

Social health insurance in developing countries: A continuing challenge

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This paper addresses the issue of the feasibility of “social” health insurance (SHI) in developing countries. SHI aims at protecting all population groups against financial risks due to illness. There are substantial difficulties in implementation, however, due to lack of debate and consensus about the extent of financial solidarity, problems with health service delivery, and insufficient managerial capacity. The transition to universal coverage is likely to take many years, but it can be speeded up. Adopting a “family” approach to financial protection, sustained financial support from governments and donors, and deconcentrating the development of SHI may slash several years from the time needed to achieve full universal protection against healthcare costs.

Healthcare expenditure has risen drastically, from 3 per cent of world gross domestic product (GDP) in 1948 to 7.9 per cent in 1997.¹ However, this has certainly not been accompanied by an equally drastic improvement in universal coverage. Scarce economic resources, modest economic growth, constraints on the public sector and low institutional capacity explain why design of adequate health financing systems in low-income developing countries remains cumbersome and the subject of significant debate.²

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¹ WHO, 2000: World Health Report 2000-Health systems: Improving performance. Geneva, World Health Organization.

² Low-income developing countries are defined as having a gross national product per capita of US\$ 760 or less.

User fee schemes were often established as a first response to lack of public finance. Many studies have warned decision-makers, however, that user fees can have a negative effect on the utilization of care,³ especially among the poorest.⁴ If greater equity remains a key health policy goal, more public involvement will be needed in the financing and organization of healthcare. An important step forward is to develop health systems that are financed via general taxation revenues and/or health insurance contributions, and that pool risks. These health financing mechanisms separate utilization from direct payment, and thereby can ensure access to health care, even for the most vulnerable groups.

Health financing via general taxation will not be easy, especially in low income developing countries, owing to a limited tax base and a low organizational capacity to enforce tax compliance or to avoid extensive tax evasion. Health insurance, whether it is organized at the national level, on a voluntary basis or at community level, is not without its problems either. Still, there is currently a heavy interest in health insurance schemes. One important feature is that these do not put the whole financing burden on government, but instead spread the total cost of insured health care among various partners. This may partly explain why government policymakers nowadays seem to have a greater interest in health insurance. Also, international financial institutions and donors increasingly admit health insurance to the array of feasible health financing mechanisms they approve of, and this in a more explicit way than was the case a decade ago.

In this paper, we will specifically address the issue of the feasibility of “social” health insurance in developing countries, with its intention basically to involve all population groups. In the next section, we first address the concept of social health insurance, and then discuss implementation issues using experience principally but not exclusively from Asia. Several factors that obstruct a smooth path to fully fledged social health insurance will be discussed. In the third section, we ask whether there is a fast track to universal coverage, or at least faster than one would anticipate. This question is especially relevant for low-income developing countries, for which long periods of transition to universal coverage have been predicted. Concluding remarks are presented in the final section.

³ World Bank, 1994 : “Pour une meilleure santé en Afrique”, in *Findings, Région Afrique*, No. 25. Washington, DC.

⁴ B. McPake, 1993: “User charges for health services in developing countries”, in *Social Science and Medicine*, Vol. 36, No. 11.

Social health insurance: From concept to implementation

The concept

Social health insurance (SHI) pools both the health risks of its members, on the one hand, and the contributions of enterprises, households and government, on the other. Contributions from households and enterprises are usually based on income, whereas government contributions are mostly financed from general taxes. Social health insurance answers to the objective of universal coverage, whereby a set of basic healthcare services is accessible to all, irrespective of income or social status. SHI is therefore clearly different from user fee or direct payment schemes, in which the user only is responsible for the payment of his or her medical treatment. SHI shares its characteristic of pooling of risks and contributions with health financing via general taxation (GT). An important difference, however, is that in the GT method, people do contribute but only in an indirect way via general taxes. That is why it is also said that in SHI the insurance is explicit, since people are directly aware, via their social health insurance contributions, that they are the insured members. In GT, the insurance can be called *implicit*.⁵

In principle, SHI involves compulsory membership. In this way, it steers clear of the pitfalls of health insurance on a voluntary basis. First, it avoids certain population groups, such as the poorest and most vulnerable, becoming excluded. Exclusion can arise in a voluntary scheme because of lack of political interest in including the vulnerable, or because the poorest simply do not have the capacity or willingness to pay the proposed health insurance contributions.

