certain sub-Saharan countries. Democratic reform movements exist and changes of government are increasingly peaceful. The population is young and has a higher level of education than ever before. The continent’s development prospects are attracting more and more investors from overseas. China in particular discovered Africa some time ago as a continent worth investing in. In numerous countries, however, economic devel-

opment is also leading to growing social disparities and tensions. This increases the need for social policy interventions. In particular, equitable access to medical services has been thrust into the policy limelight, as policymakers explore new avenues leading to universal health coverage.

World Bank now advises against user fees. One health policy milestone was the 1987 Bamako Conference in the capital of Mali. At that time most African countries were facing the challenge of maintaining the public health system despite ever-tighter public budgets. Under pressure from the World Bank, the International Monetary Fund (IMF) and other organisations, the African health ministers present at the conference decided to give the population greater involvement in the health system – particularly in respect of financing. The decisive outcome of the Bamako Conference was the comprehensive introduction of user fees. It became apparent, however, that patients’ user charges were never going to



overcome the financial constraints affecting health care provision. Instead, these fees were deterring the poor population, especially, from using medical services. A quarter of a century after the conference in Mali, most politicians today are agreed that requiring patients to contribute to the costs of their treatment is not a solution. Direct payments for medical treatment are now accepted as socially inequitable and a cause of exclusion. Nowadays even the World Bank advises against them.

Health sector has grown. For a long time, development cooperation overestimated the potential of small, community-based health insurance schemes. Today it is known that they can, at best, make a lasting contribution to social health protection with resolute support by the state. In the quest for sources of finance, new options are now opened up by economic growth and the exploitation of raw materials. At their meeting in the Nigerian city of Abuja in 2001, the countries of the African Union (all the states of Africa except Morocco) agreed to dedicate 15 per cent of their public budget expenditures to the health sector. This target has given the health sector growing importance in many countries.

For all the fundamental similarities, African countries are each choosing their own way towards universal health coverage and equitable, sustainable health financing. The diverse approaches are exemplified by the East African countries Kenya and Rwanda, Ghana in West Africa, and South Africa. What

the four countries have in common is their striving for universal health coverage under extremely difficult conditions: widespread poverty, a large informal sector (small-scale farmers, traders and craft workers without formal employment) and sometimes unreliable public structures pose major challenges to every form of social protection.

RWANDA

The small, densely populated “land of a thousand hills” in the heart of Africa hit the international headlines in 1994 when, within a few weeks, hundreds of thousands of people lost their lives in a genocide. After the civil war was ended by the then General Paul Kagame, the political situation in the country stabilised. Today Rwanda tends to draw attention to itself rather with good news. From the health system, for instance: within the space of a few years the government succeeded in bringing almost the entire population under the umbrella of “mutuelles de santé”. These are community-based health-insurance schemes, supervised and administered by municipal representatives. Those responsible must deliver accountability reports at regular community meetings on the use of the money collected. Such micro-health-insurance schemes are particularly widespread in francophone Africa. In other countries, however, they do not reach anywhere near such a large proportion of the population as in Rwanda.

“Learning from each other”



Tim Evans is Senior Director for the Health, Nutrition and Population Global Practice at the World Bank Group.

G+G: WHO Director General Margaret Chan defines universal health coverage as the single most powerful concept in public health. What makes this concept so important?

Evans: Universal health coverage hardwires equity as a central organizing driver of health systems development. It guides rapidly growing health systems towards win-wins in equity and efficiency.

G+G: Achieving universal health coverage is a big challenge for many countries. What is the support required from the international community?

Evans: Joint learning: Recognizing that there is no one size fits all but that a huge amount can be learned by understanding how countries are overcoming challenges and seizing opportunities in their pursuit of universal health coverage. This joint learning needs to be complemented by support to the development of core financing and service delivery institutions in countries that can navigate innovative pathways towards universal health coverage. Development finance in health must move beyond its predominant focus on short-term results and measure its effectiveness increasingly in evidence that financing for health in countries is smarter, better value for money, scaled to meet the needs of all, and sustainable as countries transition from low to middle income status.

G+G: How will the new Sustainable Development Goals (SDG) contribute to promoting universal health coverage?

Evans: Goal 3 on health has a target on universal health coverage. The World Bank Group and WHO have developed a common approach to monitoring progress towards universal health coverage, thus making it clear that universal health coverage is measurable.

G+G: How do you perceive the efforts of the German government to support global health issues with a particular regard to health system strengthening?

Evans: The leadership of the government of Germany has been enormously important in bringing attention to the importance of universal health coverage and the health systems bedrock upon which progress is largely dependent. The initiative “Healthy systems, healthy lives” launched by the German Chancellor gives overdue attention to core health systems functions that are too often taken for granted such as registration systems that count every birth and death. ■

No wedding without an insurance card. What might be the explanation for this remarkable success? One peculiarity in Rwanda is certainly the ultra-strict, not to say authoritarian, system of government in the former kingdom. Decrees from the current president, Paul Kagame, land on every mayor's desk almost instantly. The former general wants to reform his Rwanda into a model country that attracts foreign investment. To achieve this aim he makes use of extraordinary means: not only every minister in his cabinet but every local self-administration has a direct performance agreement with the president. Year on year every mayor must present results and answer questions on a series of agreed performance indicators – which include the number of members in the municipal *mutuelles*. And for their part, to meet their targets, the mayors put pressure on people to pay their membership fees to the local health insurance scheme; e.g. by requiring a health insurance card to be shown at the registry office before any marriage ceremony. The government oversees the development of its prestigious “*mutuelles*” project with hawk-eyed vigilance and, if need be, highly personal attention. The health minister, Agnès Binagwaho, makes that clear: “If I hear that anybody has dipped into the fund for their own personal use, then I go there myself and confront those responsible.”

Contribution depends on estimated income. In a country in which most people live from subsistence farming, many struggle or simply cannot afford to pay a health-insurance contribution, even if it is just a few euros per year. The government therefore finances the contributions of the poorest Rwandans – which means, incidentally, a quarter of the population – from taxation and with the support of external donors. All other citizens pay contributions of between three and seven euros per year, scaled by estimated income. The criteria used as an assessment basis for this are reminiscent of the system for assessing European farmers' contributions: the amount they are charged is governed by factors like the size and fertility of their farmland. At district level the government has also set up a kind of risk structure equalisation, which supports *mutuelles de santé* in financial distress.

Money is just enough for basic care. The main burden of financing continues to rest with the central government and international partners. Overall annual per-capita health expenditure in Rwanda amounts to the equivalent of 60 euros. Although at present only a small portion of this expenditure is financed by the *mutuelles*, the Rwandan government sees their contribution as an avenue for the future, with a view to reducing the long-term dependency on national tax revenues and involving the population directly in building up the country. Despite financial participation by the government and international partners, only a meagre service package is available to the population. More can scarcely be financed, given the low level of the contributions. In the countryside, generally there is only primary health care. In the larger cities and in the capital, Kigali, there is a very limited range of more advanced medical treatments such as caesarean deliveries, incubators for premature babies, hernia surgery

International partnerships

Social health insurance – the export blockbuster

With the adoption of the Health Insurance Act of 1883 under Otto von Bismarck, Germany took on a pioneering role in social protection worldwide. Ever since that time, the system has proved to be adaptable and enduring. Many countries in Europe and elsewhere followed the German example and introduced social health insurance schemes.

Germany supports other countries in the establishment and ongoing development of health and social protection systems. It does so firstly via more than 30 bilateral programmes in German development cooperation partner countries. These currently include Burundi, Kenya, Tanzania, Rwanda, Uganda, Malawi, Mozambique, South Africa and Namibia.

Advisors from Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) in these countries draw attention to new perspectives and different models, and stimulate new thinking. Together with local experts and politicians they consider which systemic approaches and elements best fit the local conditions and how they can be adapted. **In this regard, South-South exchange plays an increasing role; that is to say, countries at a similar stage of development join forces to work on particular questions.** GIZ attempts to support and facilitate this form of cooperation.

Furthermore, as one of the leading economic nations, the Federal Republic of Germany ranks among the largest donors contributing to multilateral institutions like the World Bank, the World Health Organization and the Global Fund to Fight AIDS, Tuberculosis and Malaria. ■

P4H: Global network concentrates aid

In order to support the request for “Social Health Protection” in international development cooperation, the German and the French governments jointly launched the Providing for Health (P4H) initiative in 2007, which has continued to grow in the meantime. All bilateral (Germany, France, Spain, Switzerland) and multilateral partners (International Labour Organization, World Health Organization, African Development Bank, World Bank) have undertaken to **pull together in the developing countries and concentrate their health policy advice.** Currently 20 countries worldwide are taking advantage of support from the P4H network.

For many years, Germany has been advocating that greater weight be accorded to social health protection at international forums and bodies like the World Health Assembly or the General Assembly of the United Nations, and endeavouring to persuade the international community to pursue a common approach against social exclusion and impoverishment caused by ill health. Notable successes in this area were resolutions of the 2011 World Health Assembly and the 2012 General Assembly of the United Nations. ■

Jens Holst/Jean-Olivier Schmidt

More information:

www.who.int > programmes and projects > providing for Health



and other simpler operations. Members of the *mutuelles de santé* are entitled – at least in theory – to the same services.

Model for other health systems. Even if other reforms in the Rwandan health sector are simultaneously taking place, such as the introduction of partly performance-based provider payment if certain quality criteria are met, the expansion of health insurance coverage in Rwanda has undoubtedly contributed to these considerable successes. In particular, infant and maternal mortality has fallen continuously in the past ten years. The numbers of AIDS, tuberculosis and malaria victims have declined by 80 per cent in recent years. This can be assessed as a major success, considering the relatively modest health expenditure. Rwanda has become a model for other health systems in southern Africa.

SOUTH AFRICA

The health care system of the Rainbow Nation could hardly be more contradictory. Back in the late 1960s in Cape Town, the surgeon Christiaan Barnard caused a sensation with the world's first heart transplant (which, incidentally, took place in a public hospital). Meanwhile, the black majority of the population only had access to scant health care under the apartheid regime. Since then, the chasm has only grown between high-tech medicine, which mainly benefits white South Africans, and the meagre public provision of basic health care in a country with one of the world's highest HIV infection rates. Because for many years nobody paid attention to quality assurance in public health centres and hospitals, anyone in South Africa who can afford to do so takes out a policy from a private health insurer – which have sprung up like mushrooms – so that they can make use of private practices or hospitals. Today South Africa effectively has a two-class system of health care.

Quality standards for public facilities. In the interim, however, there have been serious political efforts to introduce a nationwide social health insurance scheme (*see interview on page 18*). South Africa has set itself the goal of extending social health protection to the entire population in the next twelve years. As a first step, the government is endeavouring to implement quality standards in the public facilities in order to enforce uniform minimum standards of health services. Furthermore, greater administrative autonomy is planned for the public health facilities. In future the Ministry of Health will actively purchase services from these instead of continuing to finance them by means of a fixed budget. Those insured under the National Health Insurance Scheme will also be able to use medical services from private providers. To make this work, the public sector will be required to regulate the private health care sector effectively. These are complex and politically demanding reforms, for which capacities have not previously been available. Therefore South Africa is initially testing the new functions, roles and procedures in selected pilot districts.

KENYA

The motto on Kenya's national coat of arms reads „Harambee”. It means something like community spirit, which also encompasses the concept of solidarity. Perhaps for that reason, Kenya has the oldest social health insurance scheme in South Africa, the “National Hospital Insurance Fund” (NHIF). The insurance fund was established in 1966 and, as its name already implies, it reimburses almost exclusively the costs of inpatient treatment for its nearly three million members. To this end, the NHIF has concluded 500 service agreements both with public and private hospitals.

That said, this social health insurance scheme does not even cover one in ten Kenyans – for the most part, employees in formal employment whose companies have to pass on social security contributions. Although those working in the informal sector can take out health insurance for themselves and their children for a monthly contribution of 1.60 euros if they have the financial means to become members, in practice hardly anyone does so.

Certainly this is due in part to the low motivation of the NHIF to approach people in the informal sector and to drum up enthusiasm for the health insurance scheme. The management's concern about financial losses is too great. “Can we afford that, or does it threaten our solvency?” asked the long-standing NHIF director Richard Kerich every time discussion turned to expanding health insurance protection in Kenya, be it by accepting people from the informal sector or by extending coverage to outpatient services.

Many have no idea that insurance is available. But there are also other reasons, such as the population's poor knowledge. Pascal, a taxi driver in Nairobi, responds with immediate enthusiasm when he learns about the benefits of membership: “I'll go there tomorrow to get myself and my children registered – that is a very affordable amount indeed.” Many people in the bustling commercial metropolis of Nairobi might come to the same conclusion if they knew about the NHIF, and would be in a position to afford the contribution. Things are different in the countryside, where income fluctuates depending on the seasons and harvest times. Furthermore, many Kenyans reside in remote areas. They live so far away from the nearest hospital that insurance simply is not worthwhile because they can barely access the services. Transport connections to the nearest town, let alone far-off Nairobi, scarcely exist.