Second, compulsory insurance by its very nature also inhibits “adverse selection”. The latter occurs in a voluntary framework when people in good health judge the health insurance contributions to be too expensive, and choose not to insure. Voluntary insurance may as a result become overburdened by insured persons with medium to high health risks. Adverse selection and its impact on costs and health insurance contributions may even lead to the discontinuation of voluntary insurance: because of the bad risks, contribution levels may rise so high that the health insurance package offered finally stops attracting the remaining potential members.

⁵ See the *World Health Report, 2000*, op. cit.

Difficulties in implementation

SHI is recognized to be a very powerful method for granting the population access to health services in an equitable way. Around half of the industrialized countries have chosen social health insurance as their health financing system. In contrast, in 1998, not one developing country with a gross national product (GNP) per capita below US\$ 761 had a social health insurance scheme. Among the lower middle-income countries (with a GNP per capita between US\$ 761 and US\$ 3,030), the only country with a fully fledged social health insurance scheme was Costa Rica.

A number of developing countries are certainly planning to introduce health insurance, or to further extend the system they started up. A worldwide overview and analysis of the plans and experiences are beyond the scope of this paper. We will refer, however, to two selected experiences in the Asian region. First, Viet Nam took the bold step of initiating a social health insurance scheme in 1992.⁶ It is basically compulsory for workers and civil servants, and voluntary for the population in the agricultural and non-formal sectors. Second, China has been trying, since 1994, to establish a decentralized rural health insurance system.⁷ The idea of rural health insurance was a response to the ever increasing problem of access in China, as a result of the breakdown of its former barefoot doctor system. Below we discuss some of the main hurdles in health insurance development, as experienced by the Vietnamese scheme and the Chinese rural scheme. This information should lead to a better insight into the factors that should be improved upon in the implementation of SHI in other developing countries.

Four main reasons for implementation difficulties may be invoked.

First, it may be particularly difficult to arrive at a consensus on the part of the population to accept the basic rule of SHI, which is to guarantee similar health service benefits to those with similar healthcare needs, regardless of the level of contributions made. In fact, this problem is very acute when countries prove to have a significant inequality of incomes and assets. Should SHI seek a contribution in the form of a percentage of income, contributions will obviously differ substantially across households. In China, for example, the highest and middle incomes of a household at village level may easily be ten and five times the lowest income, respectively. Theoretically, then, the former

⁶ For an overview of Vietnamese health insurance, see A. Ron, G. Carrin and Tran Van Tien, 1998: "Viet Nam: The development of national health insurance", in *International Social Security Review*, Vol. 51, No. 3.

⁷ In China, these are known as the rural cooperative medical schemes and are run at county or township level. See G. Carrin, A. Ron and Yang Hui et al., 1999: "The reform of the rural cooperative medical system in the People's Republic of China: Interim experience in 14 pilot countries", in *Social Science and Medicine*, Vol. 48, No. 7.

should pay, respectively, ten and five times as much. In practice, this proves to be too much to ask of middle and higher income households. Policymakers may thus be forced to take account of some limit in society on the degree of solidarity across socio-economic population groups.

If financial solidarity is so hard to achieve within one village, it may be even harder to accomplish across villages, certainly when health insurance is voluntary. Imagine geographically separated villages in the mountainous areas of one of the low-income provinces of China, such as Jiangxi. The populations of these villages may hardly know each other. Moreover, some villages may be somewhat better off economically than others. It is quickly understood by the population of those villages that part of their contributions might well serve to cross-subsidize the even poorer and perhaps sicker population in other villages. Add the fact that at least some part of the population in the better-off villages may associate poverty with unwillingness to work, thereby blaming poverty on the poor themselves. In such circumstances, and given that health insurance is voluntary, solidarity is hard to achieve. Still, one may hope that solidarity improves with economic development spread out relatively equally over regions and villages. In such a setting, people may come to have more “room” to share resources.

Second, SHI schemes need to assure their members that they will in fact receive the promised health insurance benefits. This implies that the health services that are part of the health insurance benefit package need to exist or be created by the health insurance funds. It is evident that the health services infrastructure, the human resources and the other necessary components of health services, such as drugs and laboratory examinations, all need to be available in order to produce adequate health services. If health services cannot be delivered, it makes little sense to start an SHI scheme. If a government still goes ahead with such a scheme, it will quickly find out that the trust of the population disappears, leading to non-compliant behaviour such as a refusal to pay scheduled health insurance contributions.