Lots of money goes into real estate. The NHIF is the starting point for the introduction of universal health coverage, which is the stated goal of Kenyan health and social policy. Despite the scheme's long prior history – or perhaps precisely because of it? – nothing much has happened. Neither politicians nor the health insurance scheme seem interested in a fundamental reform of the NHIF. The board of directors and management had re-

Country survey: health and society in figures

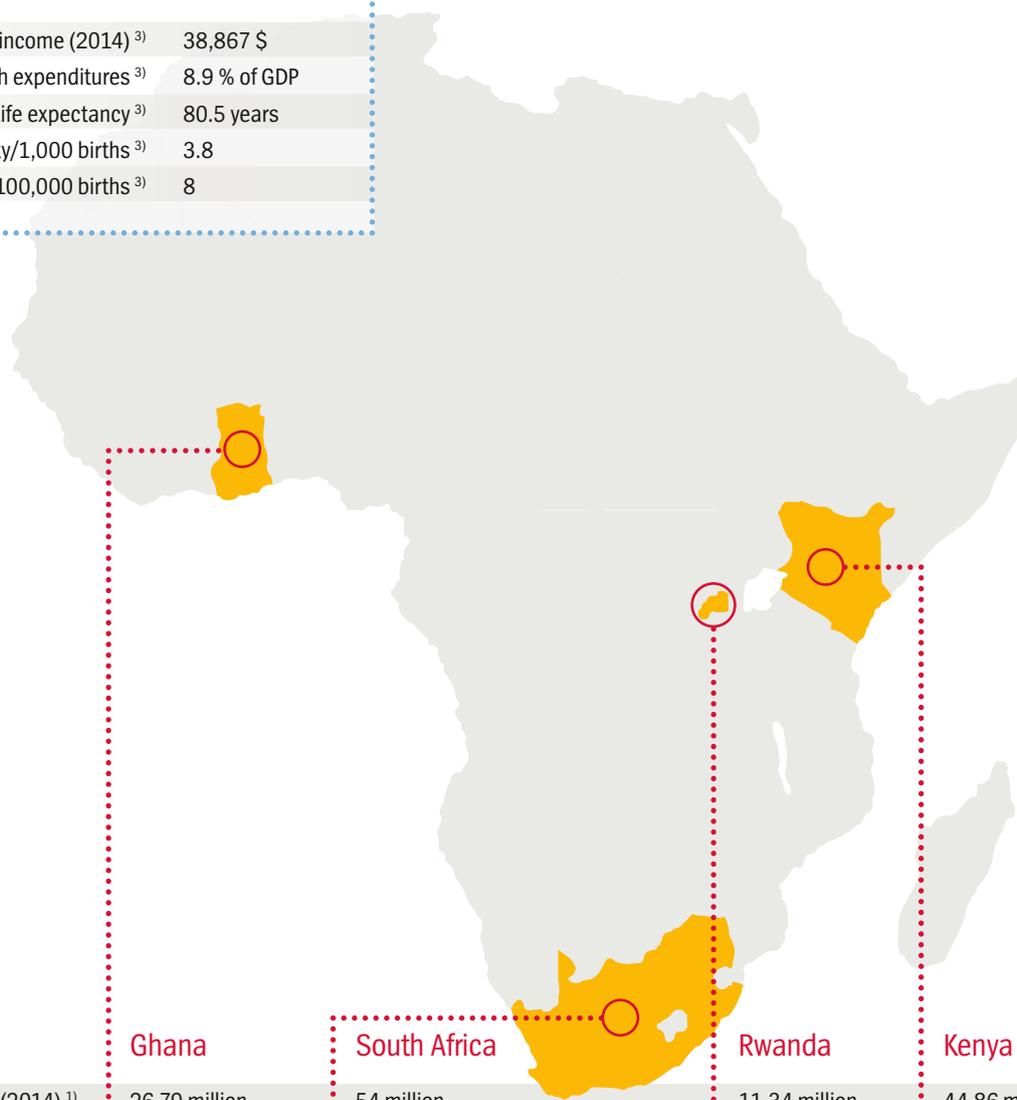


africa

OECD average (2013)

(Countries of the Organization for Economic Cooperation and Development)

| | |
|---|--------------|
| Per-capita income (2014) ³⁾ | 38,867 \$ |
| Health expenditures ³⁾ | 8.9 % of GDP |
| Life expectancy ³⁾ | 80.5 years |
| Infant mortality/1,000 births ³⁾ | 3.8 |
| Maternal mortality/100,000 births ³⁾ | 8 |



Ghana

South Africa

Rwanda

Kenya

| | Ghana | South Africa | Rwanda | Kenya |
|--|------------------------|-------------------------|-----------------------|-----------------------|
| Population figure (2014) ¹⁾ | 26.79 million | 54 million | 11.34 million | 44.86 million |
| System of government ⁴⁾ | presidential democracy | parliamentary democracy | presidential republic | presidential republic |
| Literacy rate (2015) ²⁾ | 76.6 % | 94.3 % | 70.5 % | 78 % |
| Gross domestic product (GDP) (2014) ¹⁾ | 38.62 billion \$ | 350.1 billion \$ | 7.89 billion \$ | 60.94 billion \$ |
| Per-capita income (2014) ¹⁾ | 1,590 \$ | 6,800 \$ | 700 \$ | 1,290 \$ |
| Health expenditures (2013) ²⁾ | 5.4 % of GDP | 8.9 % of GDP | 11.1 % of GDP | 4.5 % of GDP |
| Life expectancy (2013) ¹⁾ | 61.1 years | 56.7 years | 63.4 years | 61 years |
| Infant mortality/1,000 births (2015) ²⁾ | 37.37 | 32.99 | 58.19 | 39.38 |
| Maternal mortality/100,000 births (2015) ²⁾ | 319 | 138 | 290 | 510 |

Sources: ¹⁾ worldbank.org, ²⁾ CIA World Factbook, ³⁾ stats.oecd.org, ⁴⁾ auswaertiges-amt.de



mained in the same hands for many years, during which little improvement has been seen in the scope and quality of services. The finances are non-transparent, and the NHIF's reputation among many Kenyans is quite poor. Public perceptions mainly focus on the smart office tower blocks and the luxurious vehicle fleet of the public insurance fund. The extraordinarily lavish administrative expenditures, running close to 20 per cent, and the relationship between contribution revenues and service expenditures confirm this perception: only 30 cents out of every euro received are devoted to health care. The NHIF invests the rest in real estate and capital investments.

Trade unions put up resistance to increases in contributions. The NHIF contributions are income-scaled fixed amounts, accounting for a share of salary that declines gently from three to slightly more than two per cent as income rises up to the upper assessment limit. For years, contributions have failed to keep pace with the steep income growth of the growing middle class in particular. For many insureds, the maximum contribution of somewhat over three euros a month is only a tiny fraction of their salary.

All attempts to raise contributions are regularly met with

strong resistance from the trade unions, who fear that employees' incomes will fall and rising wage costs will bring competitive disadvantages. To see this as expressing a lack of solidarity between higher earners and the country's many poor people is only part of the truth. The lack of trust already mentioned, the great dissatisfaction with the public health insurance fund and, not least, the sometimes long distances to health facilities are other causes of the low willingness to pay.

In the longer run, however, Kenya will have little choice but to fundamentally reform health care financing: it is the up-and-coming economic power in East Africa, yet the population's health status is dismal. Life expectancy has fallen in the past two decades and maternal mortality has risen. These are not good starting conditions for a country that is seeking to connect with the global economy.

GHANA

At the presidential elections in Ghana around the turn of the millennium, the candidate John Kufour promised to abolish the

“South Africa’s public sector requires massive investment”



Dr. Michael Thiede is managing director of Scenarium Group GmbH, Berlin. He is currently advising the South African government on questions of health financing.

G+G: Rich South Africans have access to high-tech medicine. Health care for the majority of the population is inadequate. Does apartheid live on within the health system?

Thiede: The background is complex. Those with good access to care, members of the privately organised Medical Schemes – which is about 16 per cent of the population – are the better-off. The new middle class also belongs to this group. For

the last few years, the Government Employees Medical Scheme has been insuring public service employees and their families. Over 80 per cent of the population, however, are reliant on the wholly inadequate medical care provided by public clinics and hospitals.

G+G: South Africa is making efforts to improve health care provision for the entire population. How far have these efforts flourished?

Thiede: The Ministry of Health introduced plans for a national health insurance scheme, the NHI, in 2011. The reform aimed at a unified health system for all South Africans is expected to be implemented by 2026. The plans envisage the establishment of a largely centralised, tax-financed health system. The most glaring challenge is the low quality of care in the public sector. If the public service providers are to be the first-choice source of care for the entire population, a number of things must change. This means that massive investment is called for, particularly in infrastructure and staff. Otherwise the NHI has a big credibility problem from the outset.

G+G: To what extent is German expertise helping to overcome the challenges?

Thiede: German experts are glad to contribute their experience with the self-administration principle to discussions on the institutional arrangements of health systems. A further strength of German expertise, from my own observation, lies in urging that the principles of good governance be implemented, particularly in the health and social policy context.

G+G: You work as a consultant in South Africa. With which institutions are you mainly involved, and how does the cooperation work?

Thiede: I am currently in South Africa on a contract with Deutsche Gesellschaft für Internationale Zusammenarbeit. There is a productive cooperation with the South African exchequer. Whilst I am primarily engaged with financing issues there, I also try to do something about interministerial communication. Occasionally, when there are divergent interests, there can be a need for an intermediary. I also hope to be able to contribute to the de-ideologisation of the reform debate. ■



existing system of user fees, i.e. direct payments for medical treatment. He won the elections and kept his promise. The small West African country on the Gulf of Guinea, which is considered one of the most stable democracies in Africa today, began to establish a nationwide health insurance fund in 2004. The National Health Insurance Scheme (NHIS) was initially open to civil servants and those in formal employment only. So far they still make up the bulk of paying members. One implication of the enrolment of dependent children, in a young population like Ghana's, is that almost half the members are under 18 years of age.

Accordingly, contributions from members only account for a quarter of the NHIS financing. The majority of the health insurance scheme's revenue is generated through a fixed proportion of value-added tax. A fierce controversy has broken out in Ghana over the social justice of health-insurance financing. For although the entire population pays value-added tax, the burden it places upon poor households is disproportionately heavy. And precisely those poor people make less use of medical services because more complex treatments can only be found in special facilities in the cities.

Aspiring towards mandatory universal insurance. The Ghanaian government is carving out interesting and innovative paths to link the community-based health insurance schemes that exist in many places with the National Health Insurance Scheme. The NHIS accepts the members of such village micro-insurance schemes, sometimes offering locally adapted service packages. Currently, membership of community-based health insurance schemes is still voluntary. In principle, health insurance cover is mandatory for all citizens. Since it will now be obligatory to take out health insurance, Ghana must examine the sources of financing. Higher taxes on collective assets such as revenues from petroleum exports would be one possibility. Meanwhile, the Ghanaian government has approved a supplementary deduction for beneficiaries of private health insurance, to be levied for the benefit of the public insurance scheme.

One third of the population is covered. Beyond this, the government provides all pregnant women with insurance cards for medical treatment around pregnancy and childbirth via a social programme. Recipients of welfare benefits also receive a free health insurance card in addition to their cash transfers. Thus, the number of beneficiaries has risen drastically since the scheme was founded: from one million citizens initially to eight million currently, which is a respectable one-third of the population. The service package is reasonably extensive and includes everything that the health system actually makes available. Excluded treatments are dialysis for kidney failure, and heart, neurosurgical and cosmetic operations. The Ghanaian service package can certainly hold its own in comparison to other countries in sub-Saharan Africa. However, the small West African country still has a long way to go before its citizens can

hope to receive the kind of treatment available in Europe. Lydia Dsane-Selby, head of the department for hospital accreditation at the NHIS, says: "While we have created a remarkable, comprehensive system in Ghana within a short time, we still face the problem of ensuring the quality of the treatments. Here we must still make improvements."

Sub-Saharan countries boost health expenditures. In spite of the enormous burden of ill health weighing down on the African continent, the recent evolution of African health systems sows the seeds of hope. Even if some countries like Kenya or Tanzania tend to maintain the status quo, clear progress is discernible elsewhere. More and more sub-Saharan countries are introducing fundamental reforms of their systems and boosting their health expenditures.

Ghana, Kenya, Rwanda and South Africa are currently spending more per capita on health today, in proportion to national income, than Bangladesh or India. It has become evident that community-based health insurance schemes, which have long been promoted by international cooperation, are reliant on state support to be in any position to make a lasting contribution to universal health coverage. Political will and good governance are decisive. The situation only improves when people have access and entitlement to quality care. More and more governments in Africa are taking this task seriously and investing in health care for the population. ■

3

GLOBAL HEALTH



Latin america



Testbed for reforms

Chile has been providing its population with health insurance coverage according to the Bismarckian model for almost a hundred years. But market-oriented reforms have weakened the welfare state. Mexico and Colombia have undergone similar transformations. The third chapter describes how countries in Latin America are adjusting their social protection systems in the aftermath.