Another situation may arise when services are in principle available but providers do not comply with the newly introduced SHI system. One major reason for non-compliance may be providers' uncertainty about the impact of health insurance on their incomes. This lack of collaboration was initially observed in Viet Nam, where some doctors even refused to give health services to insured patients. The main reason was that doctors hoped to continue to receive under-the-table payments (as compensation for the meagre level of their official salaries). However, health insurance members thought that once they had paid their health insurance contribution, they no longer needed to give such payments to doctors. When doctors anticipated this new attitude, some indeed did not want to treat the insured patients.

Third, governments may not yet have the necessary managerial or administrative capacity to design a health insurance scheme and then to implement it.⁸ Health insurance management has a greater chance of success, though, when it has a good grasp itself of the basic principles of health insurance. In turn, health insurance management can then explain these principles to the population. For example, it can explain to its members that a number of them, the very healthy, may not always “benefit” regularly from the insured health services, simply because they have no need for them. Even these so-called healthy members need to be convinced that, one day, they may come to suffer from a grave illness or accident, at which time they will then fully benefit from the scheme. One county health insurance scheme in the Chinese province of Zhejiang, for example, had problems with its citizens not accepting this long-term view of insurance. The scheme’s management thought that members would be lured into it by severely reducing health insurance contributions, hoping that low contributions would make health insurance very attractive. But in doing so, management fell into another trap: the reduction of contributions led to such a severe drop in the level of insurance protection (the insured part of the cost of health services amounted to a mere 8 to 10 per cent, implying a copayment of 90 to 92 per cent!) that members concluded it was no longer worth insuring.

In many cases, governments cannot introduce compulsory membership for all population groups right away, but start by insuring salaried workers in the public and private sectors. Usually health insurance contributions are levied on wages. Information on wages should in principle facilitate the collection of these contributions. However, there always remains the risk of low compliance with agreed contribution rules and other arrangements, certainly at the start of a health insurance scheme. This is why monitoring by the scheme itself of members’ wages and contributions is indispensable. In one province in Viet Nam, a chapter of a bank stated that all employees, from the senior manager to the janitor, had the same nationally defined minimum wage. Obviously this led to a serious underestimation of the contributions that were due. One explanation for this behaviour is that the required solidarity and the level of health insurance contributions exceeded what the population would accept, which made both employers and employees misrepresent reality. Still, enrolment of the population in the agricultural and informal sectors is likely to be even more difficult. Income for this population fluctuates and spontaneous willingness to declare true income and pay regular contributions is low. Often, then, health insurance remains voluntary for this group. This means that in order to secure or increase enrolment, extra marketing efforts are needed. In

⁸ The need for administrative capacity is stressed by Aviva Ron in “New strategies for the formal sector: Focus on Vietnam and Zimbabwe”, in A. Ron and X. Scheil-Adlung (eds.), 2001: *Recent health policy innovations in social security* (chap. 2). New Brunswick, NJ, Transaction Publishers; Geneva, ISSA.

many Chinese counties, this need for effective marketing was not yet well understood. In many rural cooperative medical schemes, there was a drive by management to sign up members, but only once a year on one particular day. People that wanted to sign up later were no longer admitted. This rigidity made them lose many potential members.

Fourth, many social problems may not be discussed openly, which is a particular problem in countries with a low degree of political freedom. In China or Viet Nam, there do exist forums for discussion, and there is often heavy debate at lower levels of government and in villages. However, open political and scientific debate at the highest level is needed in order better to assess the bottlenecks but also the opportunities. In both countries, one has also seen reluctance on the part of government to take strong policy views on social health insurance principles. In the meantime, the population may have particular demands for social protection but experience difficulties in transmitting these to government. One understands therefore that the lack of political debate may delay the development of social health insurance.

*Factors that facilitate the transition
to social health insurance: A summary*

From the difficulties encountered, one also learns about the factors that would facilitate the transition to social health insurance. Indeed, “learning by doing” should be an important way of working in the development of social health insurance. As Confucius said, “Learning without thought is labour lost; thought without learning is perilous”.