For many years, dictatorships and civil wars defined the image of Central and South America. But beyond the Cold War, which also played out in the “USA’s backyard”, in the late 1970s Latin America was the birthplace of a gigantic sociopolitical upheaval, the full implications of which only became recognisable much later. The sub-continent was the testbed for market-oriented reforms of welfare systems. Back in 1981, Chile introduced competition between health insurers and strove for privatisation of the entire health system – long before such ideas reached Europe.

Reforms heighten social inequality. In the 1980s and 1990s, almost all countries in Latin America more or less followed the Chilean model. Even Costa Rica, which was gradually expanding its social health insurance system, came under privatisation pressure. With their structural adjustment measures and conditions attached to loans, development institutions – particularly the World Bank and the International Monetary Fund – pressured indebted developing countries towards market-oriented reforms. Only a few governments initially resisted the slipstream of neoliberalism. Other than Cuba, Brazil was the

main country to introduce a state health system, which it did in 1988. Over 25 years later, despite its remarkable social protection system, South America’s largest country is struggling with the previous model’s unmistakeable shortcomings and supply shortages. The other countries in the region are devoting considerable resources to practising damage limitation. The market-oriented reforms of past decades have barely improved the situation of many people in the affected countries, but have certainly broadened the social disparities. For some years now, universal health coverage and more social justice have been at the very top of the health policy agenda.

Mineworkers fight for their rights. Unlike most countries in Africa, Southeast Asia and Indochina, the countries of Latin America cast off colonial rule more than 200 years ago. It took another 100 years or more, though, before the first welfare systems emerged in Central and South America. Even back then the pioneering country was Chile, which started to set up a health system in 1918 and passed its first social legislation in 1924/25. Coinciding with the boom in nitrate – the base material for fertilisers and explosives was highly coveted during the period



“Brazil promotes citizen participation”

Lígia Giovanella is a health scientist at the National School of Public Health in Rio de Janeiro and advises the intergovernmental South American Institute of Governance in Health ISAGS.

As an adviser to ISAGS you have an overview of the health systems in South America. Where do you see the most important reform approaches on the subcontinent at the moment?

Giovanella: In almost all countries, the main concerns in the last few years have been the statutory and constitutional anchoring of the right to health, and universal health coverage. The approach is trans-sectoral. It centres around the responsibility of the public sector for the citizens' health. The underlying foundation is a more holistic understanding of health, along the lines of a right to live well. This is already incorporated in the constitutions of Bolivia and Ecuador. The health reforms of recent years give expression to the search for new models of public health care and the explicit desire for equitable economic growth; for any reduction of the great social inequality in South America has positive impacts on the population's health.

When it comes to the health policy debate, are there fundamental differences between Europe and Latin America?

Giovanella: Yes, of course. European countries have achieved universal health coverage in conditions of greater social justice, by comparison. In South America, on the other hand, segmented systems have arisen which allowed different access to various population groups, depending upon income. Given the policy of cuts as a result of the current crisis, the most important cause for concern in Europe is the reining in of health spending. In Latin America the greatest challenge consists in building up truly universal health systems. This requires an increase in public expenditure and the establishment of integrated care networks.

You know the German system very well. What can we learn from Brazil?

Giovanella: In Brazil, popular participation is very much flourishing. Participation is institutionally anchored in the National Health Council, in the 26 health councils at federal state level, and in more than 5,000 municipal health councils. These are the forums where representatives of the authorities, service providers and civil society make health-policy decisions. It seems to me that primary health care is also further developed in Brazil than in Germany, because over several years we have systematically built up interdisciplinary teams and promoted citizen participation.

Jens Holst was asking the questions.

of the First World War – a strong workers movement, fighting for more pay, better working conditions and social protection, grew up in the North Chilean Atacama desert. Entirely in the style of Germany's first chancellor, Otto von Bismarck, the mine owners countered the striking workers with a combination of carrot and stick: on the one hand they ordered the brutal crushing of the labour disputes; on the other hand they responded to the demands. This is how, in the 1920s, a Bismarckian style social insurance system for workers and employees came into being.

Sizeable groups excluded. In the wake of gradual industrialisation, initially in the larger coastal cities of the other Latin American countries, social insurance schemes emerged, mostly for those in public services like the railway and port workers in Brazil and Argentina, but also for those in formal employment in larger private companies. In this process, the European influenced elites adopted the social insurance models of the Old Continent. Despite a stepwise expansion to new groups of workers, however, sizeable parts of the population remained excluded from the emerging welfare systems. The enrolment of informal employees like smallholders, self-employed craft workers, travelling traders, day labourers and all poor people into a social insurance scheme is difficult, and only possible with state support. Even in Germany it took up to 80 years before farmers, students and freelance artists and journalists were brought into the statutory health insurance system. In developing and newly industrialising countries, the share of the population living from informal employment is disproportionately higher than in an industrialised country. In Latin America not all citizens have access to affordable medical treatment even today.

CHILE

Health policy in Latin America was not always determined by the demand for social protection and more equitable access and financing. In the 1980s and 1990s, the subcontinent was dominated by a different prevailing wind, emanating from Chile. That country, under the then government of dictator Augusto Pinochet, sought advice from the neoliberal market economists of the Chicago School, who placed unconditional reliance on market forces. It was not just the pension system that the “Chicago boys” turned completely upside down but also the South American country's health system. Previously, thanks to a combination of insurance contributions and tax financing, all Chileans benefited from affordable access to medical services. Although universal mandatory health insurance and income-related contributions were maintained, the reformers in Chile abolished the employer's share. Above all the social insurance market was opened up to private insurance companies. Since 1981 these have been competing with one another, and with the sole public health insurer, for beneficiaries. After many years of government cuts, some public health centres and hospitals were in a pitiful condition, so that everyone aspired to a private policy if they could afford one. This has been and remains the preserve of higher-income earners, however. Despite state subsidies,



the market share of the private health insurance industry was never over 30 per cent. Today somewhat more than one in six Chileans can afford private health insurance.

Private insurers indulge in cherry picking. Apart from Germany, Chile is the only country in the Organisation for Economic Cooperation and Development (OECD) with universal mandatory health insurance which allows people to switch from the public scheme into comprehensive private health coverage. Unlike in Germany, the private health insurance contribution in Chile is not based merely on the individual's risk at the time the insurance is taken out, but is continually adjusted to a person's changing risk profile over lifetime. By the time people reach pension age, at the latest, the contributions are unaffordable for the vast majority, which creates scope for the Chilean private insurer to indulge in risk selection and cherry picking. The public scheme safeguards the provision of care for those who are unprofitable under the business model of the private insurance companies. Major challenges arise from this with regard to social fairness and redistribution. At the end of 2014 a commission appointed by President Michelle Bachelet submitted reform proposals; these remain to be implemented.

Risk structure compensation failed. Scarce public resources lead to long waiting times and shortages despite extensive investments in recent years. In the private sector, on the other hand, unpredictable, sometimes very high and socially unfair out-of-pocket payments are the main problem. The most extensive re-reform of the Chilean health system to date, the Universal Access and Explicit Guarantees (AUGE) plan, was intended to rectify these imbalances. It specifies treatment guarantees for common illnesses by restricting the maximum waiting time to two months and the highest permissible co-payment to two months' pay.

Patients have legal recourse if guarantees are breached. While the much-praised AUGE plan does improve the situation, particularly for the chronically ill, at the same time it highlights the limitations of catch-up reforms. Before the introduction of treatment guarantees, in 2003 an attempt by the then social-democrat-led coalition government to introduce a risk equalisation mechanism between the public and private insurance schemes had failed; the political resistance mounted by the private sector and conservatives was too strong. All that remained of the ambitious reform project was the statutory capping of waiting times and co-payments for selected treatments. But such vertical approaches harbour the risk of neglecting unlisted diseases and encouraging parallel markets for the selected therapies: instead of operating in their hospitals, ophthalmologists from public clinics have opened practices in the direct vicinity to treat cataracts, one of the first diseases of the AUGE plan, and are now working for their own profit.

COLOMBIA

Other countries which, in the past, took the Chilean route towards deregulation and commercialisation of the health sector are now similarly endeavouring to make corrections and alleviate the undesired consequences of market-oriented reforms. 20 years ago Colombia had likewise introduced competition between privately operating health insurers. Since then, every Colombian earning an income of more than two statutory minimum wages has had to pay a contribution of twelve per cent to the insurer of his choice for social health protection. Provision of care for the poor and indigent happens within the subsidised system, which is predominantly financed from taxes but only provides a limited package of services.

Solidarity funds for poor people. Unlike the Chilean liberalisers, however, the health reformers in Colombia attempted to control the social rifts caused by competition between essentially profit-oriented health insurers. They maintained the employer's contribution – which for employed staff is a remarkable two-thirds of the total contribution. In addition, they introduced a risk equalisation mechanism along with competition between insurers to prevent ruthless selection. And better-off wage-earners see one-twelfth of their contributions go to subsidise the country's poor population, who are protected free of charge in the subsidised system by means of a solidarity fund.

While the repercussions of the Colombian reform of 1993 are not as dramatic as in Chile, after 20 years the country's health system still exhibits substantial shortcomings. "Even now, not all Colombians have the benefit of health insurance coverage. Different population groups are entitled to different service packages, but those for members of the subsidised system are inadequate. What is more, patients sometimes have to find the money for high out-of-pocket payments," says health scientist Ramón Castaño from Colombia. The profit-oriented health insurers refuse to reimburse the costs of many treatments. And the separation between the contribution-based and contribu-

Global Alliances for Social Protection

Economic growth in emerging developing and newly industrialising countries often goes hand in hand with an increase in social inequalities and political conflicts. Social protection and the adaptation of social systems to the new challenges are gaining in importance. In their social policy endeavours and in search of inspiration in terms of content and organisation, these countries desire more vigorous dialogue with each other.

In order to support cooperation with and between the emerging countries, the Federal Ministry for Economic Cooperation and Development (BMZ) commissioned the project "Global Alliances for Social Protection". Within that framework the Gesellschaft für Internationale Zusammenarbeit (GIZ) promotes the exchange of experience between countries such as India, Indonesia, Brazil and Mexico as well as China, Chile, Peru and South Africa. The focus is on the social policy dialogue between interested countries and on problem-oriented knowledge transfer, which also involves the contribution of experience from Germany. Specific collective learning and dialogue formats were delivered on questions of "productive inclusion" in Peru, Mexico and Indonesia, and learning forums with the partner countries were offered in cooperation with the World Bank.

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tion-free system leads to two-tier medical care – comprehensive protection is only possible with supplementary private insurance.

Abandoning competition between health insurers? In June 2013 the Colombian government therefore passed a further health reform. The core element is the establishment of a single public payer, which collects contributions and pays service providers. This reform means no less than the abandonment of competition between health insurers. Other components of the reform would be the introduction of an insurance supervisory authority and the expansion of integrated care structures.

MEXICO

From 1943, Mexico established a social health insurance scheme for people in formal employment based on the German model. The Jewish Hamburg doctor, Ernst Frenk, fled in 1930 from the rising anti-Semitism in Germany to Mexico, where he actively participated in setting up the social insurance system. A good half-century later, his grandson, Julio Frenk, was to introduce the last major health reform to date in his position as Mexican Minister of Health. The goal of this ambitious project was the extension of the health insurance system to the entire population.

For only a few years ago, Mexico was still far from any such achievement: at the start of 2004, eleven million Mexican families were still lacking health-insurance cover. At the beginning of this century, the existing healthcare system was fragmented, with several social insurance schemes for half of the citizens, a state health system providing medical care to one in three Mexicans, and a small private sector. The various subsystems operated separately, for the most part. Members of a social health insurance scheme could only make use of its own health facilities, and people in informal employment had access to public health centres or hospitals only. At least in the cities, this led to wasteful duplications and multiple structures: in Mexico City, high-tech intensive care government clinics are sited just a few kilometres from the social insurance clinic, which is also superbly equipped to European standards.

Popular insurance for the previously uninsured. The core element of the reform brought in under Minister Julio Frenk in 2004 was the introduction of an additional pillar to the multiple structures of the Mexican health system. Tax subsidised “Popular Insurance” (Seguro Popular) is open to all previously uninsured citizens, and covers outpatient care as well as simpler hospital treatments. It is financed by means of income-dependent contributions from members, a standard federal allowance per family from the Federal Government, and a social levy from the individual federal states which depends on the number of Popular Insurance enrollees.

Two years later than planned, Mexico officially celebrated the introduction of universal health coverage on 1 April 2012. Only some very creative handling of figures and data made this

possible. There were considerable problems, firstly concerning the willingness to pay of those citizens previously not insured, and secondly concerning the payment practices of the wealthier federal states in particular, who are still not meeting their financial commitments in full.