A first factor then is the general *level of income*. More income means, *ceteris paribus*, better capacity to pay health insurance contributions. Second, it is essential that there exist sufficient *administrative capacity* to run health insurance. While this is a requirement in its own right, it is heavily linked to the *structure of the economy*. What is relevant, indeed, is the relative size of the formal and informal sectors. The larger the informal sector, the greater the administrative difficulties in assessing incomes, setting the health insurance contributions of informal sector workers, and collecting contributions. Third, an essential characteristic identified is the level of *solidarity* within a society. However, it becomes very difficult to pool resources when society is already quite unequal from the start. Finally, another essential determinant of achieving universal coverage is the extent to which the population has a *voice* in social policymaking. Open political debate is necessary to move ahead, and for the population to have some trust in the government effectively to engage in a process of health insurance development. It is therefore essential that any existing trade unions, for example, have opportunities to make their demands

for healthcare coverage clear to government. Very worrying, however, is the large informal sector population in many developing countries,⁹ which is usually too unorganized to communicate with the government about its needs. Even in democracies, the voice of this particular population group is generally quite *weak*, as it has few skills in lobbying and few sponsors in advocacy.

One further issue is related to the level of income that is needed to proceed with SHI. It is in fact very difficult to define an absolute income threshold below which it would be very hard to progress. To illustrate this, note that several lower middle-income countries either have developed a scheme (Costa Rica) or are developing one (Colombia) or are studying an appropriate design (Jamaica). Another low-income country, Mongolia, is establishing a SHI scheme. We certainly admit that a significant effort would have to be undertaken, especially by low-income countries, to embark on social health insurance. But there are facilitating factors. Income growth will, *ceteris paribus*, facilitate SHI development. In addition, we hypothesize that several factors, especially solidarity and voice, may compensate at least partially for a relatively low level of economic resources. In other words, steady political action that is rooted in society's feelings of solidarity and responsive to population demands for better protection may well trigger advances in social health insurance, despite a modest income level. Similarly, solidarity and voice may be a support to decision-makers in overcoming administrative obstacles to initiate SHI.

Time implications: What does history tell us?

Time may be needed to fulfil the conditions discussed above and, hence, to reach universal coverage. In another paper,¹⁰ predictions were made that it would take another 35 to 50 years for Viet Nam to achieve universal coverage. For China, the prediction is not that different. For low-income African countries with a GDP per capita of less than US\$ 1,000, such as Zambia,¹¹ the prediction was 45 to 50 years before reaching universal coverage. These predictions were based, however, on historical world experience and therefore could be labelled "conservative".

⁹ It is reported that in developing countries, in the early 1980s, 20 to 70 per cent of the urban labour force was engaged in informal sector activities, the average being around 50 per cent. See M. P. Todaro, 1997: *Economic development in the third world*. New York, Longman.

¹⁰ G. Carrin and C. James, 2002: "The determinants of universal coverage: An empirical analysis". Forthcoming in CERDI, *Financement des systèmes de santé dans les pays à faible revenu d'Afrique et d'Asie*. Paris, Khartala.

¹¹ In 1997, Zambia had a GDP per capita of US\$ 857.

From a strict historical perspective, however, the projections may be qualified as plausible. They may even look optimistic, compared with experiences in countries like Germany, which took basically a century to develop its SHI system. Its first sickness law was passed in 1883, covering about 10 per cent of the population from the start.¹² The coverage rate proceeded to 35 per cent in 1914 and 88 per cent currently.

Another historical reference point is experience in the Republic of Korea (ROK). The compulsory health insurance programme was introduced in 1977, and universal coverage was achieved after a mere 12 years, in 1989.¹³ However, the years 1977-89 were preceded by a voluntary programme period between 1965 and 1977. In turn, the latter programme was started after the enactment of the statutory Health Insurance Act in 1963. Hence, one may say it took the ROK 26 years to achieve universal population coverage from the inception of the 1963 Act. It should be highlighted, however, that a major explanatory factor for this relatively fast transition was that during the period 1977-89, the ROK benefited from an average annual growth rate in GNP per capita of 13.3 per cent. Such a rapid growth led to job creation and increased household, enterprise and government revenues, which enhanced the capacity to contribute to health insurance. In this particular case, fast income growth may have compensated, among other things, for the lack of voice, as the ROK had an authoritarian government during most of this period.

The predictions for Viet Nam and China imply a longer transition period to universal coverage than that of the ROK. Fortunately, however, Viet Nam and China do not start from zero: by 1997, 13 per cent of the Vietnamese population had been covered by social health insurance;¹⁴ in China, about 10 per cent of the rural population was insured in 1993.¹⁵ A capital question, however, is whether they will yet again take several decades before reaching “full” population coverage. The major challenge in these countries, as in many others, is usually how to further include the rural and informal sector population in a universal coverage plan via SHI.

¹² For a detailed analysis of the social and economic history of the German health insurance system, from its start until the early 1980s, see H. Zöllner, 1982: “Germany”, in P. A. Köhler and H. F. Zacher (eds.), *The evolution of social insurance 1981-1991*. New York, St. Martin’s Press.

¹³ Moon, Ok Ruyen, 1998: “The Korean health insurance programme”, in S. Nityarumphong and A. Mills (eds.), *Achieving universal coverage of healthcare*. Nontaburi, Office of Healthcare Reform, Ministry of Public Health.

¹⁴ See A. Ron, G. Carrin and Tran Van Tien, 1998, op. cit.

¹⁵ WHO, 1999: *World Health Report 1999-Making a difference*. Geneva, World Health Organization.

Can history be beaten?

Of course, if it were possible for countries to improve upon the various facilitating factors all at once, the pace towards universal coverage via SHI would surely be much faster. But realistically speaking, many countries may have to wait for this “golden” basket of more income growth, adequate administrative capacity, a more formal economy, less inequality, and more voice for the population. So, is there really no way to beat history? One of the ways whereby faster enrolment could be achieved is to advocate and apply the “family” approach to health insurance.¹⁶ Instead of insuring only the worker or farmer, as is the case in Viet Nam and China, why not ensure his or her family as well? It may be less hard to do than one thinks, provided family contributions are made attractive and the promised healthcare delivered. As soon as child or maternity healthcare is needed and insured, families will be pleased with health insurance. An immediate criticism, however, may be that this will become too expensive for families. Indeed, the family contributions would need to reflect the costs of family care. However, most of them are already spending an important contribution of their income on healthcare. It has to be explained to families that health insurance contributions would basically replace the out-of-pocket payments, while enabling better protection against expensive healthcare costs.

We know that families are not alone in financing social health insurance, however. The role of government in cofinancing remains, especially to support the weaker groups and to cofinance their health insurance contributions. Colombia is an example of a country where this families approach was used at the same time as the government continued to cofinance the contributions of the vulnerable population. It managed to increase its coverage from 13.4 per cent in 1993 to 52.6 per cent in 2000.¹⁷ There is also a new proposal for international donors to support health insurance development. They could contribute to the financing of the health insurance membership of the poor as well. But such sponsorship should also have a built-in weaning plan.

A further opportunity for moving faster is to deconcentrate the development of SHI. Indeed, it takes a lot of administrative time and monitoring for the central administration to run social health insurance at regional or district level. This may be especially so for low-income developing countries. It may be good, therefore, to invite communities to start up local

¹⁶ Aviva Ron has brought this to my attention.

¹⁷ J. L. Londoño, 2000: *Managing competition in the tropics* (IDB Workshop on Comparative Study on Health) (draft).

health insurance schemes.¹⁸ Moreover, communities may have more confidence in local management. They may also have greater control over such schemes.

But let us be immediately aware of the pitfalls. Internationally reported experience¹⁹ shows that few of these schemes covered large populations or even high proportions of the eligible population. Another conclusion was that very few schemes reached the vulnerable population groups that in principle should be able to benefit significantly from health insurance. It will therefore be an important task for government, generally from the central level, to develop a suitable policy towards such schemes, facilitating their creation and replication,²⁰ yet steering them towards an adequate health insurance design. In addition, government should pay attention to the gradual integration of local insurance initiatives into a country's social health insurance system, as this will generate improved risk sharing among the population. For the same reason, government should also stimulate networks or alliances of local insurance schemes. Some form of national guidance is needed to achieve minimum benefits and portability, pass on lessons learned, and maybe share some data processing and improve pooling if possible.

Central government regulation is also needed in the case of decentralized government-initiated schemes. A case in point is the Rural Cooperative Medical System (RCMS) in China, which is run on a decentralized basis but badly needs strong guidance from the central government about the degree of protection and the inclusion of the low-income population. The experience has been that too many counties did not have clear targets for their RCMS, and therefore came to a standstill.

Thus, so far we posit that the combination of family health insurance, enhanced government and donor co-financing and regulated decentralization is likely to slash several years from the above-mentioned "conservative" estimates of the length of transition.