Criticism of the limited service package. Without a doubt, since Seguro Popular was introduced, considerably more people now have health insurance coverage and access to health services. But the healthcare providers are running up against capacity limits. Doctors and nurses perceive an overload because, while working in the existing facilities and with unchanged staffing levels, they now have to treat the additional beneficiaries of the new health insurance scheme. The greatest criticism refers to the limited “Popular Insurance” service package, which does not reimburse the treatment costs for cardiovascular diseases, tumours, chronic kidney disorder and other serious illnesses. For these conditions there is a “Fund for Protection against Catastrophic Health Expenditures” available, but no legal entitlement to its benefits. “Someone who has the wrong disease must pay out of their own pocket,” as health scientist Jesús del Real Sánchez succinctly puts it.

BRAZIL

In the largest country of the subcontinent, the history of social health protection similarly began with Bismarck-style social insurance schemes. These covered about half of the population in the 1980s. But unlike the neighbouring countries, which were taken in by neoclassical economic theory and developed their health insurance systems in the direction of market economics and private enterprise, the Federative Republic of Brazil opted for a radical overhaul, moving towards tax financing in order to overcome the exclusion of the large informal sector. Social health protection became an essential component of a comprehensive social policy which does not stop at poverty reduction but sees itself as the realisation of social rights.

Free access to health care. The health movement played an important role in the resistance against the military dictatorships which ruled Brazil from 1964 to 1985. Their influence on the democratisation process was reflected in the new Brazilian Constitution of 1988, which enshrines health as a social human right and an obligatory function of the state. This was an unmistakable counterpoint to privatisation and dismantling of the state in the other countries of the region. By introducing the Unified Health System SUS (Sistema Único de Saúde), Brazil accomplished the structural change from a social-insurance to a national health system.

Cornerstones of the 1989 reform were universality, social justice, decentralisation, subsidiarity, participation and integral and integrated care, in the aim of overcoming the past exclusion of the informal sector from social protection. Since then all people in Brazil have had free access to tax-financed health care. Responsibilities and financing are shared out between the Fed-



latin america



Mexico

Chile

Brazil

Colombia

| | | | | |
|--|-----------------------|------------------------|-------------------------------|------------------------|
| Population figure (2014) ¹⁾ | 125.4 billion | 17.76 billion | 206.1 billion | 47.79 billion |
| System of government ⁴⁾ | presidential republic | presidential democracy | presidential federal republic | presidential democracy |
| Literacy rate (2015) ²⁾ | 95,1 % | 97,5 % | 92,6 % | 94,7 % |
| Gross domestic product (GDP) (2014) ¹⁾ | 1.295 trillion \$ | 258.1 billion \$ | 2.346 trillion \$ | 377.7 billion \$ |
| Per-capita income (2014) ¹⁾ | 9,870 \$ | 14,910 \$ | 11,580 \$ | 7,790 \$ |
| Health expenditures (2013) ²⁾ | 6.2 % of GDP | 7.6 % of GDP | 9.7 % of GDP | 6.8 % of GDP |
| Life expectancy (2013) ¹⁾ | 76.5 years | 81.2 years | 74.1 years | 73.8 years |
| Infant mortality/1,000 births (2015) ²⁾ | 12.23 | 6.86 | 18.6 | 14.58 |
| Maternal mortality/100,000 births (2015) ²⁾ | 38 | 22 | 44 | 64 |

OECD average (2013)

(Countries of the Organization for Economic Cooperation and Development)

| | |
|---|--------------|
| Per-capita income (2014) ³⁾ | 38,867 \$ |
| Health expenditures ³⁾ | 8.9 % of GDP |
| Life expectancy ³⁾ | 80.5 years |
| Infant mortality/1,000 births ³⁾ | 3.8 |
| Maternal mortality/100,000 births ³⁾ | 8 |

Sources:

¹⁾ worldbank.org

²⁾ [CIA World Factbook](http://cia.gov)

³⁾ stats.oecd.org

⁴⁾ auswaertiges-amt.de



eral Government, the federal states and the municipalities according to clearly defined criteria. On all three levels, health councils ensure citizen participation and have an important say in all health policy decisions.

Floating hospitals on the Amazon. The inauguration of the SUS was marked by substantial teething troubles. It took place in the heyday of neoliberal politics, from which even Brazil did not escape unscathed and which led to scarce resources and shortages of capacity in the publicly financed health system. Immense challenges have to be faced when providing care in structurally weak and sparsely populated regions, for in the poor hinterland of the north-east and especially in the Amazon Basin, medical provision is unsatisfactory. Floating hospitals are one way to alleviate this situation but their penetration is limited by their very nature.

Lígia Giovanella, professor at the National School of Public Health in Rio de Janeiro (*see interview on page 22*) sees another fundamental problem, particularly in the cities: “The growing number of citizens with private supplementary insurance is leading to a new segmentation in the Brazilian health system.” One in four of Brazil’s almost 200 million citizens makes use of private complementary insurance today, two-thirds of them via their workplaces. Better earners do so to avoid the waiting lists and patchy availability of services in the public sector. However, they then place themselves at the mercy of a perfidious network of profit-oriented private insurers and providers, with vertical integration of financing and service provision. “Private insurance companies are in the luxurious position of not having to reimburse costly treatments,” explains Lígia Giovanella, “because they simply shunt many of these onto the SUS, which is ultimately open to all citizens.”

A more equitable tax system is unavoidable. A core problem for equitable financing is the tax system in Brazil, which continues to be regressive. High earners in particular practice tax evasion to place themselves beyond the reach of the fiscal authorities. Furthermore, a good 70 per cent of taxation revenue is attributable to indirect, particularly value-added taxes, which place a disproportionately higher burden on low-income earners than on the better off. “What we absolutely need is a fundamental tax reform”, comments Armando de Negri, health scientist and co-organiser of the international social forums in Porto Alegre. “An equitable health service cannot be financed by means of a socially inequitable tax system.”

In any case, the downturn in economic growth since 2014 and increasingly tight public budgets are undermining the stability of Brazil’s comprehensive social policy efforts. Its extensive social programmes have lifted many people out of poverty, but at the same time rising inflation threatens their chances of participation just as much as the financial viability of public measures. The social protests of recent years highlight the population’s growing dissatisfaction.

“Living well” in Bolivia, Ecuador and Venezuela. In principle, the left-wing governments in Bolivia, Ecuador and

Venezuela follow the Brazilian model of a tax-financed social health protection system. Unlike in Brazil, the health reforms in the three countries are part of a more comprehensive development model known as *Buen Vivir*. The right to “live well” is enshrined in their constitutions; it comprises the right to good nutrition, access to water, health and education, and is ultimately aimed at rejection of an economic order geared towards growth. Health reforms in the context of the *Buen Vivir* model go far beyond improvements to health financing and medical care, and assign overriding importance to the social determinants of health. An important approach in all three countries is the strengthening of primary health care. This is delivered predominantly in health centres, where doctors and nurses are also actively involved in shaping the arrangements for matters relevant to community health as well as caring for families locally. To guarantee everyone the same right not only to medical care but also to “live well” and not to exclude anyone is an objective that can only be met by means of tax funding, in the view of the left-wing governments. However, apart from Venezuela the oil exporter, where the recent election victory of the conservative opposition will call the previous social policy into question, it is not easy for the Latin American countries to free up the requisite resources.