At this stage it is important to refer to the international macroeconomic environment, as this may help determine countries' path to SHI. Indeed, an important issue raised is whether the new international General Agreement on

¹⁸ See D. M. Dror and C. Jacquier, 1999: "Micro-insurance: Extending health insurance to the excluded", in *International Social Security Review*, Vol. 52, No. 1. The authors introduce the concept of "micro-insurance" in the context of extension of health insurance to the hitherto excluded.

¹⁹ See for example S. Bennett, A. Creese and R. Monasch, 1998: *Health insurance schemes for people outside formal sector employment* (WHO/ARA/CC/98.1). Geneva, World Health Organization; and W. van Ginneken (ed.), 1999: *Social security for the excluded majority: Case studies of developing countries*. Geneva, International Labour Office.

²⁰ W. van Ginneken, 2001: "Health protection for informal sector workers: New approaches to a long-standing problem", in A. Ron and X. Scheil-Adlung (eds.), op. cit. (chap. 3).

Trade in Services (GATS) of the World Trade Organization would not stand in the way of social health insurance development. One question, for instance, is whether the presence of international private insurance companies in domestic markets would not jeopardize the important objective of pooling of SHI, by insuring selected occupational groups only.²¹ However, GATS seems to have built in a safeguard, in that countries are permitted to strictly regulate private insurance companies. Regulation could include strict rules to prohibit risk selection. One GATS provision even suggests that in view of a country's felt necessity to protect human health, social health insurance laws could be entitled to exemption from GATS requirements in free trade of insurance services. There is a caveat, however, in that the country invoking this exemption will be subjected to severe tests regarding the necessity to protect human health in this way.²² In any case, one will need to watch closely in the following years whether GATS is sufficiently respectful of a country's choice to pursue SHI.

Concluding remarks

Universal coverage, involving risk sharing between all population groups in a community or a nation, ultimately remains a laudable goal. It will take a lot of political will to extend coverage, including for the poorest population groups. The population's voice as well as feelings of solidarity will have to bolster a political drive towards universal coverage. SHI with cofinancing from several partners is one important option currently being explored by several governments of developing countries. Compared with the health financing method of general taxation, SHI spreads the direct burden of financing among various partners. These groups usually include employees, self-employed workers and enterprises. They are not the only ones, however, that should be held responsible for health financing. Indeed, extension of coverage could be facilitated through sustained financial involvement from government and donors. Communities may also become partners in social health insurance development, via the establishment of local insurance schemes.

It would also help if economic growth were spread more equitably within countries. Furthermore, through poverty reduction policies, more people could step out of poverty, so that willingness and capacity to contribute to SHI could be enhanced. There should in fact be a lot of synergy between SHI, on the one hand, and poverty reduction and growth on the other. Indeed, SHI will ultimately result in better access to basic healthcare services, which should

²¹ Given the for-profit nature of these companies, this "risk selection" is predictable.

²² For a detailed discussion on GATS and health insurance, see especially D. Lipson, 2001: *GATS and trade in health insurance services*. Background note for the WHO Commission on Macroeconomics and Health (Working Group No. 4). Geneva, WHO/HSD.

further contribute to improved health status. In turn, the latter is bound to stimulate growth and poverty reduction. In this context, it should be noted that one of the objectives of the World Bank in the health, population and nutrition sector is to help client countries secure sustainable health financing by, among other things, establishing broadbased risk pooling mechanisms.²³ In other words, it faces the challenge of truly facilitating the development of social health insurance in those countries that decide to opt for this health financing method. It could also influence discussions in GATS to permit countries to exercise important autonomy in health financing policy.

It is realized, however, that time and tedious discussions may be needed before reaching overall population coverage via SHI. The establishment of the appropriate institutions will also require time. However, countries that have decided to embark on social health insurance should not invoke this argument to justify standing still, but are invited to take well-planned steps towards a workable social health insurance structure. Low-income developing countries especially may want to adopt a scenario with a role for locally run health insurance schemes. In any case, all along these steps, mistakes are likely to be made. These cannot always be avoided. But, more importantly, one should learn from them to speed up the implementation of social health insurance. The advice from Confucius is to the point: “Our greatest glory is not in never falling, but in rising every time”.

²³ World Bank, 1997: “Sector strategy: Health, nutrition and population”, in *The human development network* (summary). Washington, DC. See also <http://www.worldbank.org/whatwedo/strategies.htm>