Europe can learn from Latin America. The current reform efforts in hand almost everywhere in Latin America are aimed at alleviating the undesirable consequences of earlier reforms. A core wisdom of medicine applies equally to health policy: prevention is better than cure. Inequity and a two-tier system can only be overcome at what feels like a snail’s pace. But today the debate in Latin America revolves primarily around the right to health, and far less around market forces and competition in the health system than in Europe. Thus, Brazil has demonstrated above all else that comprehensive social protection need not delay economic growth in any way, as the debate in Germany about “ancillary” labour costs attempts to suggest, but can lead to the formalisation of employment and contribute to higher incomes. Latin American welfare systems can still undoubtedly learn a few lessons from the long experience of European institutions. In the meantime, however, those former European colonies can attest to some remarkable health policy experience and successes of their own. The growth of unstable and precarious labour conditions in Europe calls for new social policy strategies in the Old Continent, as well. Latin America has plenty to offer in this area – international cooperation need not be a one-way street. ■

“The Millennium Goals must still be pursued”

Ill health presents the greatest risk of impoverishment worldwide. To lower that risk, it will take robust health care systems and universal social health protection. This can only be accomplished through the international community's collective efforts, says **Hans-Peter Baur**.

How is Germany supporting the establishment of socially equitable health systems around the world?

Baur: We support partner countries in organising their health care in such a way as to make it accessible to all people and fairly financed. German funding supports programmes in which international experts work hand in hand with the local professionals and politicians in-country to establish health and social protection systems which are financially viable and adapted to the given conditions. Beyond this, Germany is also one of the biggest supporters of global initiatives in the health sector. We invest an annual total of around 800 million euros in relevant bilateral and multilateral activities.

What are the greatest obstacles to establishing socially equitable health care worldwide?

Baur: In most developing countries, the lack of qualified medical staff, inadequate supply of medicines, and underfinancing and, to some extent, poor organisation of the health sector constitute the greatest challenges. It is especially problematic that the access to life-saving medical care often depends upon income, which excludes sections of the population that are already disadvantaged.

What is necessary to overcome these obstacles?

Baur: Strong health systems and social health protection! For ill health presents the greatest risk of impoverishment worldwide. That is why many countries have opted for the objective of universal social health protection. Political will is a crucial factor here, as well as a long-term approach based on close cooperation between health, finance and other ministries. This course of action should receive coordinated support from the international community. For that reason, Germany and France founded the Providing for Health (P4H) network at the G8 summit in 2007. Additional partners are the World Bank, the World Health Organization (WHO) and the International Labour Organization (ILO). This network is the central coordination platform for investments targeted at universal social health protection.

Where are there signs of good progress so far?

Baur: Universal social health protection can only be achieved over a lengthier period of time. Good progress is already evident in a few countries: for example, Rwanda and the Philippines have achieved over 75 per cent coverage of their population. Ghana, Indonesia and Vietnam are achieving over 50 per cent. The Millennium Development Goals agreed by the international community in the year 2000 plotted a course for the health sector. Thanks to those collective efforts it was possible to reduce child and maternal mortality by 45 per cent, and we are well on the way to meeting the HIV/AIDS, malaria and tuberculosis

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targets. Mortality rates from AIDS and malaria, for example, could be reduced by 50 per cent and deaths related to tuberculosis by 45 per cent. Further efforts by the countries themselves and by the international community are essential, however.

Many countries did not achieve the Millennium Goals in the health sector by the 2015 deadline. How should they proceed?

Baur: Germany is strongly advocating universal access to comprehensive health care as an overarching goal of the 2030 agenda. It will take robust health care systems to achieve this. The Millennium Goals must still be pursued, particularly in the countries of sub-Saharan Africa and South Asia, where some goals were not achieved despite major strides in the right direction. That's why the German Federal Ministry for Economic Cooperation and Development launched the special programme “Health in Africa”, which it funds with 600 million Euros in the next four years. ■

Health in focus

GLOBAL HEALTH is a special issue of the magazine „G+G – Gesundheit und Gesellschaft“ (Health and Society). G+G covers health-related topics ranging from politics and practice to research. It is published by the German health insurer AOK. The articles in this issue were first published in G+G in 2014. Their authors Jens Holst and Jean-Olivier Schmidt are experts on health topics and social protection and work for the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). They have reviewed and updated the articles for this special publication.



Health is a core competence of the **Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)**, which operates in more than 130 partner countries worldwide. Drawing upon decades of first-hand experience in the field of health in many of these countries, GIZ is presently advising some 80 countries in Africa, Asia, Latin America and increasingly in Europe on health-related matters. Its main client is the Federal Ministry for Economic Cooperation and Development (BMZ). GIZ and its business division, GIZ International Services (GIZ IS), also work for other national and international customers and partners, like the European Union and the World Health Organization (WHO), and with the private sector in over 15 countries and in a growing number of regional and global projects. GIZ is a designated WHO Collaborating Centre for Health Systems Strengthening.

Bilateral, multilateral and regional cooperation covers a wide range of topics, such as:

Preventing and tackling disease

- Infectious and non-communicable diseases
- Nutrition
- Climate change and health
- Pandemic preparedness

Addressing health across the lifecycle

- Sexual and reproductive health and rights
- Maternal, newborn and child health
- Adolescent health
- Health promotion and demographic changes

Improving systems and structures

- Health systems development and strengthening
- Health workforce
- Health financing
- Systemic quality improvement
- Hospital management

Working together for health

- Health partnerships

GIZ employs approaches aimed at all levels of health systems and of societies – from national and international agenda setting and policy advice in partner countries, to targeted interventions, such as improved access to services and promoting community involvement in addressing local health challenges. Throughout, it places emphasis on capacity development, quality and sustainability.

Approaches are sector-wide, systemic, cross-cutting and often transnational. Projects and programmes implemented by GIZ take political, economic, social and ecological factors into account. They are culturally appropriate, gender-sensitive and inclusive; dedicated to improving cooperation between donors, institutions and organisations; and committed to improving the access of women and girls, the poor and the most marginalised groups to quality health services.

Further information about GIZ's health portfolio is available at:

www.giz.de/health | www.giz.de/international-services | www.health.bmz.de